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Dorset Police

• Infectious and Parasitic Disease Policy and Procedure

Reference No.	**P29:2009**

Implementation date	**September 2010**
Version Number	**1.10**

Linked documents	
Reference No:	**Name.**
P22:2004	Health and Safety Policy and Procedure
P18:2000	Clinical Waste and Infection Control Policy
P12:2006	The Control of Substances Hazardous to Health Regulations 2002 (COSHH)
	The Management of Health and Safety at Work Regulations 1999 (MHSW)

Suitable for Publication	
Policy Section	**Yes**
Procedure Section	**Yes**

PRINTED VERSIONS SHOULD NOT BE RELIED UPON. THE MOST UP TO DATE VERSION CAN BE FOUND ON THE FORCE INTRANET POLICIES SITE.

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1 Policy Section

1.1 Statement of Intent – Aim and Rationale

1.1.1 This policy, depending on the individual circumstances can apply to both the Chief Constable as the employer of Police Officers and Police Staff and the Office of the Police and Crime Commissioner as the employer of staff employed by them. Where the phrase ''Dorset Police'' is stipulated, this policy may apply to the Chief Constable or the Office of the Police and Crime Commissioner, or potentially both acknowledging that they are in their own right separate corporations sole and both have legal responsibilities under the Health and Safety At Work etc. Act 1974.

1.1.2 The purpose of this document is to bring to the attention of staff the health issues concerning infectious diseases (biological hazards) and parasitic complaints, with the primary purpose of informing and reassuring staff of the perceived level of risk of contracting an infection through a work related activity.

1.2 Police Mission

Our **Mission** for policing is:

To make communities safer by upholding the law fairly and firmly; preventing crime and antisocial behaviour; keeping the peace; protecting and reassuring communities; investigating crime and bringing offenders to justice.

The **Values** of Dorset Police are detailed within the Code of Ethics. We are committed to the nine principles which underpin and strengthen the existing procedures and regulations for ensuring standards of professional behaviour for both police officers and police staff. Respect for Human Rights will be central to everything we do.

Our **purpose** is to work towards a "Safer Dorset for you"

National Decision Model

The National Decision Model (NDM) is the primary decision-making model used in Dorset Police. The NDM is inherently flexible and is applied to the development and review of all policy, procedure, strategy, project, plan or guidance. Understanding, using and measuring the NDM ensures that we are able to make ethical (see Code of Ethics), proportionate and defensible decisions in relation to policy, procedure, strategy, project, plan or guidance.

Code of Ethics

The Code of Ethics underpins every policy, procedure, decision and action in policing today. The Code of Ethics is an everyday business consideration. This document has been developed with the Code of Ethics at the heart ensuring consideration of the 9 Policing Principles and the 10 standards of professional behaviour. Monitoring is carried out through the Equality Impact Assessment process which has been designed to specifically include the Code of Ethics.

1.3 People, Confidence and Equality

This document seeks to achieve the priority to make Dorset feel safer by securing trust and confidence. Research identifies that this is achieved through delivering services which:

1. Address individual needs and expectations
2. Improve perceptions of order and community cohesion
3. Focus on community priorities
4. Demonstrate professionalism
5. Express Force values
6. Instil confidence in staff

This document also recognises that some people will be part of many communities defined by different characteristics. It is probable that all people share common needs and expectations whilst at the same time everyone is different.

Comprehensive consultation and surveying has identified a common need and expectation for communities in Dorset to be:-

- Listened to
- Kept informed
- Protected, and
- Supported.

2 Standards

2.1 Legal Basis

2.1.1 The Health and Safety at Work Act 1974 places a general duty on employers to ensure so far as is reasonably practicable the health, safety and welfare of employees at work and other persons who could be affected by the employer's work activities (risk of cross infection through inappropriate hygiene arrangements etc.).

2.1.2 The Control of Substances Hazardous to Health 2002 as amended place specific obligations on employers when working with hazardous substances (bodily fluids) in the workplace. The purpose is to ensure that hazards are being correctly managed to reduce any risk of cross infection so far as is reasonably practicable. Employers are obliged to undertake an assessment where there is a risk to staff from biological hazards. (See paragraph 5).

2.1.3 The Management of Health and Safety at Work Regulations 1999 require employers to make a suitable and sufficient assessment of the risks to which their employees could be exposed to whilst at work. Assessments must be reviewed and updated as necessary. Only significant risks need be recorded, e.g. potentially harmful viruses.

2.2 People, Confidence and Equality Impact Assessment

During the creation of this document, this business area is subject to an assessment process entitled “People, Confidence and Equality Impact Assessment (EIA)”. Its aim is to establish the impact of the business area on all people and to also ensure that it complies with the requirements imposed by a range of legislation.

2.3 Monitoring / Feedback

The HR Specialist Officer, Health & Safety, will be responsible for overseeing this procedure to ensure a consistent Force approach is maintained. Monitoring will be primarily carried out subject to Force processes of continuing review.

Feedback relating to this procedure can be made in writing or by e-mail to:

Address: Andy Cole, Health and Safety Manager, Alliance People Department, Devon and Cornwall Police, Exeter, Devon, EX2 7HQ

E-mail: andy.cole@devonandcornwall.pnn.police.uk

Telephone: 01392 226765

3 Procedure Section

3.1 Introduction

3.1.1 An infectious or communicable disease is caused by a biological agent such as by a virus, bacterium or parasite entering the body. Infectious diseases are the invasion of a host organism (humans etc.) by a foreign replicator, generally microorganisms, often called microbes that are invisible to the naked eye. Microbes that cause illness are also known as pathogens. An infectious disease is termed *contagious* if it is easily transmitted from one person to another. In infection, the infecting organism seeks to utilize the host's resources in order to multiply (usually at the expense of the host). Zoonotic diseases are infectious diseases of animals that can cause disease when transmitted to humans.

3.1.2 Contraction of infectious diseases generally takes place either through social behaviour or occupational contact. Social contact risks are predominantly related to intravenous drug misuse and sexual activity. Occupational contact is related to workplace related health tasks.

3.1.3 Well-known examples of biological hazards include blood borne virus (BBVs) such as human immunodeficiency virus – HIV, hepatitis B (HBV) and hepatitis C (HCV) virus. Parasites, bacteria, fungi and prions also come within the term of biological hazard.

3.1.4 The means of transmission (the means by which the virus is transported) of diseases can be via various routes e.g. blood, blood products, urine, vomit, faeces, sweat, sputum, semen and vaginal fluid. The quantity, the environment and age of the bodily fluid are important factors to consider when deciding on the appropriate level of risk. Blood carries the highest risk of potential cross infection.

3.1.5 The route of transmission (the means by which the virus travels) can be varied and range from sneezing, coughing, blood soaked clothing, breaks in the skin's surface, puncture of the skin (needles), unprotected sex and human bites that break the skin etc.

3.1.6 The risk of transmission through human bites that break the skin, spitting in the eye and mouth are exceedingly low. The risk through spitting is heightened but is still very low if the sputum contains blood.

3.1.7 Parasitic infestations involve the invasion of a host (the human body). Parasites derive nourishment (blood) from the body. They are spread by direct contact with an infected person, their linen, clothing, brushes etc. They pose no threat to life and simple remedies eradicate them.

3.1.8 Staff who believe that they may have come in contact with a known or possible carrier of an infectious disease or a parasitic complaint must refer to appendix 'A' for appropriate action and advice.

3.1.9 Occasions may arise where staff may wish to consider retaining a syringe or like object for possible evidential purposes. On such occasions the item must be placed inside either a secure approved sharps container or an approved screw operated plastic exhibits container. It is generally not viable to retain a syringe for pathological analysis.

3.2 *Risk Assessments*

3.2.1 The employer is obliged to undertake an assessment under either 'The Control of Substances Hazardous to Health Regulations 2002' (COSHH) or the 'The Management of Health and Safety at Work Regulations 1999' (MHSW). There is no need to repeat the process by carrying out two assessments to satisfy both sets of regulations.

3.2.2 In most situations an assessment carried out under the Management Regulations using form A48 will be sufficient to satisfy the legal requirement. The assessment must contain the potential hazard of infectious diseases, the appropriate control measures employed to either avoid or mitigate the risk and that it is annually reviewed and updated as appropriate.

3.2.3 Roles where the risk of exposure to an infectious disease is assessed as a significant potential foreseeable hazard, individual role risk assessments must reflect this potential hazard and state the measures taken to either avoid or mitigate any risk.

3.2.4 The Health and Safety Business Support Teams can advise managers where they have concerns as to whether an assessment under MHSW or COSHH would be appropriate to complete depending on the circumstances. In the majority of cases an assessment under MHSW will be sufficient.

3.2.5 In cases where it would be appropriate to complete an assessment under COSHH e.g. scientific support laboratory, reference must be made in the general risk assessment form A48 (undertaken under the MHSW) to the fact that a more detailed COSHH assessment was required and has been completed.

3.3 *Managers Responsibilities (Duty Holders)*

3.3.1 Managers (duty holders) who are responsible for staff who have been identified as working in the roles as listed at Appendix 'A', are to ensure the following arrangements are implemented:

- A copy of this policy is to be made readily available to every "at risk group" member of staff. Each member of staff is to be made aware of this policy and given the opportunity to read it and discuss with their line manager in the first instance and secondly, they can contact the Forces' Occupational Health provider if they have any concerns.

- At risk groups of staff are to be strongly encouraged to undergo any immunisation programme where deemed appropriate in this policy. A written record of such advice given is to be placed on the individual's personal record.

- Staff who are to be appointed into an "at risk group" post are to be advised of this policy before commencing employment in that role so that they have the opportunity to seek further medical advice if they so wish.

3.3.2 The Force's contracted-in Occupational Health provider is available for advice and after-care treatment on telephone number: 01305 363800 (not available at weekends or Bank Holidays).

3.4 *At Risk Groups*

3.4.1 A minority of Force staff, because of the nature of the work they undertake, may be at slightly greater risk of contracting an infectious disease than the majority of Force staff. It must be stressed that the majority of infectious diseases are contracted through social behaviour rather than through occupational contact. Whilst the potential for infection is assessed as overall low, staff should be vigilant to the issues so that the risk remains low.

3.4.2 The level of risk to staff of contracting an infectious disease depends on the: frequency of exposure, the severity and length of the exposure the person is exposed to the harmful virus.

3.4.3 Low Risk - groups at no more risk than that of the general population or where no serious medical effects are likely.

3.4.4 Medium Risk - groups for whom exposure to potentially infectious material over and above the general population risk is possible or where moderate medical effects may be expected.

3.4.5 High Risk - groups who are frequently exposed to potentially infectious material, which they would be unlikely to encounter in everyday life, or where medical effects may be severe/life threatening, e.g. healthcare professionals, forensic, pathology and mortuary staff, tattooists, body piercers and refuse staff etc. Persons who have a challenged immune system

3.4.6 At Risk groups are listed for each disease at Appendix A.

3.5 Occupational Control Measures (measures to reduce not necessarily avoid the risk altogether)

Standard Precautions (previous term used - Universal Precautions)

- Be aware of the issues/inform (training, information and instruction);
- Treat all bodily fluids as being infected therefore, high risk;
- Avoid contact with potentially infectious material if possible;
- Cover cuts, wounds and abrasions with waterproof dressings;
- Wear disposable gloves (nitrile) where there is likelihood of exposure to blood or body fluids;
- After any exposure to blood or other body fluids thoroughly wash all potentially effected surface skin;
- Take the sharps container to the sharp and never attempt to re sheath needles;
- Follow correct office/room/cell cleaning procedures;
- Dispose of contaminated/clinical waste correctly;
- Follow correct laundry procedures;
- Good hand hygiene is very important.

3.6 *Immunisation*

3.6.1 Everyone should be immune to Tetanus. Specific at risk groups (refer to Appendix 'A') are encouraged to undergo vaccination against other diseases.

3.6.2 All "at risk" staff should have a card (example attached to this policy) giving details on action to take in the event of receiving a needle stick type injury. The card also contains telephone contact numbers when seeking advice.

3.6.3 At risk staff requiring immunisation should in the first instance seek assistance from their general practitioner (GP). The GP may provide immunisation free of charge but is not under any obligation to do so as the risk is work related.

3.6.4 Where the GP provides immunisation and wishes to seek reimbursement, the options are; an invoice is sent to Human Resources and payment will be made, or the person undergoing immunisation can pay the surgery directly out of their own pocket and later claim back the cost again through Human Resources on production of a receipt. If GPs are reluctant to provide immunisation regardless of cost concerns, arrangements can be made through the Human Resources Department for the individual to undergo immunisation through the Force's contracted in Occupational Health provider by contacting .occupational.health@nhs.net

3.6.4 The individual retains part 'A' of the Hepatitis card. It is the responsibility of the individual to ensure that they remain in date for any booster inoculations and that they may require. The medical professional will enter their immunisation status on the back for reference. Part 'A' should be carried at all times and presented to any medical staff when seeking treatment or advice.

3.6.5 There are rare occasions where persons are not able to build up a satisfactory level of protection despite having undergone two full courses of immunisation. It is important that the individual is aware of this and in the event of exposure to blood and bodily fluids that they attend A&E immediately for assessment as they may need to be administered with Hepatitis B immunoglobulin. Non-responders should try to avoid work situations where contact with blood of bodily fluids will knowingly take place or exercise caution through wearing needle resistant and or disposable gloves.

3.7 *Dealing with Body Fluids*

3.7.1 The safe removal and treatment of bodily fluids from impervious surfaces can be a simple low risk process providing the appropriate control measures are adhered to. Non-impervious surfaces, e.g. carpets, upholstery are difficult to clean and staff should ensure adequate disinfection has taken place. Textured surfaces too can be difficult to clean; particularly when faeces or other contaminate is either smeared across or present on the surface to be cleaned.

3.7.2 Simple but effective procedures covering the safe removal and subsequent treatment of a surface containing bodily fluids, parasitic infestations can be found in the Clinical Waste and Infection Control Policy P18:2000.

3.8 *Post Exposure Arrangements*

3.8.1 Taking the correct prompt action after exposure is very important. Exposure could take place through a needle stick injury, human bite, sputum containing blood, blood/blood contaminated liquid etc. entering through damaged skin or mouth/eye.

3.8.2 The following action must be taken immediately after exposure has taken place:

- Follow the actions on page 14 (Hepatitis B same as for HIV).
- Go immediately to your local A&E with the following information regardless of the time of day:-
- Can the source of the exposure be identified?
- Is the source a known IV drug misuser?
- Is there knowledge of the source's medical circumstances e.g. known or declared infectious medical conditions?
- Is the source's HIV status known?

3.8.3 If the source of exposure is believed to be from an HIV carrier, the A&E Department on the information provided to them by the affected person and after having undertaken a careful and thorough assessment may prescribe prophylaxis treatment (anti-viral medication). Prophylaxis treatment must be administered within 72 hours from exposure. A&E will prescribe sufficient medication for an extended weekend period if required. A&E will then make a referral to a Genito Urinary Medicine Clinic (GUM clinic). The GUM clinic is the primary medical aftercare provider. At the GUM clinics discretion only, individuals may be referred to the Force's Occupational Health provider for medical aftercare which will take the form of blood tests and advice. GUM clinics offer a professional, friendly, confidential, sympathetic and discreet service. It is appreciated that a GUM clinic environment may not be conducive to Policing. Staff have the option of using a GUM clinic located elsewhere in the County. Prophylaxis, anti-viral medication does have the potential to cause serious side effects and will therefore only be prescribed after consultation has taken place with a GUM consultant.

3.8.4 If the source is believed to be from a HEP B carrier, The A&E Department will normally administer a HEP B booster. Medical after care will then be provided in the form of blood tests at the prescribed intervals and advice by the Force's Occupational Health provider.

3.8.5 It is the responsibility of the affected individual to contact Occupational Health on the first working day available after exposure has taken to make them aware of the event. **For staff East of the County contact the Boscombe office 010202 443066. For staff in the West of the County contact the Dorchester office on 01305 363800**. Occupational Healthy are available should staff wish to seek reassurance or further advice. GUM clinics are the primary providers of aftercare treatment and counselling for HIV exposure.

A&E facilities are at:-
Dorchester County Hospital 01305 251150
Poole General Hospital 01202 665511
Royal Bournemouth Hospital 01202 303626

Gum Clinics are at:-
Weymouth 01305 762682
Bournemouth 01202704644

3.9 *Hand Hygiene*

3.9.1 Hand Hygiene is extremely important in the prevention of cross infection. Hand Hygiene can consist of alcohol based products or hand washing facilities containing soap and water.

3.9.2 It is essential that all staff have access to hand hygiene facilities to maintain personal hygiene. Alcohol gels etc. will not be so effective against visibly soiled hands. Ideally, visibly soiled hands must be washed with soap and water first before applying alcohol gels etc. Hands should be first wet before applying soap and then thoroughly rinsed. Hands must be thoroughly dried. Wet hands easily pick up contamination.

3.9.3 Hands should be washed:

- Before and after each shift;
- Before putting on and after removal of PPE;
- After using the toilet or covering a sneeze;
- Whenever hands become visibly soiled;
- Before preparing or serving food;
- Before eating, drinking and after smoking;
- After physical contact with a person;
- After handling contaminated or suspected contaminated items.

3.9.4 Alcohol gels etc. will only be effective if the hands are free from dirt and organic material. For the gel etc. to be effective the hands must be rubbed together vigorously paying particular attention to the tips of the fingers and thumbs and the areas between the fingers until the solution has evaporated. An emollient hand cream is recommended and should be applied regularly to protect the hands from drying effects of regular contact.

3.10 Contacts for Further Advice

3.10.1 Occupational Health – Dorset

Telephone: 01300 363800

Occupational Health – Devon and Cornwall

Telephone: 01392 225672
Email: OHSU General

For further specialist advice on communicable diseases:

Public Health, England – Infectious Diseases

Telephone: 020 8200 4400

4 Consultation and Authorisation

4.1 Consultation

Version No:	Name	Signature	Date
Police & Crime Commissioner			
Police Federation			
Superintendents Association			
UNISON			
Other Relevant Partners (if applicable)			

4.2 Authorisation of this Version

Version No:1.10	Name	Signature	Date
Prepared:	Andy COLE	Health & Safety Manager	12/05/2017
Quality assured:			
Authorised:	Pete CHANNON	Head of HR Operations (Dorset)	17/05/2017
Approved:			

5 Version Control

5.1 Review

Date of next scheduled review	**Date: Two years from publication**

5.2 Version History

Version	Date	Reason for Change	Created / Amended by
1.0	Sept 2010	Initial Document	Mr R Aiston
1.1	Jan 2011	Minor Amendments	Mr R Aiston
1.2	July 2011	Update on action to take in the event of BBV exposure	Mr R Aiston
1.3	Oct 2011	Document reviewed against HPA document “Prevention of Infection and Communicable Disease Control in Prisons and Place of Detention”.	Mr R Aiston

1.4	Nov 2012	Amended to reflect the transition from DPA to the PCC	Mr R Aiston
1.5	Aug 2013	Introduction paragraph introduced. HIV guidance reviewed and updated. Minor grammatical changes made	Mr R Aiston
1.6	Feb 2014	Policy reviewed to reflect 2nd stage transfer arrangements. Clarification at paragraph 3.6.4 on how to seek inoculation	Mr R Aiston
1.7	14/11/14	The policy has been reviewed in preparation for NICHE implementation (April 2015), no changes necessary	Policy Co-ordinator (6362)
1.8	16/7/15	Paragraph 3.8.5 post exposure contact details clarified.	Mr R Aiston
1.9	3/3/2016	New paragraph 3.6.5 Non-responders	Mr R Aiston
1.10	12/05/17	Addition of contact numbers for further and operational advice on infectious diseases	Mr A Cole

5.3 Related Forms

Force Ref. No.	Title / Name	Version No.	Review Date

5.4 Document History

Present Portfolio Holder	Director of Human Resources
Present Document Owner	Mr A Cole
Present Owning Department	Alliance People Department
Details only required for version 1.0 and any major amendment i.e. 2.0 or 3.0:	
Name of Board:	
Date Approved:	
Chief Officer Approving:	

Template version Dec 2016

Appendix A

Tetanus, Hepatitis A B & C, HIV, Lyme's Disease, Parasitic Infections

HEPATITIS A

Hepatitis A is a viral infection, which results in fever, diarrhoea and vomiting and then jaundice. The disease is generally mild though severity increases with age. There is no chronic carrier state and little likelihood of chronic liver damage.

Mode of Infection:

Hepatitis A is transmitted through ingestion of food/fluid, which is contaminated with the virus (faecal – oral infection). The virus is common in countries where standards of food and water hygiene are low but does occur sporadically in the UK.

At Risk Groups:

- Workers exposed to untreated sewerage
- Travellers abroad to high-risk countries
- Marine Section may be at some increased risk but this remains low and is not felt to merit vaccination.

Preventative Measures:

An effective vaccine to protect against Hepatitis A is available through GP surgeries and travel clinics. A single dose vaccine confers protection for at least one year. A booster dose at six to 12 months after the initial dose will extend protection for up to ten years. Access to hand washing facilities if operational possible, is essential. Food handling is to be avoided by persons who are suspected or known to be infected.

Action if Exposed:

No vaccination is a total guarantee of protection. If you believe you have been in contact with someone suffering from Hepatitis A or have symptoms of concern after travel abroad seek prompt medical advice.

HEPATITIS B

Hepatitis B is a blood borne viral infection. It causes serious illness, which may lead to long-term liver disease in 1% of cases. 2 to 10% of those infected, as adults become chronic carriers of the virus.

Mode of Infection:

Hepatitis B virus is carried in blood and body fluids. Infection results from contamination incidents involving blood-to-blood contact following injury with contaminated sharp instruments such as needles or other equipment used by intravenous drug misuses. It can also result from exposure to other body fluids – through bites from infected persons and from spillage/splashes onto mucous membranes or non-intact skin, e.g. pre-existing cuts/skin disease such as eczema.

Hepatitis B is also transmitted via vaginal/anal intercourse and directly from mother to child and tattooing or body piercing with contaminated equipment.

The risk of infection from Hepatitis B depends on exposure to the virus in the source blood. It is greatest when the source is suffering acute infection and in some 'high risk' carrier groups. The risk is much less when the source is a 'low risk' carrier and there is no risk from a potential source who has made a full recovery and does not go on to become a carrier.

Relative risks from sharp injury: -
Acute infection/'high risk' carrier 1 in 3
'Low risk' carrier 1 in 3,000
After recovery (as above) nil

At Risk Groups:

The general population risk is low. Groups at increased risk are those who may be exposed to used hypodermic needles/blood/bodily fluids. All operational police officers are at some increased risk above the general population in that exposure is possible. However, some groups are frequently exposed more than others, such as: -

- Drug/Vice Squad
- Coroners Officers
- Crime Scene Investigators
- Vehicle maintenance and cleaning staff
- Search teams
- Custody Suite staff
- Warrants Officers
- Property Store Staff
- Firearms Officers
- Marine Section
- Police Community Support Officers
- Disaster victim identification officers

Preventative Measures:

All staff that find themselves exposed to bodily fluids should take preventative measures. The groups detailed above are regarded as at medium risk. Prevention against avoidable exposure is a priority. Infectious disease carried in blood/body fluids is only a threat if the skin barrier is broken or where exposure to mucous membranes (mouth, eyes) occurs. Infection cannot occur through intact skin by contact and cannot move through air.

Effective vaccines to prevent hepatitis B are available. Vaccination consists of a course of three injections followed by a blood test to check response. Where a good response is made to the initial course of vaccine a single booster is required after 5 years. Additional boosters may be required where the initial response is weak and following an exposure incident. Vaccinations in the first instance are to be arranged through GP surgeries. Regular visitors to custody centres should be advised to undergo hepatitis B vaccination.

The following control measures are important:

- Avoid unnecessary searches of high risk groups and where possible ask the subject to empty their own pockets and turn them inside out
- Wear standard uniform leather gloves for preliminary searches for contaminated needles or syringes (dexterity could be affected)
- Wear disposable gloves for intimate searches
- Wear disposable gloves where called upon to take finger or palm prints of persons with open wounds on hands or post-mortem cases
- Use apron and gloves where there is a likelihood of contamination with blood or body fluids
- Use facemasks incorporating a non-return valve for resuscitation where possible
- Remove all slightly contaminated bedding and uniform and send for cleaning as per Force procedures (Clinical Waste and Infection Control Policy).
- Ensure that if you are in a high-risk group you obtain initial vaccination and keep your vaccination in date with booster doses at appropriate intervals. If you are in doubt about whether you are at risk contact the Health and Safety Business Support team or the Force's contracted in Occupational Health provider.

If you are exposed to blood-body fluids through injury/mucous membrane you are advised to: -

Needle stick:

- Make any wound bleed freely.
- Wash the affected part with soap and plenty of water.
- Report the injury immediately to your line manager, custody nurse or local casualty department.
- If the source is identifiable and is able and willing to provide a sample of blood for testing and storage, this should be sought with the help of the police surgeon/custody nurse. Seeking prompt medical advice is particularly important particularly concerning post-exposure prophylaxis.
- Post-exposure prophylaxis is the term used for emergency treatment, which aims to prevent the onset of infection when exposure has occurred. Emergency starter packs of five days' supply of treatment are available in most if not all casualty units. There are possible side effects from prophylaxis treatment. These will be explained at the time of treatment.
- Medical advice should be sought in ALL cases.

Sputum:

- Sputum on the skin should be removed and the area thoroughly washed immediately after exposure. Use a disinfectant wipe or alcohol gel if washing facilities are not immediately available. Care must be taken to avoid any alcohol gel or fluid from the wipe entering the eye or open cuts.
- Sputum entering the mouth should be removed immediately and not swallowed and the mouth thoroughly rinsed out.
- Sputum entering the eye should be immediately removed as far as possible and the eye should be thoroughly rinsed out with sterile/clean water.
- Report the event to your line manager and seek medical advice from the custody nurse or local casualty department.

- If the source is identifiable and is able and willing to provide a sample of blood for testing and storage, this should be sought with the help of the police surgeon/custody nurse. Seeking prompt medical advice is particularly important particularly concerning post-exposure prophylaxis.
- Post-exposure prophylaxis is the term used for emergency treatment, which aims to prevent the onset of infection when exposure has occurred. Emergency starter packs of five days' supply of treatment are available in most if not all casualty units. There are possible side effects from prophylaxis treatment.
- Medical advice should be sought in ALL cases.

HEPATITIS C

Hepatitis C is a blood borne viral infection of the same type as Hepatitis B. It can also lead to long-term liver disease.

Means of Infection:

As for Hepatitis B – through exposure to infected blood or body fluids. However, the relative risk of infection is lower than for Hepatitis B and generally of the order of 1 in 30 in high-risk groups. There is no immunisation available to prevent infection against Hep C. There are treatments available but not everyone is suitable for treatment. Injecting drug use is the most common way to acquire hepatitis 'C' infection.

At Risk Groups:

As for Hepatitis B.

Preventative Measures

As for Hepatitis B except that there is no vaccine available.

Advice if Exposed:

As for Hepatitis B.

HIV

HIV is a fragile virus, which attacks and damages the immune system and reduces the body's ability to fight infection. It is carried in blood and body fluids in the same way as hepatitis B/C but is far less infectious. HIV can be successfully treated provided that people are diagnosed in good time and are on treatment. HIV is a long term manageable condition. Due to recent medical advances, people living with HIV can have an active normal life span. HIV and AIDS (acquired Immunodeficiency Syndrome) are separate medical conditions. Left untreated HIV can lead to aids. Provided that the person with an HIV condition adheres to their daily treatment and has a low level of virus in their body, it is extremely unlikely they can pass on the virus to others. There has never been a case of infection through biting or a discarded needle outside of the health care setting. There has been no known case of occupational HIV transmission to a police officer or a member of police staff.

Mode of Infection:

HIV infection is primarily due to unprotected sexual activity. You cannot get HIV from social contact such as: kissing, touching, superficial scratches, coughing, sneezing, handling/lifting someone, tooth brushes, toilet seats, cutlery or spitting. It can, however, be transmitted through contact with infected blood as in injury with contaminated sharp instruments such as needles. There is a heighten risk of infection if sputum contains blood and enters skin cuts or sores in the mouth but the risk is very low. Similar, there is a low risk of infection if sputum containing blood enters the eye; again, the risk is very low.

The risks of acquiring HIV after occupational exposure to blood are estimated as: -

Percutaneous injury (needles etc.)	3 in 1,000
Exposure to mucous membranes (mouth, eyes)	less than 1 in 1,000
Exposure of broken skin (cuts, eczema)	less than 1 in 1,000
Exposure of intact skin	no known risk

HIV is not transmitted through other body fluids – urine, vomit, saliva, faeces (unless visibly bloodstained).

At Risk Groups:

As for Hepatitis B.

Preventative Measures:

The risks of infection can be substantially reduced if sensible safety precautions are taken. The precautions and procedures to be followed in the event of possible contact with infected body fluids are the same as those for Hepatitis B/C. However, no vaccine is yet available.

- Avoid unnecessary searches of high risk groups and where possible ask the subject to empty their own pockets and turn them inside out.
- Wear standard uniform leather gloves/disposable gloves for preliminary searches for contaminated needles or syringes (dexterity could be affected).
- Wear disposable gloves for intimate searches.
- Wear disposable gloves where called upon to take finger or palm prints of persons with open wounds on hands or post-mortem cases.
- Use apron and gloves where there is a likelihood of contamination with blood or body fluids.
- Use facemasks incorporating a non-return for resuscitation where possible.
- Remove all contaminated bedding and uniform and send for cleaning as per Force procedures.
- Employ good hand hygiene

Action in the event of Exposure:

Needle stick:

- Make any wound bleed freely.
- Wash the affected part with soap and plenty of water.
- Report the injury immediately to your line manager/ and seek medical advice from the custody nurse if in custody
- Medical advice should be sought in ALL cases. Go to your local casualty department.
- Post-exposure prophylaxis may be prescribed and is the term used for emergency treatment and must commence within 72 hours after exposure. The purpose is to attempt to prevent the onset of infection. Emergency starter packs of five days' supply of treatment are available in most if not all casualty units. There are possible side effects from prophylaxis treatment. These will be explained at the time of treatment.
- Contact Occupational Health for after care support.

Sputum containing blood:

- Sputum on the skin should be removed and the area thoroughly washed immediately after exposure. Use a disinfectant wipe or alcohol gel if washing facilities are not immediately available. Care must be taken to avoid any alcohol gel or fluid from the wipe entering the eye.
- Sputum entering the mouth should be removed immediately and not swallowed and the mouth thoroughly rinsed out.
- Sputum entering the eye should be immediately removed as far as possible and the eye should be thoroughly rinsed out with sterile/clean water.
- Report the event to your line manager and seek medical advice from the custody nurse if in custody
- Go to your local casualty department.
- Post-exposure prophylaxis may be prescribed and is the term used for emergency treatment and must commence within 72 hours after exposure. The treatment aims to prevent the onset of infection when exposure has occurred. Emergency starter packs of five days' supply of treatment are available in most if not all casualty units. There are possible side effects from prophylaxis treatment.
- Medical advice should be sought in ALL cases.

Weil's Disease

Weil's disease commonly called Leptospirosis is a zoonosis - an infection that can be transmitted from animals to humans. It is more common in tropical areas of the world but is also found in temperate areas such as Europe, including the United Kingdom (UK). Leptospirosis is caused by spiral-shaped bacteria. In general, leptospirosis is uncommon in the UK. There are usually less than 40 cases per year in England and Wales.

Mode of Infection:

Weil's disease is contracted through contact with fresh, surface water *e.g.* canals, ponds, rivers or flood water which have been exposed to rat's urine. Simple precautions below can reduce the risk. Leprosies enter the body through a cut or damaged skin, but may also pass across damaged or intact mucous membranes, and the eyes. The risk is reduced in moderately to fast flowing water. The virus can also be contracted thorough contact with livestock.

At Risk Groups:

- Search teams
- Wildlife officers
- Dog handlers
- Officers undertaking work in or in close proximity in water
- Officers working with or near livestock
- Fast water teams

Symptoms:

- Flu like symptoms
- Severe headache
- Chills
- Muscle aches
- Vomiting
- Jaundice (yellow skin)
- Red eyes
- Abdominal pain
- Diarrhea
- Possible rash.

Preventative Measures:

- Cover cuts, scratches or sores with a waterproof plaster and thoroughly clean cuts or abrasions received during activities
- Wear appropriate protective clothing, gloves or protective footwear
- Wash or shower promptly after water sports, especially if you fall in
- Avoid capsize drill or rolling in stagnant or slow moving water
- Wear thick gloves when handling rats
- Wash hands after handling any animal, and before eating
- Risk can be greatly reduced by not swimming or wading in water that might be contaminated with animal urine

Treatment:

Leptospirosis is treated with antibiotics such as penicillin or doxycycline, which should be given early in the course of the disease. Intravenous antibiotics may be needed for people with more severe symptoms.

Tuberculosis (TB)

Mode of Infection:

Tuberculosis, often referred to as TB or consumption, is a curable infectious disease. TB can affect any part of the body but is most common in the lungs and lymph glands. The microscopic bacillus hitches a lift on an aerosol of tiny droplets of mucus and saliva produced when an infectious person talks, coughs or sneezes - others then inhale these droplets. Prolonged exposure to an infectious person is generally needed to contract the disease.

At Risk Groups:

- Potentially all staff but those at increased risk:
- FNO staff
- Staff who deal with illegal immigrants
- Custody staff

Symptoms:

- Cough - lasting for more than two weeks and sometimes with blood streaked sputum
- Shortness of breath
- Chest pains
- Loss of appetite and weight loss
- Fever and sweating - particularly at night
- Extreme fatigue and tiredness

Preventative Measures:

- BCG immunisation increases a person's immunity to TB
- Good Diet
- Maintain effective immune system
- Area is well ventilated to reduce concentration of spores
- Exercise caution when dealing with: vagrants, travelers, illegal immigrants, and the social deprived, chronic alcohol or drug misuses due to increased risk.
- Avoid standing directly in front of someone coughing etc.

Treatment:

TB can be diagnosed through an x-ray or sputum test and is now curable with antibiotics that must be taken for at least six months. Modern anti-TB drugs are extremely effective and in nearly all cases TB sufferers are not infectious and feel much better after the first two weeks of medication

Lyme's Disease (Tick Bites)

Mode of Infection:

Infected ticks can transmit the organisms during blood feeds on their host, when they may be attached to the skin for several days if left undisturbed. Late spring, early summer and autumn are peak times for tick feeding, and ticks tend to be found seeking feeds in areas of long grass. A lower level of tick feeding activity can take place at other times of the year, even on mild winter days.

Ticks live on livestock and the undergrowth they are small in appearance but become larger after gorging the host's blood. Incorrect removal can cause an infection which can lead to contracting Lyme's disease so it is important to ensure that the bitten person checks them self carefully for any signs of an infection up to 30 days after having been bittern. Staff must seek immediate medical attention if the bite area becomes infected

A tick can be easily removed from the skin by twisting it anti clockwise without using excessive grip or by using a tick hook in an anti-clockwise motion and then crushing the tick The jaws of the tick could remain in the skin causing an infection if the tick is lifted directly from the skin or a clockwise motion is employed.

At Risk Groups:

- Search teams
- Wildlife officers
- Dog handlers
- Officers undertaking work in rural areas

Symptoms:

- Some infected people show no signs.
- Itchy red spot at the site of the tick bite (3-30 days after being bitten)
- Red spot expands into red border.
- Area between spot and red border clears and expands and becomes hardened and flat.
- Tiredness
- Feeling unwell
- Headache
- Fever
- Muscle/joint ache
- Stiff neck
- Swollen glands

Preventative Measures:

- Cover the skin particularly the ankles, legs and arms.
- Cover up exposed skin
- Remove tick from the skin immediately
- Use tweezers or tick hook to remove tick from the point of attachment slowly
- Ensure that tick head/jaws are removed.
- Frequently check bite site for possible infection
- Thoroughly check over the body after working in woodland etc.
- Seek medical advice promptly if feeling unwell/ feverish particularly after having been working in a rural area.

Treatment:

- Antibiotics
- Full recovery could take some time

Tetanus

Commonly known as “lockjaw”. Tetanus is a bacterial infection, which causes severe muscle spasms and can be fatal. Infection is now rare in the UK as a result of effective childhood vaccination. Symptoms could be: stiff muscles near wound, stiffening jaw muscles and painful spasms.

Mode of Infection:

The spores, which carry tetanus infection, are found in; soil, intestines of animals and may be introduced into the body by a penetrating wound/area of broken skin, which is or becomes dirty. Wounds need not be serious or deep to cause infection. Tetanus is not spread from person to person. Cases have been reported where injecting persons have become infected.

At Risk Groups:

Everyone is exposed to a low level risk in everyday life and all should take preventative measures. Particular occupational groups within Dorset Police, which are assessed as medium risk, are: -

- Search teams
- Accident investigators
- Dog handlers
- Wildlife officers
- Firearms officers

Preventative Measures:

Effective prevention is provided by immunisation, which is provided by GP surgeries. Immunisation consists of a primary course of three vaccines followed by at least two booster doses. Adults who have received five doses in total will only require a booster dose in the event of a tetanus prone wound. Types of wound, which are tetanus prone, are: -

Any wound or burn sustained more than six hours before medical attention or shows one or more of the following characteristics: -

- A significant degree of tissue damage
- Puncture type wounds
- Contact with soil or manure
- Evidence of infection such as redness or discharge

Treatment:

If you have a wound, which fits any of the above descriptions, you should contact your GP for advice or contact the local casualty department – depending on the severity of the injury.

Scabies

Sarcoptes scabei is a human mite which penetrates the outer layers of the skin. The body's immune system reacts to the mite's droppings and saliva resulting in an immune reaction, which produces an intense itching.

The incubation period is up to 8 weeks after contact with an affected person. Skin penetration is visible as papules, vesicles or tiny linear burrows containing the mites and their eggs. The lesions occur mainly on the hands, finger webs, wrists and inside of arms, abdomen/waist, and groins and under buttocks.

The mite is transferred to other people by prolonged, direct skin-to-skin contact, especially via the hands. It can also be acquired during sexual contact. Transfer from underclothes or bed linen may occur if these items have been contaminated by an affected person immediately before contact; mites do not survive away from their host, as it is too cold for them to survive outside the skin

An individual remains infectious until after effective treatment and should be kept away from work, school, day hospital etc., until this has been completed.

Treatment:

Usually with a cream or lotion, available through your general practitioner. The following principles should be followed:

- A prescribed cream is applied over the whole body onto clean, cool, dry skin, but not directly after a bath or shower.
- Ensure the cream is put under the nails, on the skin of the face up to the hairline, behind the ears and the soles of feet.
- Directly after treatment, put on clean clothes and change the bed Linen.
- Leave the cream on for 8-12 hours (overnight treatment will ensure this).
- Bed linen etc. must be treated as infected laundry.
- All bed partners and CLOSE family contacts should also be treated.
- After treatment it may take up to 3 weeks for the itching to stop, but this does not mean treatment has failed. Itching is a result of an allergic reaction to the mites. Piriton may help to relieve the itching.

Preventative Measures:

- Staff particularly custody staff should use disposable gloves and cover up arms when handling a suspected or infected person.
- Laundry should be removed and sent for washing.
- Vagrants, travellers and illegal immigrants are at increased risk

Lice

Head and pubic lice are parasitic insects called Pediculus humanus capitis. They only live on the heads of people. Head lice cannot jump, hop or swim. Anyone can catch head lice, but preschool children, primary school children and their families are most at risk.

Head lice are transmitted through direct, prolonged head-to-head contact with an infested person. This is especially common during school play or sport and with close contacts at home.

Transmission is possible through infected clothes, combs, brushes or towels, but extremely unlikely. The lifespan of a louse is very short once detached from the hair so fumigation is not necessary.

There are three forms of head lice:

- Nits are head lice eggs. The oval, yellowy white eggs are hard to see and may be confused with dandruff. They attach themselves to the hair shaft and take about a week to hatch. The eggs remain after hatching and any nits are empty egg cases.
- Nymphs hatch from the nits. The baby lice look like the adults, but are smaller. They take about 7 days to mature to adults and feed on blood to survive.
- Adults are about the size of a sesame seed. They have six legs and are tan to greyish-white. The legs have hook-like claws to hold onto the hair with. Adults can live up to 30 days and feed on blood.

Treatment:

- Normally diagnosis of head lice can only be made if a living, moving louse is found by a family member.
- Combing using a fine toothed comb using a hair conditioner is the preferred treatment.
- Chemical treatments are available, but must only be given after a doctor or experienced nurse has made a diagnosis.
- Bed linen etc. must be treated as infected laundry.

Preventative Measures:

There is very little that can be done to prevent contracting head lice except to be aware of excessive itching/scratching in children especially. The best way to stop infection is for people to learn how to check their heads for lice.

Good hair care only helps to control lice in as much as it will help to spot and treat lice early.

Fleas

Fleas thrive in a warm moist environment. In the UK human fleas are rarely a problem and can be cured by removal of infested clothing. Cat fleas and dog fleas can be a considerable nuisance.

Eggs and larvae can contaminate a pet's bedding and favourite resting places. The eggs are just visible to the naked eye as small pearly white round objects. Adult fleas require blood meals to survive.
Fleas have four main stages in their life; egg, larva, pupa and adult. The total flea life can range from a couple of weeks to several months.

Cat/dog fleas will bite humans - bites tend to be concentrated on accessible areas such as the lower leg. A flea may have several attempts at obtaining a meal, so bites tend to be clustered. A wheal appears after 5-30 minutes accompanied by intense itching, which in the next day or so becomes a small vesicle. Sometimes reactions are delayed up to 24hr in sensitised people. Scratching leads to secondary infections.

Treatment:

The most effective treatments are available only from veterinary surgeons in the form of flea collars for animals and sprays for general use.

Preventative Measures:

Prevention is by treatment of pets together with thorough washing/cleaning of bedding and other favourite areas, vacuuming of carpets and application of preventative sprays or powders to carpets.

Lost/found dogs should not be left in enquiry offices or any other room contained within a building which is occupied by staff.

Appendix B

Hepatitis Information Card

(Rev 3/10)

Dorset Police

HEPATITIS B

What is Hepatitis 'B?'

Hepatitis 'B' is a viral infection. It can cause illness which can lead to long term liver damage. Approximately 5% of those who contract Hepatitis B develop liver problems. The virus is carried in bodily fluids, i.e. blood, urine, vomit etc. One common mode of infection is via a puncture wound to the skin, caused by sharp instrument, i.e. a needle which has been used by drug misuses. The virus can also be transmitted through bites, cuts grazes and sexual activity. Inoculation is a way of substantially reducing the risk of contracting an illness through contracting the virus. Immunisation is no substitute for good controls i.e. avoiding the risk, disposable gloves or good hygiene measures etc.

Those at potentially greater risk:

All operational police officers and the following categories of police staff; custody staff, station desk officers, PCSOs, property officers, coroners officers, CSIs and garage mechanics, are asked to complete and retain Part 'A' and kept with the individual at all times and if required, produced to a health care professional if having to seek treatment.

Preventative Measures:

1. Always treat bodily fluids as **high** risk.
2. Avoid the risk if possible.
3. Staff awareness through information, instruction and training.
4. Cover cuts and abrasions.
5. Wear disposable gloves.
6. Good Hygiene
7. Use sharps containers
8. Good cleaning procedures.
9. Correct disposal of clinical waste.
10. Immunisation

More information can be located under SharePoint entitled, 'Infectious and Parasitic Disease Policy'. You are strongly advised to read this document.

Action to take in the event of a needle stick injury:

1. Attempt to make the wound bleed freely.
2. Clean the wound/skin with soap and water or
3. Use alcohol gel/non-alcohol wipe.
4. Attempt to establish;
5. Can the needle source be identified?
6. Is the needle source an IV drug misuse?
7. Can the HIV status be established?
8. Seek medical advice in the first instance from A&E:
9. Dorset County Hospital 01305 251150
10. Poole General Hospital 01202 665511
11. Royal Bournemouth 01202 303620
12. Referral will normally follow to the Local GUM clinic.
13. Contact Occupation Health the next working day to advise them of the injury and with a view to an appointment being made with the doctor/nurse 01305 363800
14. Complete an 'e' A25 accident/injury form.

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PART A (To be retained by individual)
HEPATITIS B IMMUNITY CARD

Name.....
Collar No. .....
D.O.B.....
Date of First injection.....
Date of Second injection.....
Date of Third injection.....
Date of antibody blood test.....
Date of booster injections.....