



Public Health  
England

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# **Guidance on management of potential exposure to blood-borne viruses in emergency workers**

For occupational health service providers and frontline staff

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## Executive summary

This guidance has been developed for frontline emergency workers to support them in understanding their potential risk of blood-borne virus (BBV) exposure following injury or assault and the steps that should be taken to manage and support them by health services including occupational health. It intends to relieve the stress that such events can bring to staff and dispel the stigma and myths often associated with concerns about transmission of infection. We detail the highest standard of care to be provided if exposure is thought to have occurred, with care pathways specific to each frontline service.

Public Health England (PHE), led by the National Health and Justice team, and its partners from both frontline services and expert groups have collaborated to develop this evidence-based guidance. The BBVs covered are those most common in the UK: **Hepatitis B, Hepatitis C** and **HIV**. These are specifically considered in the context of the most common injuries and incidents faced by frontline workers in the police, fire, ambulance, prison and immigration services.

This resource contains information and guidance for frontline staff and service providers on BBV prevention and control and on appropriate and sensitive treatment of staff. A generalised care pathway of management and action applicable across frontline services is provided, with first aid, risk assessment, management and follow up care identified as key elements of dealing with potential exposure to BBV. We also reiterate the **role of NHS Accident & Emergency services in providing risk assessment and initial management** for frontline workers where necessary, as per Department of Health policy.

Specific pathways have also been outlined for each of the target groups, as well as consideration of necessary education and training for staff. This guidance covers the action required at service level to provide support for staff members being managed for potential BBV exposure, including access to up to date advice, adequate follow up and psychological support.

Case scenarios of lived experiences from across the emergency settings including improper advice given and good practice following potential BBV exposure are included to contextualise the information provided.

We hope that frontline service providers at national, regional and local level integrate this guidance appropriately into the workplan of their respective services – ensuring all frontline emergency workers feel empowered to understand their risk of exposure to BBVs. Additionally, we hope that this guidance serves to foster further collaboration between frontline emergency services workers and health services to provide consistently high quality care for all staff across the country.

# Chapter 1: Remit and scope of this guidance

## The need for this guidance

Frontline emergency services workers may acquire injuries during their duty which bring a potential risk of exposure to blood-borne viruses (BBVs). Within these frontline services there is variable knowledge of the likely transmission of BBVs under different circumstances and often inconsistency in advice provided to them by medical services - leading to variable approaches to preventing and responding to potential instances of BBV exposure.

Inconsistent management and perpetuation of stigma and myths around transmission of BBVs following injury can be unnecessarily stressful to people undertaking already demanding roles. While prevention of these incidents is of course paramount, there is a need for coherent guidance on what constitutes an exposure event, instances where there is no risk of transmission and how potential exposures should be managed.

Although the operational risk to frontline staff from BBVs is very low, it is important they understand how these infections can and cannot be transmitted both for their own protection and to ensure the appropriate and sensitive treatment of others. This document therefore sets out:

- a) to provide clarity on the scientific evidence around risk of potential BBV exposure;
- b) outline of the standard of care to be provided if exposure has occurred, and
- c) provide detailed pathways specific to each frontline service covered this guidance.

## Defining blood-borne viruses

BBVs are a range of different viruses which are all carried in the blood and bloodstream. Depending on the virus, an infected person may appear very clearly unwell or else seem completely symptom free. If infection causes no symptoms, then a person may be unaware that they are infected. Sometimes infection with these viruses can have long term health consequences. There is, however, treatment available which can significantly reduce the impact of a virus, or even result in a cure for infections.

The most common BBVs in the United Kingdom (UK) are:

- **Hepatitis B virus (HBV) and Hepatitis C virus (HCV)** - both these infections affect the liver, causing both acute (short-term) and chronic (long-term) infections
  - **Hepatitis B** sometimes only causes an acute infection which the body's immune system can clear on its own, but in 3 to 5 out of 100 adult cases it leads to chronic infection which is currently not curable, but for which there are numerous treatment options available to reduce potential damage to the liver and the risk of onward transmission; there is also a vaccine available for Hepatitis B, which is very safe and highly effective in preventing infection, even if given after a potential exposure event has occurred
  - **Hepatitis C** can also cause an acute (and self-resolving) or a chronic infection. Treatment is available to clear chronic Hepatitis C infection, completely curing at least 9 out of 10 patients
- **Human Immunodeficiency virus (HIV)** - a virus which affects the body's immune system and, if not treated, makes it susceptible to severe infections and other serious illnesses; although there is no cure for HIV currently, there is treatment available which can reduce the level of virus in their blood to undetectable – preventing forward transmission to others and avoiding serious health consequences for those treated

As other BBVs are exceptionally rare in the UK, their specifics are not covered in this guidance.

## Transmission routes of BBVs

BBVs spread through contact with blood and other body fluids, such as semen and breast milk. Unless there is blood contamination there is no, or very low, risk (depending on the virus) from contact with saliva, sweat, urine, faeces, vomit or sputum.

Whether contact will lead to viral transmission also depends on the route of exposure, the type of virus, how much of the virus the carrier has in their body and the immune status of the exposed person. **When a person living with HIV is on effective HIV treatment and has an undetectable level of HIV virus in their blood, global evidence has shown that transmission of HIV does not occur and thus risk from occupational exposure is very low.**

Common routes of transmission include sexual intercourse, skin puncture by blood-contaminated sharp objects (e.g. needles) and sharing of injecting equipment. Less common routes of transmission include contamination of open wounds or skin lesions, splashing of the mucous membranes (such as the eyes or inside of the mouth) and human bites where blood is drawn.

**It is not possible for BBVs to be transmitted through social contact such as shaking hands, hugging, kissing, sharing utensils or using the same toilet. There have been no recorded cases of HIV or HBV being passed on during mouth-to-mouth resuscitation, and so such resuscitation, if deemed necessary, should never be delayed or denied because of concerns around BBV risk.**

### Categories of frontline emergency workers included in this guidance

This guidance has been created for frontline emergency workers and their employing organisations, to support their assessment of where BBV exposure risk may or may not exist following injury and help them understand how to best support their staff.

The frontline workers specifically referenced in this guidance include:

- police officers and service staff, including private sector employees providing services on behalf of the Chief Constable
- prison and probation service personnel (including private sector employees), including health care practitioners in custodial settings, who are in regular contact with detainees
- ambulance service personnel
- fire service personnel
- immigration staff, including border security and immigration detention staff

#### References and resources

Fattovich G. Natural history of hepatitis B. J Hepatol 2003;39: S50-8

NHS.UK, Hepatitis C <https://www.nhs.uk/conditions/hepatitis-c/>

Terrence Higgins Trust, 'How HIV is transmitted' <https://www.tht.org.uk/hiv-and-sexual-health/about-hiv/how-hiv-transmitted>

## Chapter 2: Risk of transmission

### Types of injury

Injuries that can facilitate BBV transmission are:

- a **puncture or 'sharps' injury**, where the skin is punctured by needles, glass or other instruments contaminated with blood
- any **bite** that involves a break in the skin and the presence of blood – with transmission also possible from the person bitten to the biter
- contamination of '**mucosal surfaces**' (**splash injuries**), body surfaces such as the eyes or the inside of the mouth, or of uncovered cuts with blood or body fluids. This includes incidents where someone has been spat at or had body fluids such as urine thrown on them

### Risk of Hepatitis B infection for front-line workers through these injuries

#### Puncture injury

The rate of HBV transmission following a puncture injury depends on a range of factors, such as the amount of virus in the blood and the severity of the injury caused. In healthcare settings, the rate of transmission is estimated to be at an average of up to 30% if there is contamination of blood, or body fluids containing blood, infected with HBV and no vaccination or treatment provided. Rates of transmission in the community are thought to be lower and previous vaccination with Hepatitis B will reduce the risk even further.

#### Biting

Even when there has been a break in the skin contaminated by HBV infected blood there are only limited cases where this was considered a potential transmission route, and so the evidence suggests these injuries are low risk.

#### Splash injury

The likelihood of acquiring HBV through exposure of an uncovered wound or internal body surface to blood (or body fluids containing blood) has not been sufficiently determined but is thought to be lower than that of other injuries, such as a puncture injury or bite wound. For body fluids (such as saliva or urine) where this is no blood present there is only a very low risk for HBV infection, with only a small number of potential cases found.

## Risk of Hepatitis C Infection for front line workers through these injuries

### Puncture injury

The rate of HCV transmission following a puncture injury is dependent on a range of dependent factors, such as the amount of virus in the blood and the severity of the injury caused. The rate of transmission is estimated to be at an average of 1-3% if there is contamination of infected blood or body fluids containing. This is based on data from healthcare settings, with rates of transmission in the community thought to be lower.

### Bite injury

Even when there has been a break in the skin contaminated by HCV infected blood there are only limited cases of plausible transmission through this route, and so the evidence would suggest these injuries are low risk for acquiring HCV.

### Splash injury

The likelihood of acquiring HCV through exposure of an uncovered wound or internal body surface to blood, or body fluids containing blood, has not been sufficiently determined but is thought to be lower than that of other injuries, such as a puncture injury or bite wound. There is no evidence of HCV having been acquired through mucosal surface exposure to saliva (where there is no blood present).

## Risk of HIV Infection for front line workers through these injuries:

### Puncture injury

The likelihood of HIV transmission following a puncture injury is dependent on a range of factors but estimated to be at an average of 3 in 1000 if there is contamination of infected blood or body fluids containing blood and if no post exposure prophylaxis is provided. This is based on data from healthcare settings, with rates of transmission in the community thought to be lower.

### Bite injury

There is no evidence of a frontline worker having conclusively obtained HIV infection through a biting injury. Any potential cases seen elsewhere of biting resulting in HIV transmission have involved extreme circumstances and been in the presence of untreated infection.

## Splash injury

The rate of transmission of HIV following exposure of a mucosal surface (such as the eyes or inside of the mouth) or an uncovered wound to blood or blood containing body fluids is less than 1 in 1000. There is no evidence that spitting incidents where no blood is present leads to acquisition of HIV.

### References:

Pintilie H and Brook G. Commentary: A review of risk of hepatitis B and C transmission through biting or spitting. *J Viral Hepat.* 2018 Dec;25(12):1423-1428

Cresswell F, Ellis J, Hartley J, Sabin C, Orkin C and Churchill DR. A systematic review of risk of HIV transmission through biting or spitting: implications for policy. *HIV Med.* 2018 Apr 23

<http://www.hse.gov.uk/biosafety/blood-borne-viruses/risk-healthcare-workers.htm>

## Chapter 3: Generalised care pathway for emergency care workers

### Prevention

Frontline emergency workers should follow universal precautions and use of personal protective equipment (PPE) when cleaning up bodily fluids, as well as covering any breaks in their skin, as needed and directed by their employing organisation.

Vaccination against Hepatitis B is also available and is highly effective at preventing transmission (when administered as per appropriate guidelines). Frontline emergency workers should have their likelihood of exposure assessed by their employer to determine if vaccination is required. For those with frequent exposure, pre-exposure immunisation is recommended by the Green Book: Immunisation against Infectious Disease. Such a risk assessment should be carried out locally by occupational health services or as a result of appropriate medical advice.

### Elements of the care pathway

#### First Aid

If a person has sustained a human bite, a piercing injury or had a mucosal surface such as the eyes or inside of the mouth) contaminated by blood or body fluids, appropriate first aid should be given. Guidance on first aid should be readily available and staff should know how to access this. All services provide some level of first aid training, with most having specifically trained first aiders amongst their staff (although these personnel may not be available at all times).

Public Health England guidelines state if any bite has broken the skin then immediate medical attention should be sought following first aid, as there are potential consequences of an injury such as this beyond BBV exposure.

#### Risk Assessment

Following administration of first aid an assessment of the risk of BBV exposure needs to be performed to determine whether further medical intervention is needed, within an hour of the potential exposure incident where possible. This includes both people involved in any biting incident. This should be carried out by an appropriately trained and competent

person – such as by a member of occupational health services or at the nearest accident and emergency or urgent care centre.

The risk of BBV infection is determined based on the nature of the injury, the presence of blood contamination and any known medical conditions in the affected worker. Injuries which have not broken the skin and/or where there is no concern of blood contamination will not confer risk of BBV transmission and as such may not require attendance at healthcare services.

If the BBV status of the source is known this should be considered during the risk assessment as it will impact the need for, and scale of, management. If BBV status is unknown, it may be possible for the potential source to be tested should they be present in an appropriate setting and able to give informed consent for this procedure.

### Management of those assessed to be at risk of BBV exposure

Following a risk assessment, medical management may be warranted if risk of BBV exposure is deemed likely. If the frontline worker has been assessed by occupational health they may be referred on to emergency health service for this care. According to the National Clinical Director for Urgent and Emergency Care, personnel from public and voluntary services involved in blood exposure incidents should receive treatment from NHS and A&E departments.

All of those who have been deemed at risk of BBV exposure may have blood taken for storage, which is used a baseline sample for testing if they are subsequently found to be positive for a BBV infection.

Hepatitis B immunisation with vaccine (and HBV immunoglobulin if necessary), which provides long-term protection against HBV infection, is given as post-exposure prophylaxis for those deemed at risk of exposure to HBV. Ideally this is given within 24 hours of the exposure incident but can be given up to 7 days after exposure. A full vaccination course is highly effective in preventing HBV infection - estimated at >95%, based on extrapolation of data from vaccination of infants exposed during birth - as well as having a good safety profile. There is therefore generally a low threshold for vaccinating following a potential exposure incident. HBV immunisation is generally recommended for any mucocutaneous exposure, any bites that break the skin and any puncture wounds from potentially contaminated objects.

Further details on HBV immunisation can be found in The Green Book, Chapter 18. There is currently no recommended post-exposure prophylaxis or vaccination for HCV.

HIV Post Exposure Prophylaxis (PEP) may be required for certain injuries or exposure incidents, such as a high-risk needle stick injury. Current UK guidance on indications for

HIV PEP state that it is not recommended following a human bite from an HIV-positive individual unless in extreme circumstances and after discussion with a specialist. In the absence of severe trauma or the presence of blood contamination PEP is not indicated. Where PEP is indicated, it must be started within 72 hours of the potential exposure incident and should ideally be initiated within 24 hours. It may be that PEP is started in an emergency care setting until a specialist opinion can be sought, and it should therefore not alarm a frontline worker if they are initiated on PEP but then this decision is reversed. When taken correctly, PEP can prevent most cases of HIV transmission from occurring.

Regardless of whether post exposure management is available or given, all deemed at risk of BBV exposure will need to have subsequent testing to determine if transmission has occurred.

### Follow up testing and support

If a frontline worker has been deemed at risk of BBV transmission following an exposure incident and the appropriate immediate management has been delivered, there should be a clear plan put in place to perform follow up care and monitoring.

Who performs this follow up is dependent on the nature of the incident, the injury sustained and the local services that are available. Occupational health departments should provide support for individuals involved in BBV exposure incidents as they would for any other injury sustained whilst at work, including arranging for follow up testing and care, such as psychological support, following BBV exposure. If the service's occupational health department is unable to perform follow up BBV testing, they should support staff in attending a sexual health clinic or other local service to have this done. NHS accident and emergency staff who review any frontline worker following a potential exposure incident should also provide advice on their need for follow up testing, as well as a discharge or referral letter for them to present to their occupational health service.

Testing for HBV and HCV infection should be performed at 6 weeks, 3 months and 6 months following exposure (or only HCV if the affected worker is adequately vaccinated against HBV). Initial HIV testing is also performed after 6 weeks, however new tests can detect HIV one month after exposure and provide a high degree of reassurance when the test result is negative. A further test is offered 3 months after possible exposure to definitively exclude HIV infection.

The follow-up testing required for high-risk cases is detailed in the table below:

<b>Time after incident</b>	<b>Hepatitis B testing</b>	<b>Hepatitis C testing</b>	<b>HIV testing</b>
4-6 weeks post exposure	HBsAg	Ag/PCR	Ag/Ab combined test
3 months post exposure	HBsAg	Ab (add Ag/PCR if high risk of HCV)	Ag/Ab combined test
6 months post exposure	HBsAg	Ab	Ag/Ab combined test (only if not tested at 3 months)

Adapted from NICE guidance

The prospect of potential BBV transmission can be stressful. It is therefore of great importance that any person undergoing investigation for potential BBV infection is given detailed information as to their risk of infection and its possible consequences. Any information on their potential or confirmed BBV status should be kept confidential and not shared with any third party without their explicit consent.

Post exposure counselling should include the need to refrain from donating blood, plasma, organs, tissue or semen until BBV infection has been ruled out. The need for modification of sexual practices, such as using barrier contraception, until infection has been ruled out should also be discussed.

A worker who has sustained a significant injury or been through a stressful experience may need time off work to recover and feel able to resume their duties. Employers should discuss with their staff what duties they feel are suitable to be continued, with the need to avoid exposure prone procedures based on the degree of risk determined based on the exposure incident.

References:

NHS.uk: [www.nhs.uk/conditions/animal-and-human-bites/](http://www.nhs.uk/conditions/animal-and-human-bites/)

NICE guidance: <https://cks.nice.org.uk/bites-human-and-animal#!scenario>

The Green Book: Immunisation against Infectious Disease, Chapter 18

## Chapter 4: Case scenarios of lived experience and practice from frontline settings

### Exemplar 1: Management of spitting incident causing unnecessary distress

This is an example of potentially improper assessment of and clinical advice for a BBV exposure incident. A police officer was involved in an incident where an offender he was putting under arrest spat in his face and mouth. As the perpetrator's BBV status was unknown, this officer was given post exposure prophylaxis for hepatitis B and HIV. As part of the precautionary advice they were given they were advised to have no contact with a family member who was undergoing chemotherapy until they had been determined as BBV free. This brought significant emotional distress for this officer, who was isolated from many of their family members during this time, for fear of onward BBV transmission compromising this immunocompromised relative.

With the risk of viral transmission through spitting being non-existent or negligible depending on the pathogen, this officer should have been reassured of his extremely low risk of infection and provided with education as to the circumstances through which he could infect others. It is unclear what potential onward transmission there was concern of that would have warranted no in person contact with a chemotherapy patient. This highlights the need for education surrounding BBV transmission and infection following spitting injuries for both frontline workers and healthcare professionals.

Given the zero risk of HIV and negligible risk of hepatitis virus transmission following spitting incidents, and the possibility of the perpetrator being within the 'window period' of variable detection, the management of this case should not have been dictated by, or relied on, carrying out this testing.

### Exemplar 2: Provision of timely clinical advice

This is an example of good practice in dealing with a BBV exposure incident, where appropriate risk assessment allowed a frontline worker to receive efficient support and reassurance. A prison officer had a bucket of bodily fluids, containing urine and faeces with unknown blood contamination, thrown in their face while on shift. There was no open skin affected, but the body fluids splashed into their eyes and mouth.

An occupational health provider was able to check that adequate first aid was performed, and cross reference the officer's Hepatitis B vaccination history and immunity status - giving reassurance that they had sufficient immunity. As the HIV risk from this type of incident is <0.1% (and only where blood contamination is present), they were able to advise that there was no indication for post exposure prophylaxis. They were also able to sign post the officer to further support due to the distress that this incident had caused them.

As this staff member was able to have professional clinical advice immediately they had their anxieties over BBV transmission allayed and avoided an unnecessary trip to A&E.

### Exemplar 3: Frontline service providing high quality clinical advice and support

This is an example of an information and risk assessment service for BBV exposure provided to staff members of the prison and probationary service.

The service commissions a phone helpline, available 24/7, 365 days a year, which provides guidance on delivery of first aid, rapid counselling on the risk of BBV transmission following a potential exposure incident and advice on where a staff member should go for further medical care if needed. This helpline is staffed by nurses, who have received specialist training in this area. Prison and probationary service staff are trained on how to use this helpline and provided with key fobs bearing the information on how to access it. Details of these incidences are logged by helpline staff, with the data gathered used to inform health and safety communications and reiterate the importance of first aid. Across the probation and prison service the calls range from 10-35 per month, mostly from prison front line staff.

This phone helpline allows for minimal delay to accessing reliable information on the risk of BBV exposure, reducing the anxiety of any affected staff. It also ensures appropriate use of NHS emergency services and reduces any disruption to prison or probation service staffing, by allowing a staff member to feel confident they have been adequately clinically assessed.

### Exemplar 4: Appropriate management of a low risk incident

While searching a potentially stolen car, a police officer was injured by a discarded needle found in the vehicle. The wound was superficial, and first aid – including encouraging bleeding and washing of the area – was administered immediately.

The officer attended their local accident and emergency department right away, without contacting occupational health as this incident occurred during a night shift. There, they were given a booster Hepatitis B vaccine (having completed the vaccination course 8 years previously) and reassured that there have been no published reports in the UK of

HIV or Hepatitis C infection being acquired following injury with discarded needles. They attended their GP for follow up testing 6 months after this potential exposure incident, having been provided with a discharge letter from A&E stipulating this was necessary. The officer was able to carry out their normal duties during this time and given reassurance as to their very low risk of BBV transmission – helping to ensure they didn't undergo any further distress.

### Exemplar 5: Cross service collaboration

In Avon & Somerset, the police force and Brigstowe (a charity supporting those living with HIV) have been working together on their knowledge of HIV and their practice with those people they meet, who are living with HIV. This has involved staff from Brigstowe and Terrence Higgins Trust attending Avon & Somerset Police's training department and completing a needs assessment – identifying key areas for training and knowledge sharing. This included providing clear information explaining that HIV cannot be transmitted through spitting, which had been identified as a key concern and area of misconception within the force. In addition, Brigstowe staff were invited to attend training on the use of spit guards to observe what officers were being told, showing a real commitment to openness and accountability within the force. Further to this, Brigstowe agreed to deliver 5 HIV Awareness Training sessions for staff, paid for by the force. A first round of training was delivered with Custody Suite Officers, due to the amount of power these officers have over members of the public who are detained.

The police force has appointed a HIV champion who Brigstowe can liaise with to help to expedite change or resolve any issues. Officers have also shown a commitment to publicly stand with people living with HIV through attendance at events such as World Aids Day celebrations.

The openness of this police force to educate their staff and dispel myths around HIV is commendable. Such a collaboration may not be possible in all areas of the country due to capacity issues, but if other forces and services could emulate its principles it would be beneficial for both staff and the population they work with. Universal provision of such reliable and comprehensive training would not only improve the experience of those living with HIV of engaging with the police force but help to allay any fears amongst officers over their risk of BBV transmission.

## Chapter 5: Service specific care-pathways

### Police officers, police staff and private sector employees working under the direction of the Chief Officer/Police and Crime Commissioner

#### Access to information

Chief officers should ensure that police officers and staff have prompt access to information to help them identify incidents which may pose a threat to their health, to understand the process of dealing with an exposure incident and where to seek advice based on the guidance below.

#### First aid

If a staff member has been injured while on duty the appropriate first aid should be given as soon as possible.

#### Reporting

Any staff member involved in such an incident should report it to their supervisor or the duty inspector as soon as possible and fill out the relevant incident paperwork when any emergency has been dealt with.

#### Risk assessment

Where there is no immediate response occupational health service available, officers should attend their nearest A&E or urgent care centre for a risk assessment and immediate management, as outlined in Department of Health Policy.

If a possible exposure event occurs during occupational health operational hours, and emergency care is not required, staff should attend this service for a risk assessment. Occupational health departments should have a clear protocol for assessing spitting and biting incidents based on up to date guidance, and staff should make a detailed record of their assessment of any injury or discussion had. Where necessary, following a risk assessment, occupational health should refer the staff member to their local A&E, calling the unit in advance to advise them.

## Follow up care and support

In house or on-site occupational health departments who have the appropriate facilities should carry out post exposure testing and provide any follow up vaccinations, as required. If they are unable to carry out post exposure viral testing, they should advise the staff member on accessing their local sexual health clinic for follow up. If the officer is seen by NHS emergency services, then information on the need for testing and any precautions to be taken should also be provided to them by hospital staff.

The supervisor on duty at the time of the incident must investigate the incident, record findings and determine how similar injuries may be avoided in the future.

Should a member of the Force acquire a BBV they will require counselling as to the consequences of their diagnosis, and any changes in practice they will need to make. Appropriate clinical referral should be expeditiously made. This should be provided by whomever delivers this diagnosis, but further support from occupational health may be required.

The frontline worker's supervisor should contact them and review the potential effects of the incident, including the need for a change or break in duties.

Occupational health and management staff should ensure that the staff member feels supported in being able to continue their duties, and that all necessary reasonable adjustments are made to allow for any impact on their health. For example, following a HIV diagnosis a staff member may benefit from modifications to work tasks or shift patterns while getting used to their medication and any side effects.

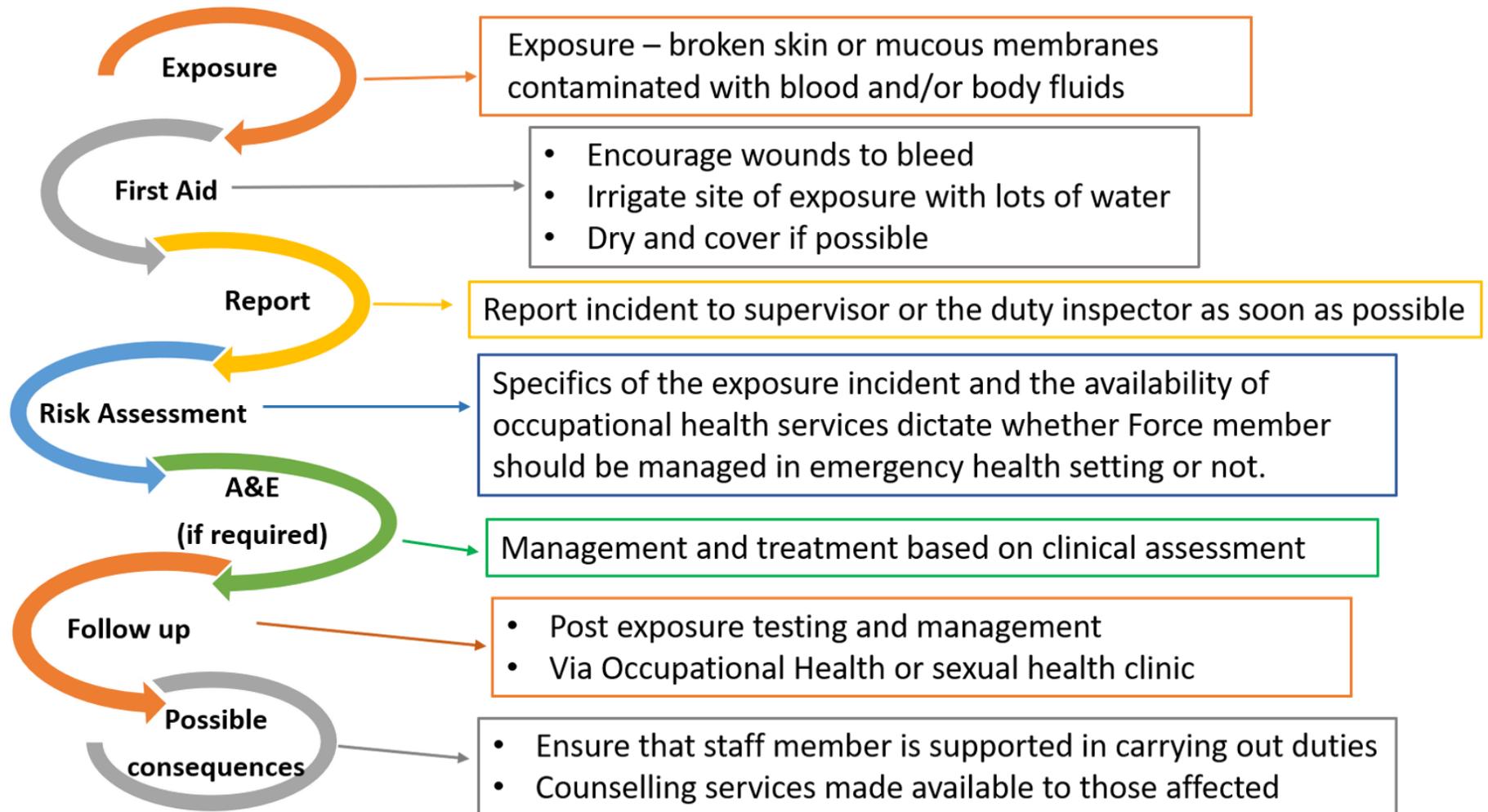
As well as coming to terms with the physical consequences, such an incident can have a significant mental health impact, and so the Force should make counselling services available to any affected staff member.

## Education and training

The amount of first aid training that police officers and staff receive is dependent on their role, but at least a one-day course should have been completed with an annual refresher. All areas of the force should have an adequate number of named first aiders and appropriate equipment and facilities to enable first aid to be given in the event someone is injured at work, based on a risk assessment of the area concerned.

Chief officers should implement whatever level of training or education they deem necessary within their forces to ensure that police officers and staff can understand basic facts about all BBVs and have sufficient knowledge to deal safely and confidently with situations where there is possible risk of infection.

## Police Service Incident Response Pathway



## Ambulance services

### Access to information

Ambulance Service NHS Trusts should ensure staff have prompt access to information to help them identify incidents which may pose a threat to their health, to understand the process of dealing with an exposure incident and where to seek advice based on the guidance below.

### First aid

If a staff member has been injured while on duty the appropriate first aid should be given as soon as possible.

### Reporting

Staff members should report any potential BBV exposure incident to the Emergency Operations Centre (EOC), so they are aware that the crew will be unable to attend emergency calls until the incident is resolved. The EOC should inform the duty operational team leader of the incident. Staff will also need to complete an incident report, such as an IWR-1 form, when any emergency has been dealt with.

### Risk assessment

Although ambulance services have their own occupational health services, they do not provide 24-hour emergency cover or timely access to the whole area. Therefore, staff usually attend NHS A&E departments for a risk assessment and management of potential BBV exposure incidents, as outlined by Department of Health Policy.

Local occupational health services will vary, with some providing a clinical advice line for injuries at work – including BBV exposure incidents. Where such a service does exist, it should be utilised to support staff in understanding their BBV exposure risk and allaying any anxiety they may have.

### Follow-up care and support

In house or on-site occupational health departments who have the appropriate facilities should carry out post exposure testing and provide any follow up vaccinations as required. If they are unable to carry out post exposure viral testing, they should advise the staff member on accessing their local sexual health clinic for follow up. If the officer is seen by NHS emergency services, then information on the need for testing and any precautions to be taken should also be provided to them by hospital staff.

Should a member of the ambulance service acquire a BBV they will require counselling as to the consequences of their diagnosis, and any changes in practice they will need to make. This should be provided by whomever delivers this diagnosis, but further support from occupational health may be required.

The frontline worker's supervisor should contact them and review the potential effects of the incident, including the need for a change or break in duties.

Occupational health and management staff should ensure that the staff member feels supported in being able to continue their duties, and that all necessary reasonable adjustments are made to allow for any impact on their health. For example, following a HIV diagnosis a worker may not be willing or able to participate in exposure prone procedures in the short, or even long term.

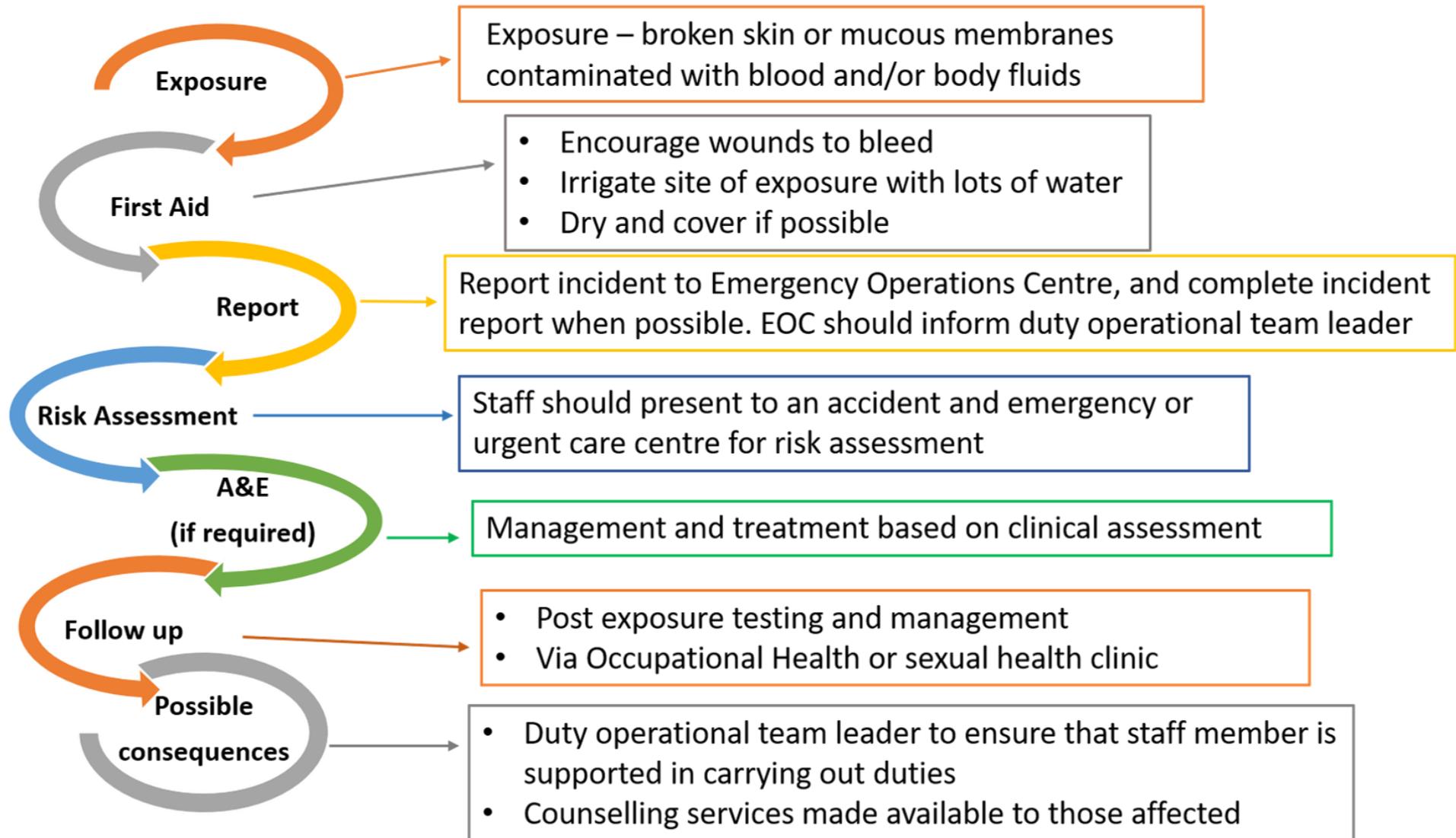
As well as coming to terms with the physical consequences, such an incident can have a significant mental health impact, and so the ambulance trust should make counselling services available to any affected staff member.

## Education and training

All ambulance workers will have received first aid training as part of their training and qualifications for their role.

Ambulance Service NHS Trusts should also ensure their staff have access to training or education as necessary, to ensure staff can understand basic facts about all BBVs and have sufficient knowledge to deal safely and confidently with situations where there is possible risk of infection.

## Ambulance Service Incident Response Pathway



## Prison and probationary services

### Access to information

The prison and probationary service provides their staff with access to an information and help line for potential BBV exposure incidents, available 24/7, 365 days a year. Staff are trained on how to use this service, and information on how to access it is readily available.

### First aid

If a staff member has been injured while on duty the appropriate first aid should be given as soon as possible. If no trained first aider is available then staff should follow the guide available in the first aid box, or advice from the telephone helpline.

### Reporting

Staff members should report any potential BBV incident to their line manager and fill out any incident reporting paperwork as required.

### Risk assessment

The 24/7 Sharps and Body Fluid Exposure telephone helpline provides rapid risk assessment, advice and reassurance to a staff member with regards to their risk of BBV transmission. The Specialist Occupational Health Advisor can direct them as to the most appropriate facility for further assessment and management, such as their local A&E.

### Follow up care and support

In house or on-site occupational health departments who have the appropriate facilities should carry out post exposure testing and provide any follow up vaccinations as required. If they are unable to carry out post exposure viral testing, they should advise the staff member on accessing their local sexual health clinic for follow up. If the officer is seen by NHS emergency services, then information on the need for testing and any precautions to be taken should also be provided to them by hospital staff.

Should a member of the prison or probation service acquire a BBV they will require counselling as to the consequences of their diagnosis, and any changes in practice they will need to make. This should be provided by whomever delivers this diagnosis, but further support from occupational health may be required.

The frontline worker's supervisor should contact them and review the potential effects of the incident, including the need for adjustments to their work tasks or role.

Occupational health and management staff should ensure that the staff member feels supported in being able to continue their duties, and that all necessary reasonable adjustments are made to allow for any impact on their health. For example, following a HIV diagnosis a staff member may benefit from modifications to work tasks or shift patterns while getting used to their medication and any side effects.

As well as coming to terms with the physical consequences, such an incident can have a significant mental health impact, and so the prison and probationary service should make counselling available to any affected staff member.

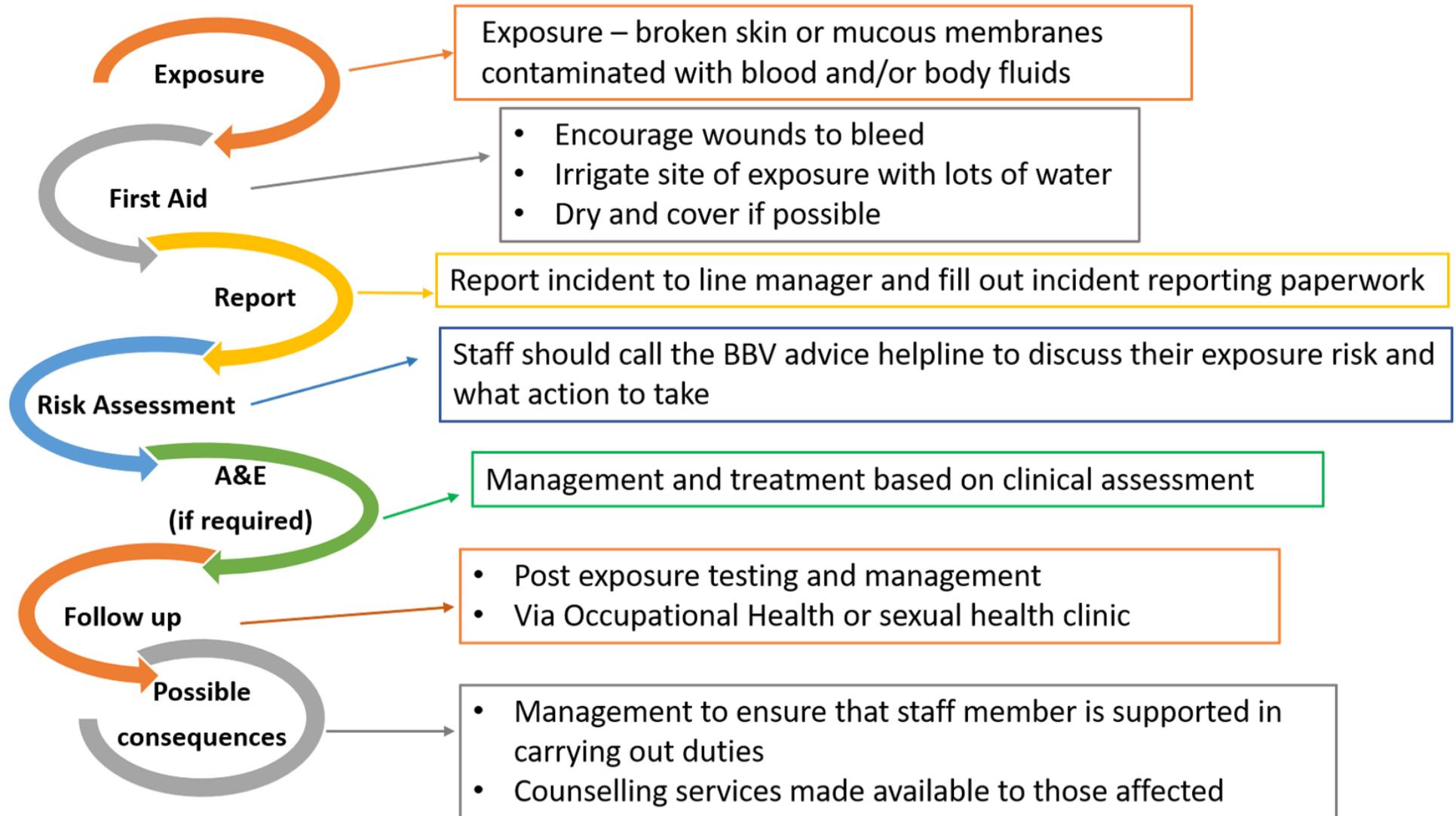
## Education and training

The needs for incident response and management including emergency and first aid provision vary both within and between prisons and probation sites and services. Governing Governors and Heads of Probation in charge of such premises and services are required, in line with statutory requirements, to carry out a needs assessment and ensure adequate capacity to provide an appropriate response.

Given the extent of risk to non-employees in HMPPS' services these assessments may well identify a need for provision at a different level to the ratios detailed in official guidance.

Although the operational risk to prison and probation service staff from blood-borne viruses is very low, they need to understand how the infections can and cannot be transmitted both for their own protection and to ensure the appropriate and sensitive treatment of others. Service leaders should implement whatever level of training or education deemed necessary to ensure that staff can understand basic facts about all BBVs and have sufficient knowledge to deal safely and confidently with situations where there is possible risk of infection.

## Prison and Probation Service Incident Response Pathway



## Fire service

### Access to information

Fire service management should ensure staff have prompt access to information to help them identify incidents which may pose a threat to their health, to understand the process of dealing with an exposure incident and where to seek advice based on the guidance below.

### First aid

If a staff member has been injured while on duty the appropriate first aid should be given as soon as possible.

### Risk assessment

If a possible exposure event occurs during occupational health operational hours, and emergency care is not required, staff should attend for a risk assessment. Occupational health departments should have a clear protocol for assessing spitting and biting incidents based on up to date guidance, and staff should make a detailed record of their assessment of any injury or discussion had as this may form part of any investigation into the incident.

Where necessary following risk assessment occupational health should refer the staff member to their local A&E, calling the unit in advance to advise them.

### Follow up care and support

In house or on-site occupational health departments who have the appropriate facilities should carry out post exposure testing and provide any follow up vaccinations as required. If they are unable to carry out post exposure viral testing, they should advise the staff member on accessing their local sexual health clinic for follow up. If the officer is seen by NHS emergency services, then information on the need for testing and any precautions to be taken should also be provided to them by hospital staff.

Should a member of the fire service acquire a BBV they will require counselling as to the consequences of their diagnosis, and any changes in practice they will need to make. This should be provided by whomever delivers this diagnosis, but further support from occupational health may be required.

The frontline worker's supervisor should contact them and review the potential effects of the incident, including the need for adjustments to their work tasks or role.

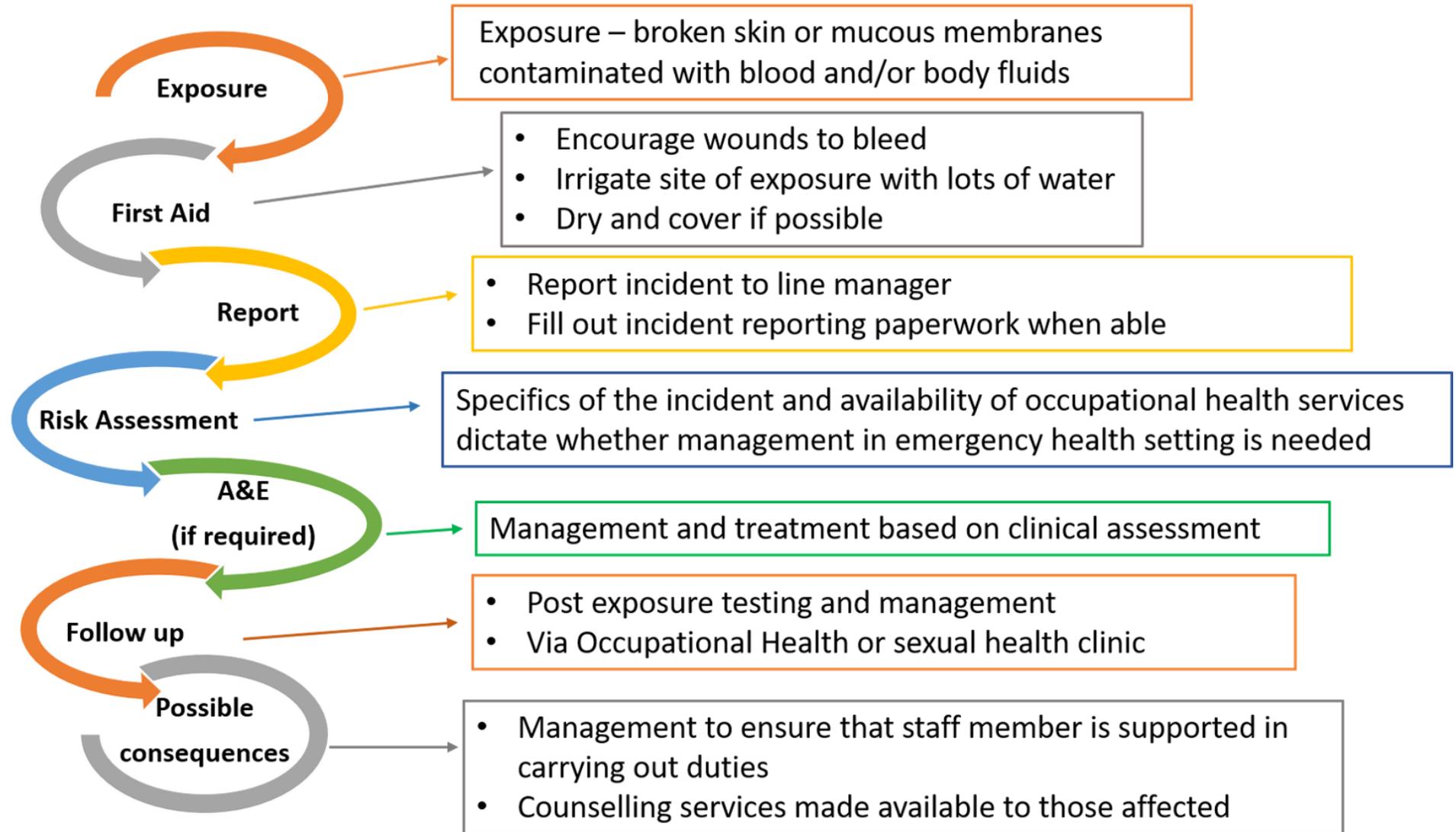
Occupational health and management staff should ensure that the staff member feels supported in being able to continue their duties, and that all necessary reasonable adjustments are made to allow for any impact on their health. For example, following a HIV diagnosis a staff member may benefit from modifications to work tasks or shift patterns while getting used to their medication and any side effects.

As well as coming to terms with the physical consequences, such an incident can have a significant mental health impact, and so the fire service should make counselling available to any affected staff member.

## Education and training

Although the operational risk to fire service staff from blood-borne viruses is very low, they need to understand how the infections can and cannot be transmitted both for their own protection and to ensure the appropriate and sensitive treatment of others. Service leaders should implement whatever level of training or education deemed necessary to ensure that staff can understand basic facts about all BBVs and have sufficient knowledge to deal safely and confidently with situations where there is possible risk of infection.

## Fire Service Incident Response Pathway



## Immigration, immigration detention and border security staff

### Access to information

The immigration, immigration detention and border security services should ensure that staff have prompt access to information to help them identify incidents which may pose a threat to their health, to understand the process of dealing with an exposure incident and where to seek advice based on the guidance below.

### First aid

If a staff member has been injured while on duty the appropriate first aid should be given as soon as possible. If no trained first aider is available then staff should follow the guide available in the first aid box, or advice from the telephone helpline.

### Reporting

Staff members should report any potential BBV incident to their line manager and fill out any incident reporting paperwork as required.

### Risk assessment

If a possible exposure event occurs during occupational health operational hours, and emergency care is not required, staff should attend for a risk assessment. Occupational health departments should have a clear protocol for assessing spitting and biting incidents based on up to date guidance, and staff should make a detailed record of their assessment of any injury or discussion had as this may form part of any investigation into the incident.

Where necessary following risk assessment occupational health should refer the staff member to their local A&E, calling the unit in advance to advise them.

### Follow up care and support

In house or on-site occupational health departments who have the appropriate facilities should carry out post exposure testing and provide any follow up vaccinations as required. If they are unable to carry out post exposure viral testing, they should advise the staff member on accessing their local sexual health clinic for follow up. If the officer is seen by NHS

emergency services, then information on the need for testing and any precautions to be taken should also be provided to them by hospital staff.

Should a member of the immigration, immigration detention or border security staff acquire a BBV they will require counselling as to the consequences of their diagnosis, and any changes in practice they will need to make. This should be provided by whomever delivers this diagnosis, but further support from occupational health may be required.

The frontline worker's supervisor should contact them and review the potential effects of the incident, including the need for adjustments to their work tasks or role.

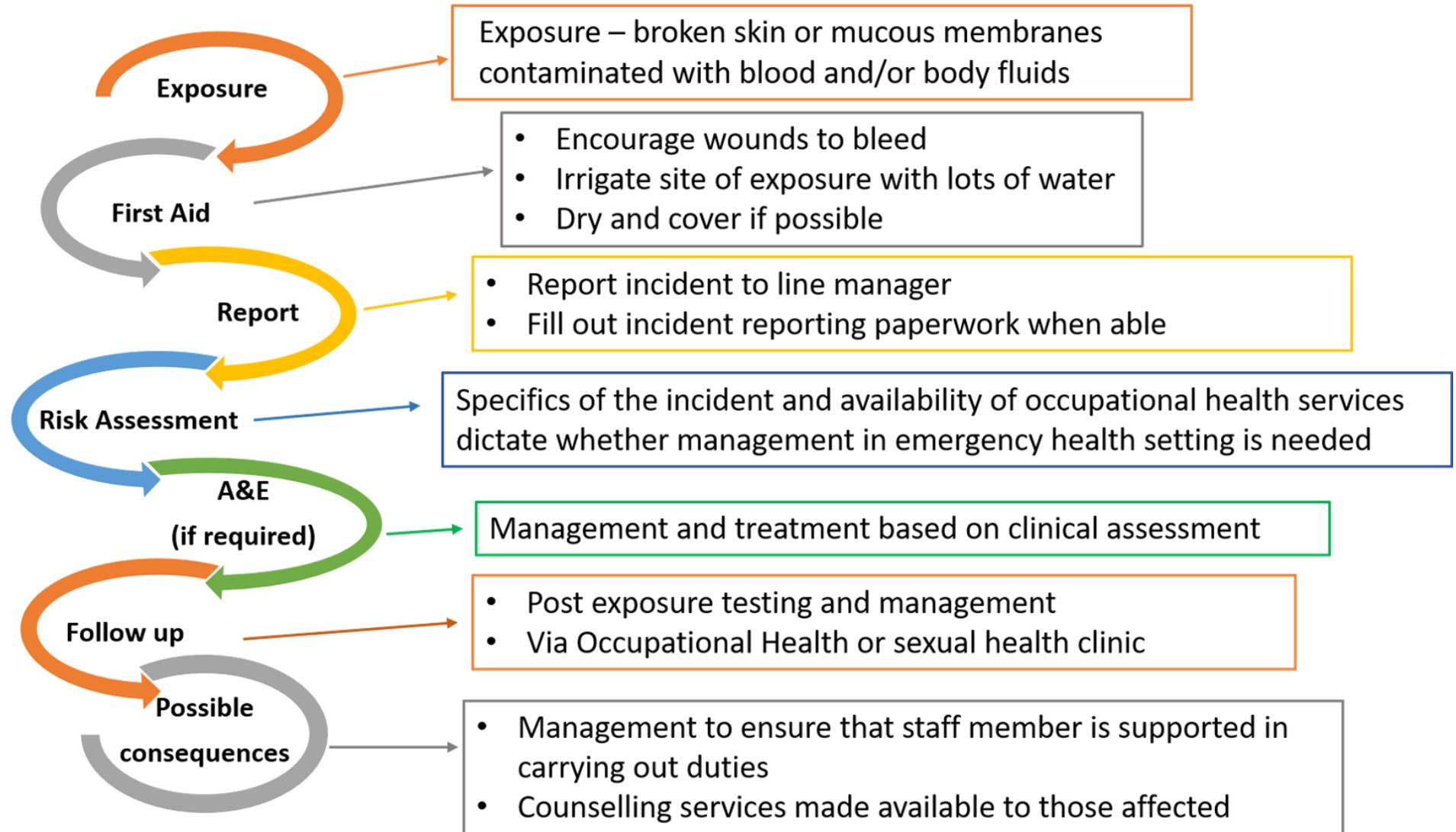
Occupational health and management staff should ensure that the staff member feels supported in being able to continue their duties, and that all necessary reasonable adjustments are made to allow for any impact on their health. For example, following a HIV diagnosis a staff member may benefit from modifications to work tasks or shift patterns while getting used to their medication and any side effects.

As well as coming to terms with the physical consequences, such an incident can have a significant mental health impact, and so the immigration, immigration detention and border security service should make counselling available to any affected staff member.

## Education and training

Although the operational risk to immigration, immigration detention and border security service staff from blood-borne viruses is very low, they need to understand how the infections can and cannot be transmitted both for their own protection and to ensure the appropriate and sensitive treatment of others. Service leaders should implement whatever level of training or education deemed necessary to ensure that staff can understand basic facts about all BBVs and have sufficient knowledge to deal safely and confidently with situations where there is possible risk of infection.

## Immigration Service Response Pathway



## Resources

Resources for helping frontline workers and organisations better understand BBV transmission and infection include:

- Health and Safety Executive, Blood-borne viruses in the workplace: Guidance for employers and employees. 2007. [www.hse.gov.uk/pUbns/indg342.pdf](http://www.hse.gov.uk/pUbns/indg342.pdf)
- British HIV Association, HIV: A guide for police forces, how to address HIV in police occupational health policies and blood-borne virus (BBV) training. 2014. [www.nat.org.uk/sites/default/files/publications/July\\_2014\\_bbv\\_report\\_0.pdf](http://www.nat.org.uk/sites/default/files/publications/July_2014_bbv_report_0.pdf)
- the website HIVAware which provides clear and useful information on HIV and HIV tests [www.hivaware.org.uk](http://www.hivaware.org.uk)