



Public Services Health
& Safety Association™

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Designated Officer

Participant Resources



Designated Officer

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Product Code: EPOPWAEN0524

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Document Name: Designated Officer Participant Resource Manual

Product Code: EPOPWAEN0524

Version Date: May 5, 2024

Table of Contents

Terms of Use i

Table of Contents ii

How to Use the Appendix 1

Appendix A: Decision Trees & Infectious Disease Fact Sheets 2

Appendix B: Designated Officer Incident Assessment Form 56

Appendix C: Legislative/Regulatory Requirements 59

 Sample Board Policy 59

 Police Service Guidelines 60

Appendix D: Mandatory Blood Testing Act, 2023 65

Glossary 66

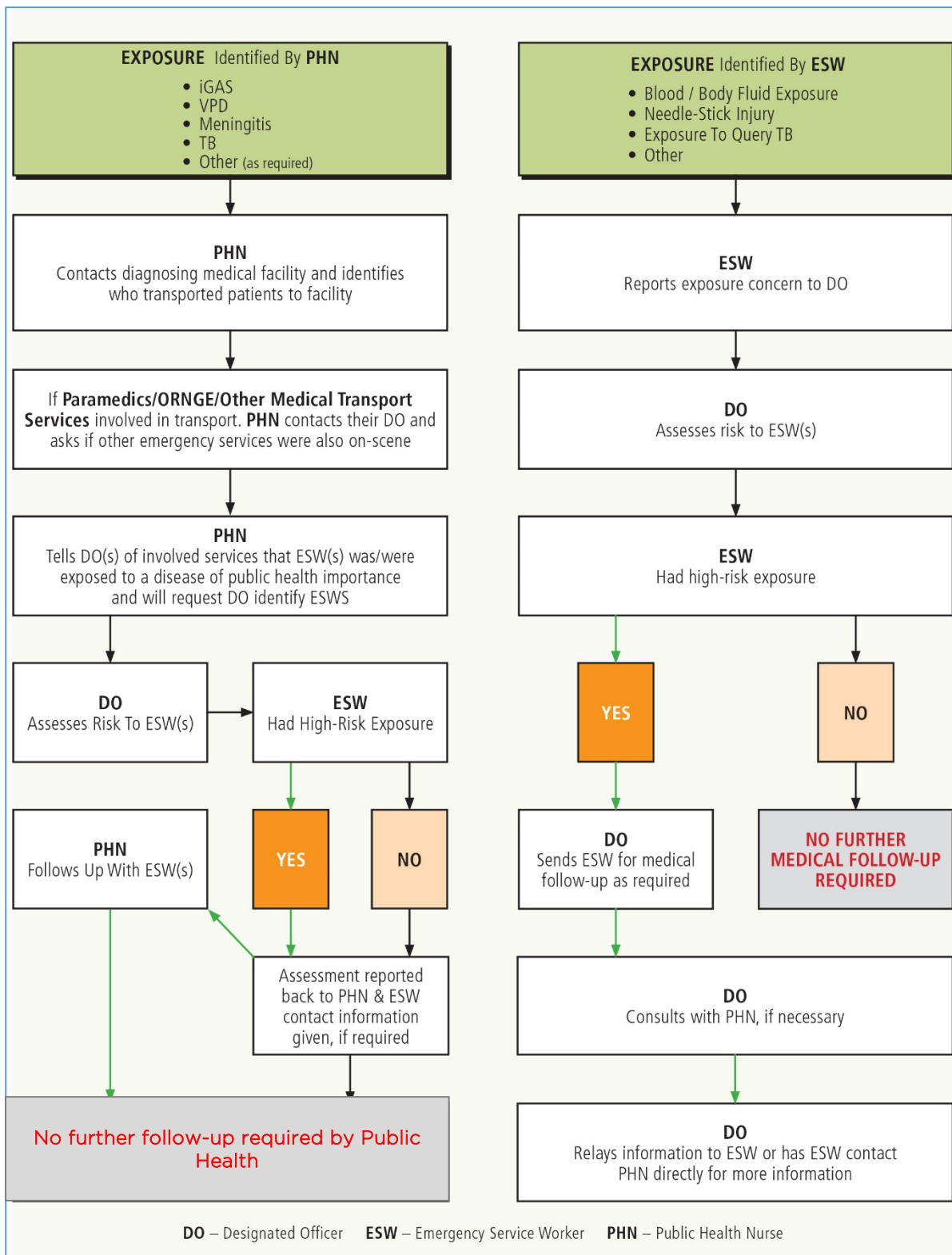
References 68

How to Use the Appendix

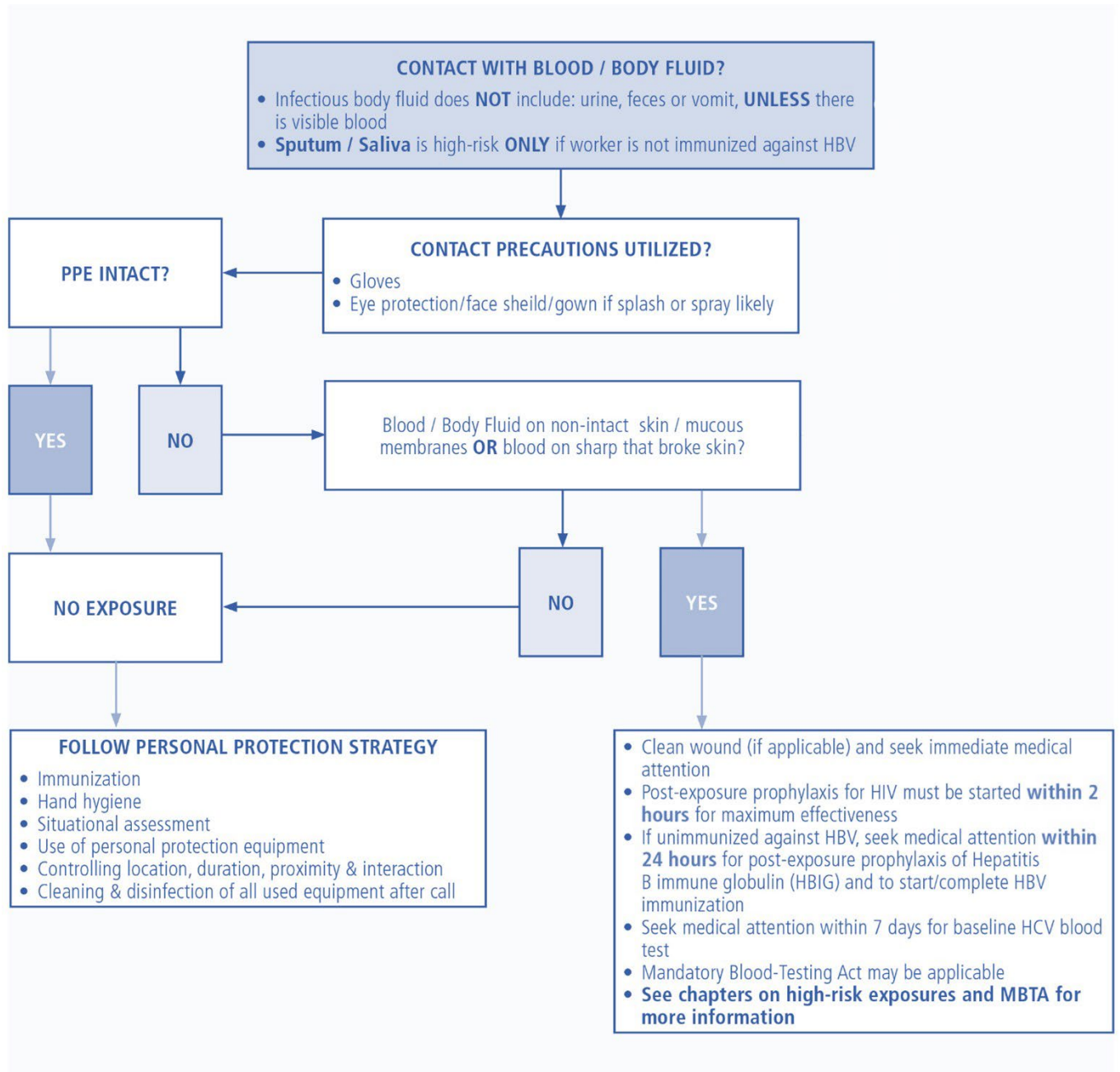
The Appendix contains a variety of supplemental information supporting the content provided during the classroom sessions. It is hoped that this Appendix will provide a document that will be of value both during and long after the initial training course.

Appendix A: Decision Trees & Infectious Disease Fact Sheets

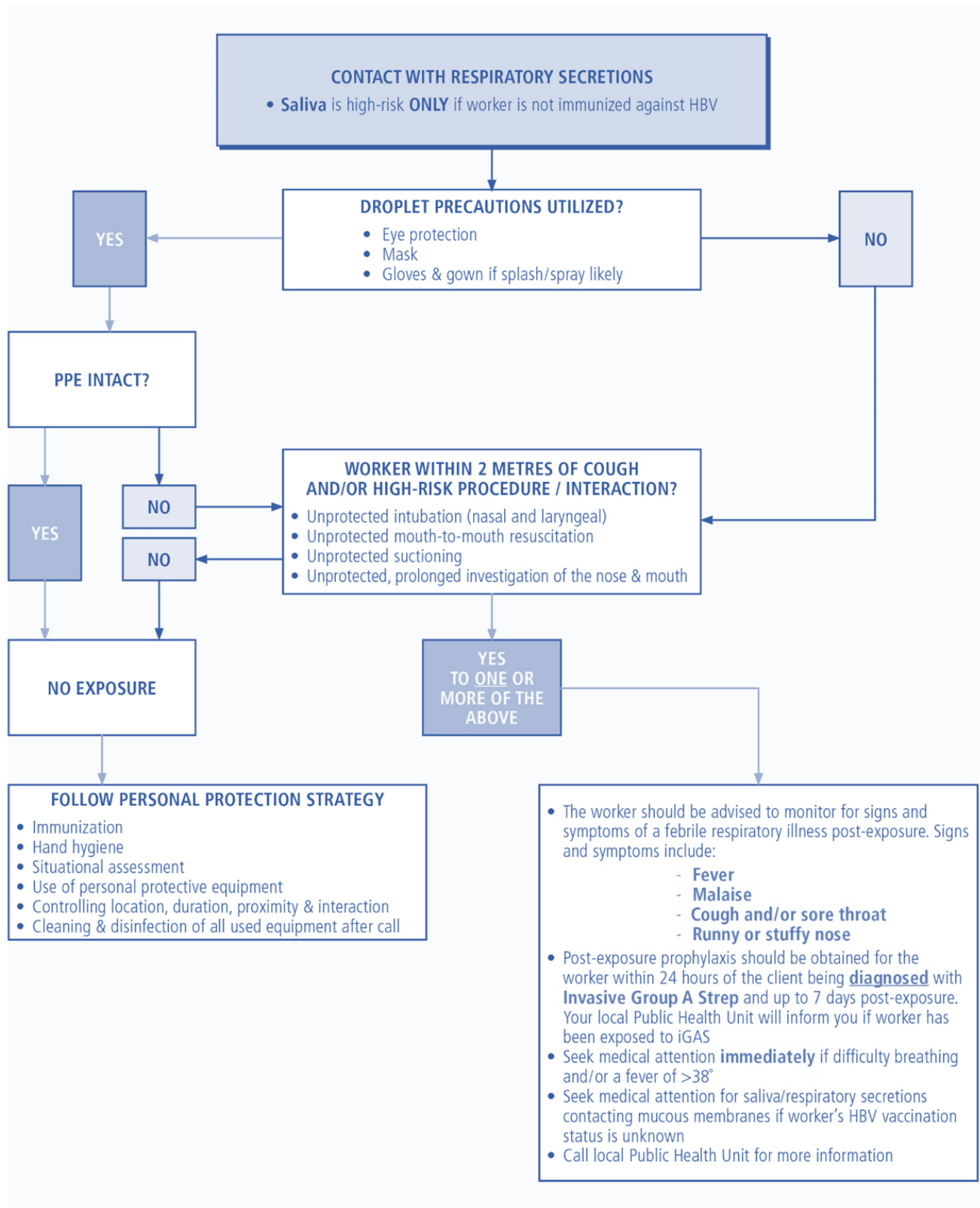
Emergency Service Worker Exposure Response Algorithm



Exposure To Blood/Body Fluid



Exposure to Respiratory Secretions



Bacterial Meningitis

Meningitis is an infection of the membranes and fluid covering the brain and spinal cord. Viruses, bacteria, fungi and toxins can cause meningitis. While all types of meningitis can be considered a serious medical condition and are reportable to Public Health, most are not a risk to ESWs/JSWs or others. Only meningitis caused by specific kinds of bacteria results in Public Health initiating contact tracing and exposure follow-up.

Bacterial meningitis can result in severe illness and may cause permanent brain damage, hearing loss and/or learning disabilities. While there are over 50 different types of bacteria that can cause meningitis in susceptible hosts, the ones of most concern in the pre-hospital environment are caused by Haemophilus influenzae type b (HiB), Streptococcus pneumoniae and Neisseria meningitides. These three types of bacteria cause over 75% of all confirmed bacterial meningitis and over 90% of all meningitis in children. There are vaccines available for Haemophilus influenzae type b (HiB), Streptococcus pneumoniae and some strains of Neisseria meningitides.

Bacterial meningitis is commonly found in infected secretions of the upper respiratory tract. Respiratory secretions from an infected individual must contact the nose and throat of a susceptible host. Emergency and justice service workers can be at risk of exposure to meningitis through any activity that can increase the risk of contact to infected respiratory secretions.

High-risk activities include:

- Unprotected intubation (nasal and laryngeal).
- Unprotected mouth-to-mouth resuscitation.
- Unprotected suctioning.
- Unprotected, prolonged investigation of the nose and mouth.

The signs and symptoms of bacterial meningitis include:

- Rapid onset of severe illness.
- Fever, headache, stiff neck that can include an unwillingness to move the head up and down.
- Nausea and vomiting.
- Sensitivity to bright light.
- People with this disease are visibly sick and may be confused, irritable or drowsy.
- Sometimes a rash may be present as well.

To prevent the spread of bacterial meningitis:

If you are with a client where bacterial meningitis is suspected or confirmed, follow the Personal Protection Strategy by:

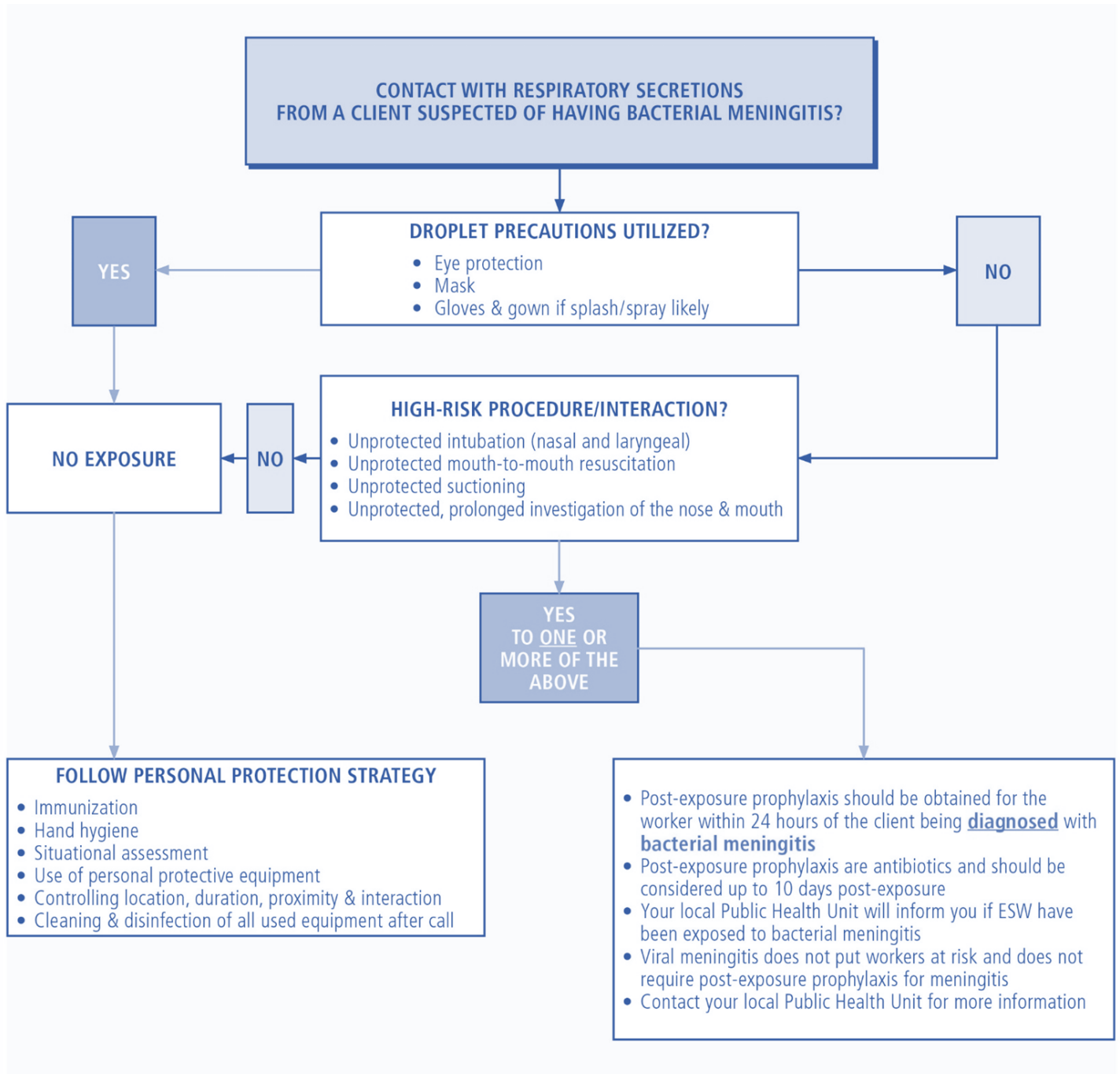
- Control your proximity if possible by staying one to two metres back from the client if they have signs and symptoms of bacterial meningitis.
- If you must be within two metres of the client, wear eye protection and a surgical mask to prevent contaminated respiratory secretions from landing on your eyes, nose and mouth. If your service does not issue surgical masks, wear your fit-tested N95, PAPR or reusable (elastomeric) respirator.
- Clean and disinfect any surface and/or reusable equipment that were within two metres of the client as it may have come in contact with contaminated respiratory secretions.
- Remove gloves and clean hands with ABHR or soap and water for at least 15 seconds before and after all client contact.

Public Health receives reports on all suspected and confirmed cases of bacterial and other meningitis in their local region, and will follow-up with emergency and justice service workers if it is possible an exposure has occurred. If an emergency or justice service worker has received a high-risk exposure, post-exposure prophylaxis with antibiotics may be recommended if indicated for that specific type of meningitis.

Remember: It is extremely rare to develop bacterial meningitis even after a high-risk exposure. The risk of developing bacterial meningitis after exposure is only 1%.

If you have any questions, contact your Designated Officer or your local Public Health Unit.

Bacterial Meningitis



Bed Bugs



Bed bugs are bloodsucking insects that feed on exposed human skin. Bed bugs are nocturnal and that is why they feed mainly at night when humans are sleeping.

Bed bugs are flat, wingless crawling insects that are reddish-brown in colour. They are approximately a quarter inch or 5 mm long (the size of an apple seed) and, after feeding, their bodies can double in size. They feed at night and hide during the day. 90% of their lifespan is spent in hiding places. Bed bugs prefer dark areas and hide in cracks and crevices to protect themselves close to where the person normally sleeps.

Bed bugs spread through two different mechanisms: Migration and 'hitch hiking.' Migration occurs when the population of bed bugs grows to such an extent that the insects migrate to new areas of the home or building in search of food. Due to their small size they can easily crawl through openings such as an electrical outlet, plumbing or under doors to migrate to different areas.

Hitch hiking occurs when bed bugs climb into bags, on clothing or even cling to the treads of shoes and boots and are then moved by the person using the bags and/or wearing the clothing to another place. This makes it possible for ESWs to become accidentally contaminated with bed bugs and then bring them into their vehicles, back to their division, hall or base, or even into their homes.

When bitten by a bed bug, human skin may become irritated, inflamed and itchy through an allergic reaction to the bug's saliva. A bed bug feeds by extracting a small amount of blood from skin, which is usually painless.

No disease is known to have been transmitted to humans through bed bugs, however, the itching is a nuisance, and intense scratching may break the skin, introducing bacteria and causing infection.

Bed bugs in a home do not necessarily mean a problem with cleanliness or personal hygiene.

To prevent the spread of bed bugs:

- Apply the Personal Protection Strategy Model.

- Learn how to identify bed bugs.
- When entering a residence, bring in only what you need.
- Keep equipment and response bags away from walls and furniture. If possible, place bags in light-coloured plastic bags and inspect the outside of the plastic bags for bed bugs when leaving. It is unlikely that bed bugs will move from the environment to equipment or response bags.
- Stand rather than sit, and avoid sitting on cloth furniture. Wood or metal chairs are harder for bed bugs to climb.
- Wear a gown when caring for the client if possible.
- Have client remove outer clothing and wear gown or jumpsuit.
- Wrap the client in a blanket before putting them in your vehicle.
- Transport client's personal belongings in a sealed plastic bag.
- Inspect shoes, clothing (especially below the knee) and belongings for bed bugs after leaving, and kill them immediately if seen.
- Spraying soles and edges of shoes with rubbing alcohol after leaving the residence can prevent bed bugs from being transported.
- If required, bag work clothes in plastic for transport, and then put them in the dryer on the hottest setting (above 50°C) for at least 30 minutes.
- If processing a client for the judicial system, bagging all their personal items, including their civilian clothes and shoes as per policy is sufficient to prevent spread.

If you think your residence is contaminated with bed bugs, you should consult with a licensed pest control firm.

Exposure to bed bugs is not considered a medical emergency and does not require immediate medical follow-up.

Further information:

Toronto Public Health: <http://www.toronto.ca/health/bedbugs/factsheets.htm>

Or contact your local Public Health Unit.

Clostridium difficile

Clostridium difficile (C. diff) is a spore-forming bacteria that produces a toxin that causes diarrhea and more serious intestinal conditions. It is one of the most common infections in hospitals and long-term care homes in Canada.

Clients can be either infected or colonized with C. diff. If they are colonized, then the client will test positive for C. diff and/or its toxin, but they have no clinical symptoms of disease and do not require contact precautions. Clients who are sick with C. diff have clinical symptoms and test positive for C. diff and/or its toxin. It is not recommended to test for the presence of C. difficile bacteria without the client having symptoms.

Symptoms of C. difficile illness (CDI) include: watery diarrhea (at least three loose bowel movements per 24 hours for two or more days beyond what is normal for the client). Fever, loss of appetite, nausea, abdominal pain and/or abdominal tenderness may also be present.

Laboratory testing for CDI involves detection of the toxins produced by C. difficile. Specimens of diarrheal stool (liquid or conforming to the collection container, not formed stools) should be collected by the hospital/LTCH as soon as possible after the onset of symptoms.

C. difficile is found in feces, and spread through the oral-fecal route, meaning that the bacteria must be eaten. Commodes, bathing tubs and rectal thermometers are examples of items that become contaminated by tiny, non-visible particles of feces and, therefore, may spread CDI person-to-person when touched. Clients and workers can become infected by touching items that are contaminated with feces and then touching their mouths, allowing them to swallow the bacteria. Clients can also become infected by Health Care Workers whose hands are contaminated with C. diff and do not clean their hands properly before providing care.

Other risk factors for acquiring CDI include older age, prolonged hospitalization, bowel surgery, chemotherapy, underlying illness and/or antibiotic usage. Treatment with antibiotics alters the normal levels of the bacteria found in the intestines. When there are fewer of these bacteria, C. difficile can thrive and produce toxins that can cause illness. People in good health usually do not get CDI.

Clients who have CDI must be transported using contact precautions (gloves and gown).

C. diff spores are not killed by low-level disinfectant. Killing C. diff requires higher concentrations of chemicals which are sporacidal (spore-killing), such as accelerated hydrogen peroxide or bleach. Refer to the product label to ensure the product being used will kill CDI. However the action of mechanical cleaning (washing and wiping) will remove spores from medical devices and equipment, rendering them safe for reuse.

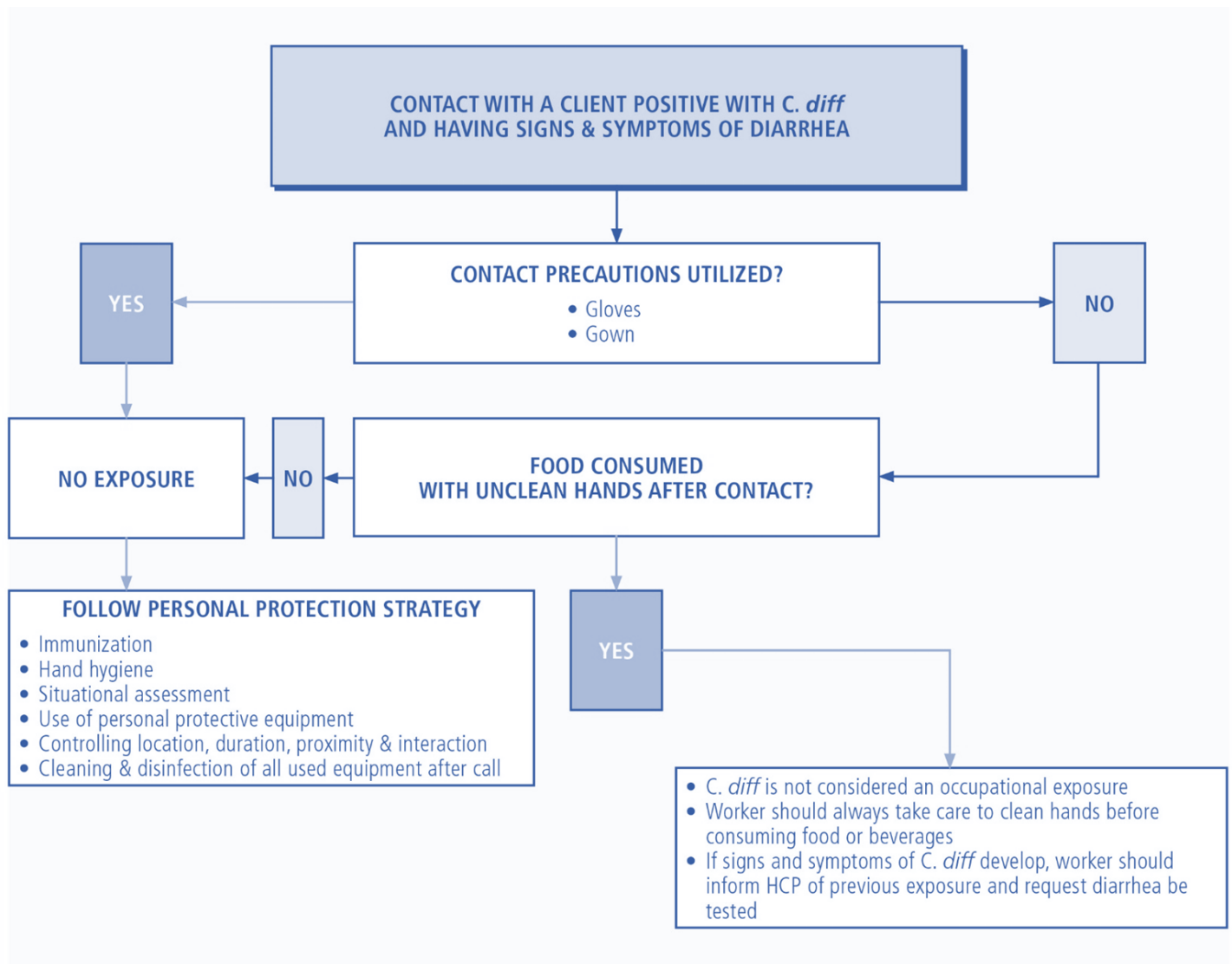
Treatment for C. diff is not required for people with mild symptoms. If antibiotic use is the cause, symptoms usually clear up once the patient stops using antibiotics. For severe cases, different antibiotic treatment may be used, and in extreme circumstances, surgical interventions may be required. After treatment, repeat C. difficile testing is not recommended unless symptoms reoccur.

To prevent the spread of C. diff:

- Apply the Personal Protection Strategy Model.
- Wash your hands with soap and water for at least 15 seconds before and after any client contact.
- As ABHR does not kill C. diff bacteria, soap and water is most recommended. If no water is available, use ABHR or 'baby wipes' to physically remove bacteria from your finger-tips and then wash hands as soon as possible.
- Use contact precautions (gloves and gown) when interacting with all clients who have signs and symptoms of diarrhea.
- Wrap the client in a blanket for transport, if possible, to minimize the chance of seats/stretchers becoming contaminated.
- Clean and disinfect all equipment used with the client, and all surfaces the client may have touched. The mechanical action of wiping down these surfaces with the wipes you've been provided removes the C. diff bacteria and prevents the bacteria from infecting others.
- Remember to always clean your hands before eating!

If you have any questions, contact your Designated Officer or your local Public Health Unit.

Clostridium difficile (C. diff.)



Ebola Viral Disease (EVD)

Ebola Viral Disease (EVD) is a severe, often-fatal disease in humans and nonhuman primates (monkeys, gorillas, and chimpanzees) that has appeared sporadically since it was first identified in 1976. The disease is caused by infection with Ebola virus, named after a river in the Democratic Republic of the Congo (formerly Zaire) in Africa, where it was first recognized. The virus is one of two members of a family of RNA viruses called the Filoviridae. There are five identified subtypes of Ebola virus. Four of the five have caused disease in humans.

Confirmed cases of EVD have been reported in the Democratic Republic of the Congo, Gabon, Sudan, the Ivory Coast, Uganda, and recently in the 2014-2015 outbreak in Guinea, Sierra Leone, Liberia and Nigeria.

Signs and Symptoms of EVD:

The Ebola virus causes a severe, acute viral illness with common symptoms of:

- Fever
- Headache
- Joint & muscle aches
- Sore throat
- Weakness
- Diarrhea
- Vomiting
- Stomach pain
- Lack of appetite

A rash may develop on the skin and mucous membranes of the mouth which can then progress to small, clustered bruises under the skin. Eyes may become red and swollen.

In about 50% of cases, the patient will start bleeding from their nostrils, gums and intestines and sites of recent injections. The bleeding is accompanied by wasting and dehydration, and in severe cases, the patient will suffer from blood disorders, multi-organ failure and death.

Transmission of EVD:

The Ebola virus spreads person-to-person through contact with infected blood and body fluid that is then transferred to unprotected mucous membranes (eyes, nose, mouth) or non-intact skin. People can also be exposed to Ebola virus through contact with objects, such as needles, that have been contaminated with

infected blood or body fluid. It is considered highly contagious. However only people with signs and symptoms of disease are able to spread EVD, and contagiousness increases with the number and severity of the symptoms.

The incubation period is 2 to 21 days after exposure, although 8 to 10 days is most common.

Treatment:

At the time of publication there is still no treatment for EVD beyond supportive therapy, which consists of replacing blood, fluids and electrolytes, monitoring of vital signs and supportive nursing care. While an Ebola vaccine is in development, currently there is no vaccine available.

To Prevent the Spread of EVD:

- Apply the Personal Protection Strategy Model.
- Follow service, municipal or provincial directives.
- Use enhanced PPE (eye protection/face shield and mask, gloves, hood, gown and leg covers) when interacting with all clients who have signs and symptoms of viral hemorrhagic fever.
- Officers should wear medical gloves over their service gloves.
- Ensure any non-intact skin (cuts, scrapes,) are covered with fluid-resistant bandages.
- Be sure to inform receiving hospital that you are bringing a client with suspected EVD.
- Wrap the client in a blanket for transport to minimize the chances of seats/stretchers becoming contaminated.
- Remove all PPE and dispose of it immediately after call is finished.
- Remove service gloves and immediately bag them for washing.
- Clean hands thoroughly with alcohol-based waterless hand sanitizer or soap and water as soon as possible after PPE is removed.
- Clean and disinfect all equipment used with the client and all surfaces the client may have touched before reuse.
- Any items of clothing and/or linens that are contaminated with blood or body fluid suspected of being infected with Ebola virus must be bagged and disposed of immediately.

It is vitally important to avoid contact with the blood or body fluid of any client with suspected or confirmed EVD. Enhanced PPE must also be used when

manipulating a deceased client with known or suspected EVD as handling of the bodies of clients who have died of EVD has caused transmission of disease.

Further Information:

Public Health Agency of Canada's Ebola information page: <http://www.phac-aspc.gc.ca/id-mi/vhf-fvh/ebola-eng.php>

Or contact your local Public Health Unit.

Extended Spectrum Beta-Lactamase Organisms (ESBL)

ESBL organisms are bacteria that are commonly found in the lower digestive tract. They can also be found in: urine, blood, wounds and sputum. Several different types of bacteria can be classified as ESBL. ESBLs produce enzymes that break down some antibiotics, specifically those in the cephalosporin class of antibiotics, which includes penicillin, and antibiotics in the class of fluoroquinolones. This means that those antibiotics are no longer effective in killing the ESBL organisms. Infections caused by ESBLs are treated with other antibiotics effective against the bacteria. Colonization of the bowel by ESBLs is not treated as it does not cause illness.

ESBLs are found in feces, and are spread through the oral-fecal route, meaning that the bacteria must be eaten. Clients become infected by health care workers whose hands are contaminated with ESBLs and who do not clean their hands properly before providing care. Non-intact skin and indwelling devices, such as urinary catheters, can become contaminated with ESBLs and cause infection if they are touched by contaminated hands of clients and their health-care providers.

Items, such as commodes, bathing tubs and rectal thermometers can easily become contaminated by tiny, non-visible particles of feces and therefore may spread ESBLs person-to-person when touched.

Clients and workers can become infected by touching items that are contaminated with feces and then touching their mouths, allowing them to swallow the bacteria.

Risk factors for colonization with an ESBL:

- Prolonged and/or extensive treatment with third-generation cephalosporin or fluoroquinolone antibiotics.
- Prolonged hospital/ICU stay.
- Severe illness requiring invasive and/or multiple medical interventions.
- Receiving a transplant.
- Having an indwelling catheter.

To prevent spread of ESBLs:

- Apply the Personal Protection Strategy Model.
- Clean your hands with ABHR or soap and water for at least 15 seconds before and after any client contact.

- Use contact precautions (gloves and gown) when interacting with all clients who have signs and symptoms of diarrhea.
- Wrap the client in a blanket for transport, if possible, to minimize the chance of seats/stretchers becoming contaminated.
- Clean and disinfect all equipment used with the client, and all surfaces the client may have touched.
- Remember to always clean your hands before eating!

If you have any questions, contact your local Public Health Unit.

Head Lice (Pediculosis)

Head Lice is an insect that lives and breeds on your head that feeds by biting your scalp to suck minute amounts of blood. Having head lice (pediculosis) is common; as many as 6 to 12 million people worldwide get head lice each year.

Anyone who comes in close head-to-head contact with someone who already has head lice can get head lice. Head lice are found more often among children between the ages of 3 to 10, and their families.

Signs & symptoms of head lice:

- Tickling feeling of something moving in the hair.
- Itching, caused by an allergic reaction to the bites.
- Sores on the head caused by scratching. These sores can sometimes become infected.

Head lice are spread by:

- Close head-to-head contact with someone who already has head lice, such as bending to care for a client in a way that allows your hair to contact theirs.
- Activities where articles that contact the head, such as helmets and protective equipment, might be shared.
- Using hats, scarves, combs, brushes, hair ribbons, pillows or towels recently used by someone with head lice where lice or nits (eggs of lice) have transferred.

Lice are tiny, wingless insects that move quickly and are difficult to see. They cannot jump or fly. They are 1 to 2 mm long and greyish-brown in colour. There are three forms of lice: the nit (egg), the nymph and the adult.



Nits are head lice eggs. They are hard to see and are often confused with dandruff or hair spray droplets. Nits are found firmly attached to the hair shaft. They are oval and usually yellow to white. Nits take about one week to hatch.

The nit hatches into a baby louse called a nymph. It looks like an adult head louse, but is smaller. Nymphs mature into adults about seven days after hatching. Nymphs must have blood within the first 24 hours of life or they will die.

The adult louse is about the size of a sesame seed, has six legs, and is tan to greyish-white. Females lay nits and are usually larger than males. Adult lice can live up to 30 days on a person's head. To live, adult lice need to feed on blood. If a louse falls off a person and cannot feed, it dies within 48 hours. Head lice do not spread disease.



There are many products available to treat head lice. Before buying any product, talk to a pharmacist to see what product may be appropriate for your use. A doctor should be consulted before treating a child less than two years of age, or people with a seizure disorder or non-intact skin of the scalp such as a skin condition or infection. Head lice treatment should not be used post-exposure if no symptoms are present.

To prevent the spread of lice:

- Apply the Personal Protection Strategy Model.
- Do not allow your head to touch the heads of clients or colleagues.
- Do not share personal items, such as hats, scarves, hairbrushes, combs and pillows. Items, such as helmet or protective equipment for the head, which may be worn by more than one person should be cleaned and disinfected as per manufacturer's instructions between uses.
- If you have long hair, tie it back. Braids hold the hair tightly and discourage lice from clinging to it.
- All family members with head lice should be treated at the same time.
- Tell all close contacts of the person with head lice to check their head. If it is a child, inform their school and/or daycare.
- Check young school age children weekly for head lice; more often if there is an outbreak.

Exposure to lice is not considered a medical emergency and does not require immediate medical follow-up.

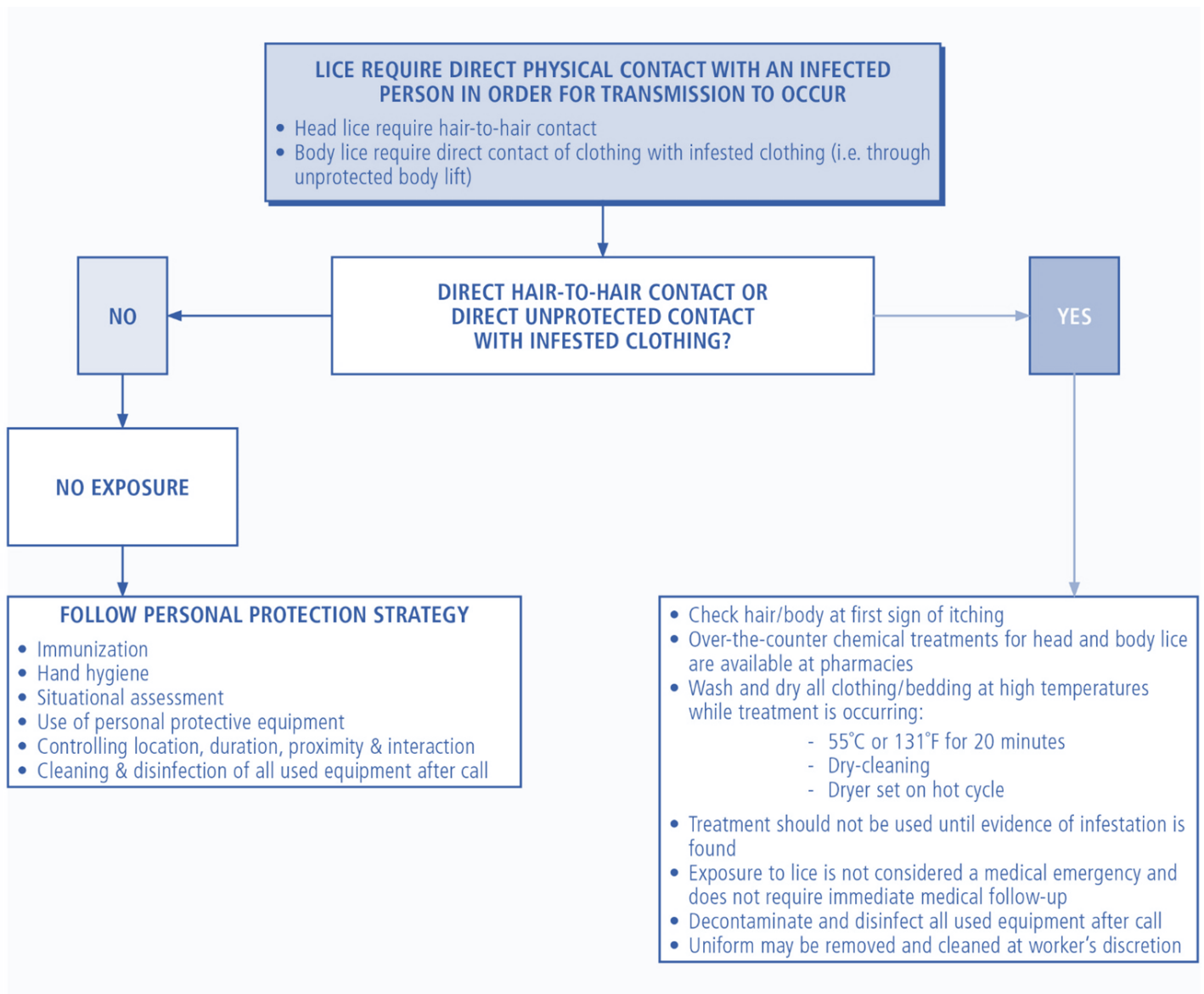
Further Information:

CDC lice treatment page:

<http://www.cdc.gov/parasites/lice/head/treatment.html>

Or contact your local Public Health Unit.

Head & Body Lice (Pediculosis & Phthiriasis)



Hepatitis A

Hepatitis A is a liver infection caused by the hepatitis A Virus (HAV). Hepatitis A virus is found in feces, and spread through the oral-fecal route, meaning that the bacteria must be eaten. It is not transmitted through blood or body fluid. People are most infectious a week or two before symptoms occur. It is most common to become infected with hepatitis A while in areas where it is prevalent such as on vacation or volunteering in a developing country. Some people may be more at risk of exposure to HAV due to their work. Hepatitis A is not considered a work-related exposure for emergency service or justice service workers.

Symptoms can last anywhere from one week to several months, however, some people, particularly young children, have no symptoms at all. Symptoms of hepatitis A infection include:

- Fever
- Body aches (malaise)
- Loss of appetite
- Upset stomach and abdominal discomfort
- Dark-coloured urine
- Jaundice (yellowing of the skin and/or the whites of the eyes).

There is no treatment for hepatitis A. Most people will suffer from an acute infection that will get better in one to two weeks. Once someone has recovered from hepatitis A infection, they develop immunity and cannot become infected again. It is unusual for people to become carriers of HAV.

To prevent the spread of HAV:

- Apply the Personal Protection Strategy Model.
- Clean hands with ABHR or soap and water for at least 15 seconds before and after any client contact.
- Use contact precautions (gloves and gown) when interacting with all clients who have signs and symptoms of diarrhea.
- Wrap the client in a blanket for transport, if possible, to minimize the chance of seats/stretchers becoming contaminated.
- Clean and disinfect all equipment used with the client, and all surfaces the client may have touched.
- Consider being vaccinated against HAV, especially if travel outside of Canada is planned. The cost of HAV vaccine is covered by service benefits packages.
- Remember to always clean your hands before eating!

Further information:

Contact your local Public Health Unit.

Hepatitis B

Hepatitis B Virus (HBV) is a viral infection of the liver. Some people who get hepatitis B never feel sick. Others develop flu-like symptoms, such as fatigue and nausea. Some become very ill with fever, loss of appetite, abdominal pain, dark urine, clay-coloured stools and develop a yellowish colour to their skin and eyes called jaundice. Most people who get hepatitis B recover completely and then have immunity to future hepatitis B infections. Less than 1% of people with acute hepatitis B die from the disease. Some people become carriers of hepatitis B and will require continual medical follow-up. Approximately 0.5% of adults in North America are chronic carriers of HBV.

Hepatitis B carriers are people who carry the virus in their blood and body fluids for the rest of their lives:

- Six to ten percent of people with hepatitis B become chronic carriers.
- Carriers look and feel well but can continue to pass the infection to others.
- Twenty-five percent of carriers develop cirrhosis (scarring) or cancer of the liver later in life.

Hepatitis B is spread to others by:

- Contact with infected blood or body fluids, including saliva. The infected blood or body fluid must enter a break in the skin or be absorbed through a mucous membrane, such as the eyes, nose, mouth or genital areas.
- Bites, if they break the skin, and infected blood or saliva from the biter is then able to contact the bloodstream.
- Through sharing of contaminated drug paraphernalia, such as needles.
- A carrier mother who can pass the virus to her baby during childbirth.
- Objects, such as patient-care equipment, which is contaminated with blood or body fluid coming in contact with non-intact skin or mucous membranes, as HBV can live on surfaces for upwards of 7 days.
- Flakes of dried blood contaminated with HBV coming into contact with non-intact skin or unprotected mucous membranes during cleaning or preparation of evidence, as HBV can live in dried blood for upwards of one month.

There is no treatment for HBV. It is highly recommended that emergency service and justice service workers vaccinate themselves against HBV. Unvaccinated people have a 30% chance of being infected with HBV every time they are exposed to infected blood and body fluids. If the person is fully vaccinated, the exposed person is provided with over 90% protection from HBV if they are

exposure to infected blood and body fluids. The cost of vaccine is reimbursable through service health benefits packages.

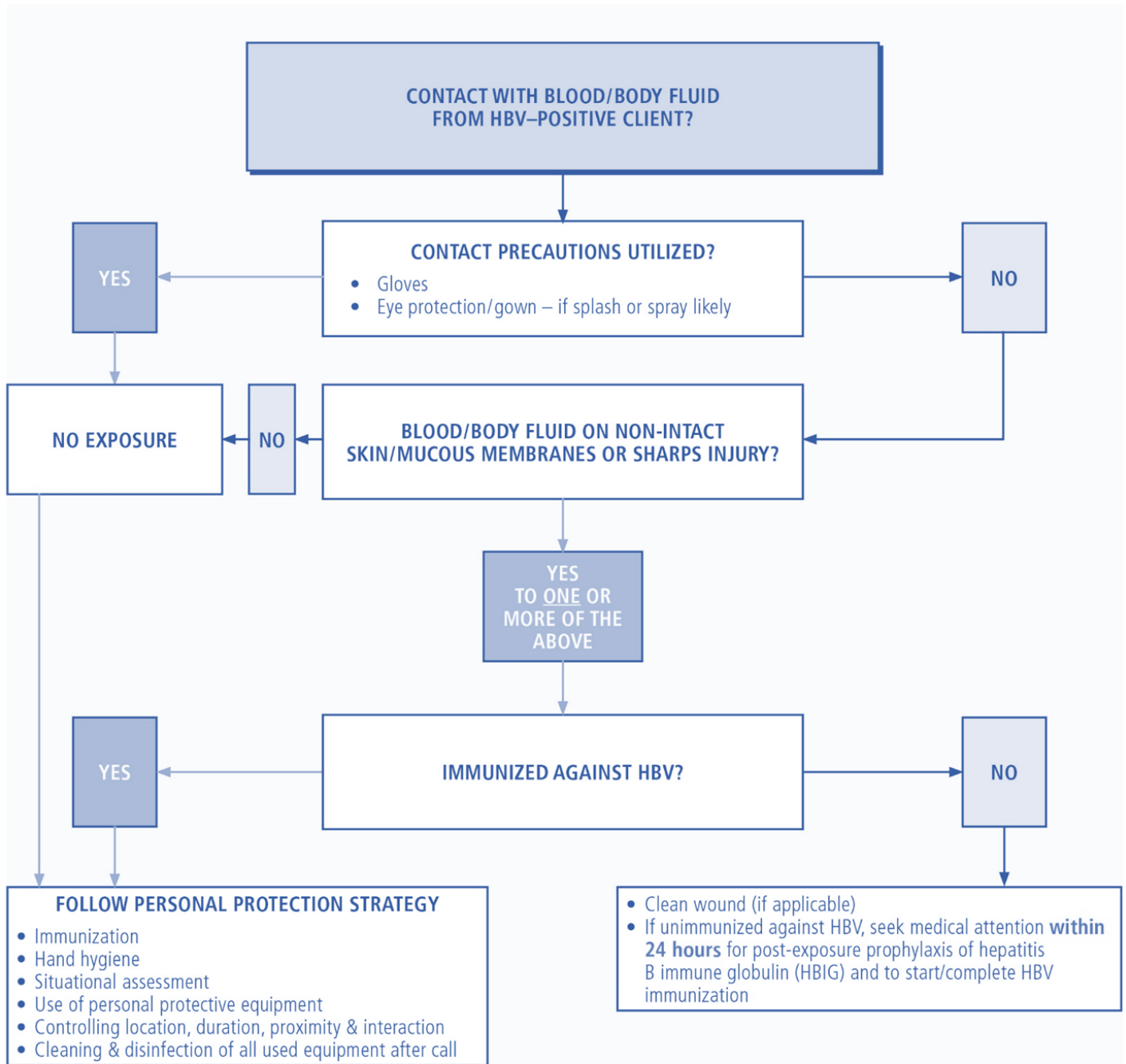
To prevent the spread of HBV:

- Apply the Personal Protection Strategy Model.
- Check skin for any areas that are non-intact and cover with a water-resistant dressing.
- Wear medical gloves to reduce the risk of blood/body fluid entering the body through breaks in the skin of the hands.
- If your service wears duty gloves, medical gloves should be worn over them to prevent blood and body fluid from leaking through.
- Wear eye protection and mask/respirators if:
 - a. blood or body fluid spray is likely.
 - b. your activity may aerosolize flakes of dried blood.
 - c. The client is likely to spit.
- Clean and disinfect any surface and/or reusable equipment that may have come in contact with blood/body fluids.
- Remove gloves and clean hands with ABHR or soap and water for at least 15 seconds before and after all client contact.

Further information:

Contact your local Public Health Unit.

Hepatitis B (HBV)



NOTE

Contact with blood/body fluid from a HBV+ client without prior HBV immunization carries a risk of infection of 30%.

Immunization against HBV is RECOMMENDED for ALL workers.

Hepatitis C

Hepatitis C virus (HCV) is a virus that causes an acute or chronic inflammation of the liver. Hepatitis C can lead to liver damage and may lead to liver cancer. As HCV is easily spread through blood and blood products, blood for donation in Canada has been screened for HCV since 1992.

Symptoms of HCV may appear 2 weeks to 6 months after exposure to the virus, but 75% of infected people will show no signs of illness. Of those with symptoms, the most common is chronic fatigue, but they may also include lack of appetite, nausea, vomiting, itchiness, development of a yellowish colour to their skin and eyes called jaundice and joint and muscle aches. Complications of hepatitis C include chronic liver disease such as cirrhosis, liver cancer and liver failure.

Seventy-five to eighty-five percent of people infected with hepatitis C become chronic carriers. This means that they will have the virus in their blood for the rest of their lives and can unknowingly spread it to others. Most carriers remain symptom-free for many years. However, some will eventually become ill because of ongoing damage to their liver. Approximately half of all carriers of HCV will develop cancer of the liver.

Hepatitis C is spread to others by:

- Sharing needles, spoons, straws and other drug-related equipment that is contaminated with HCV-infected blood or body fluid.
- Getting tattoos or body parts pierced with used or non-sterile needles that have been contaminated with HCV-infected blood or body fluid.
- Receiving medical care where multi-use patient care equipment is not adequately sterilized between uses and remains contaminated with HCV-infected blood or body fluid
- Receiving a transfusion of blood that has not been screened.
- Having received blood transfusions or blood products in Canada before 1992.
- Having an HCV-infected mother. Studies show that 5% to 10% of women who have HCV pass it on to their babies before or at the time of birth.
- The risk of HCV through occupational exposure, such as through needle-stick injuries or splash or spray of infected blood or body fluid on non-intact skin is less than 3%.
- Hepatitis C cannot be transmitted through mucous membranes.

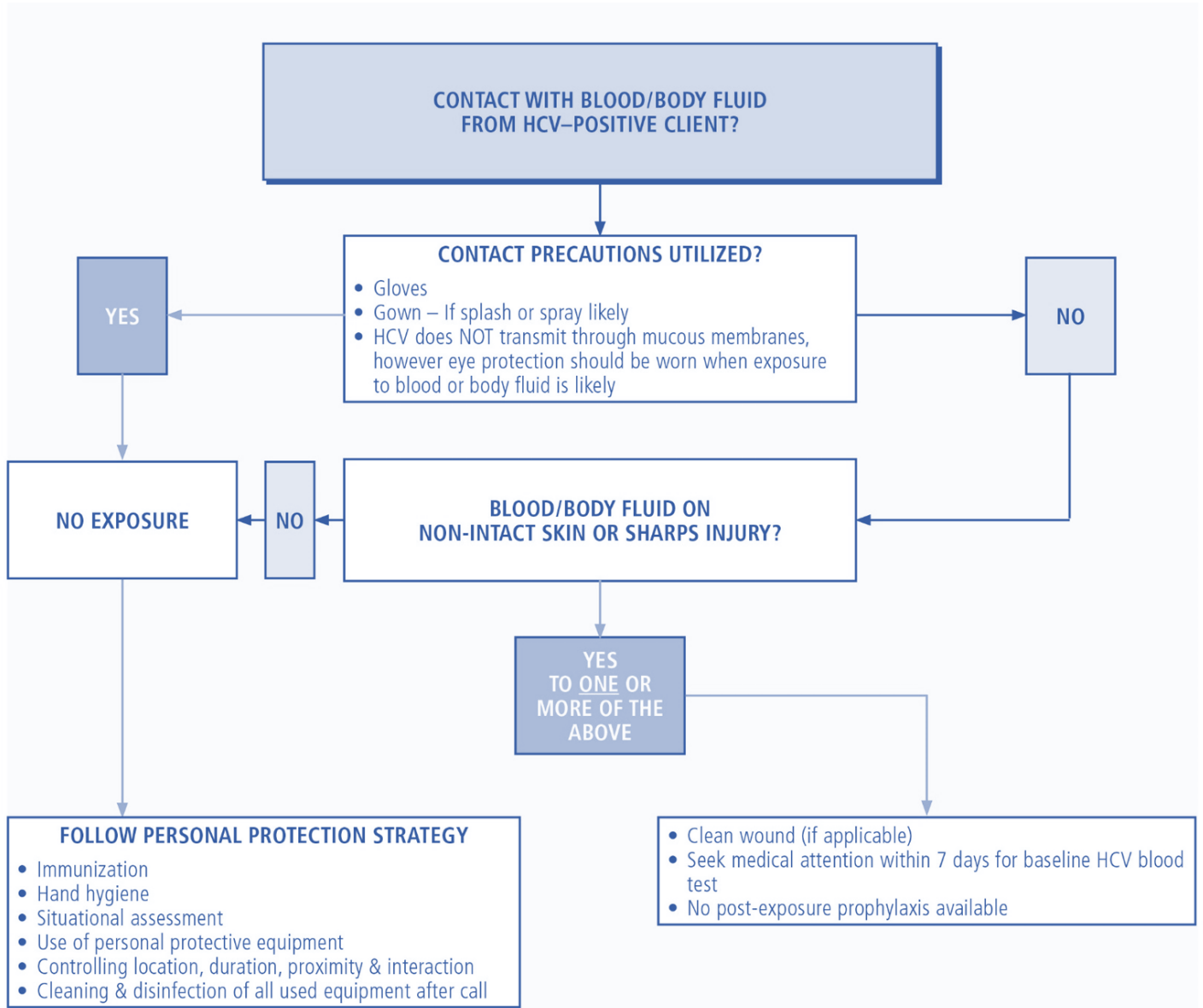
To prevent the spread of HCV:

- Apply the Personal Protection Strategy Model.
- Check your skin for any areas that are non-intact and cover with a water-resistant dressing.
- Wear medical gloves to reduce the risk of blood/body fluid entering your body through breaks in the skin.
- If your service wears duty gloves, medical gloves should be worn over them to prevent blood and body fluid from leaking through.
- Clean and disinfect any surface and/or reusable equipment that may have come in contact with blood/body fluids.
- Remove gloves and clean hands with ABHR or soap and water for at least 15 seconds before and after all client contact.

Further information:

Contact your local Public Health Unit.

Hepatitis C (HCV)



NOTE

Contact with blood/body fluid from an HCV+ client including sharps injury, carries a risk of infection of only 3%.

Hepatitis C CANNOT be transmitted through mucous membranes.

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). This virus attacks the body's immune system, lowering its ability to fight disease. According to the WHO, it is estimated that 37 million people worldwide are infected with HIV in 2014.

HIV is spread to others by contact with infected blood or body fluids. The infected blood or body fluid must enter a break in the skin or be absorbed through a mucous membrane, such as the eyes, nose, mouth or genital areas. HIV cannot be passed through casual contact such as shaking hands or hugging. HIV does not survive on inanimate objects and cannot be transmitted through them. It is not spread through saliva, urine, feces or vomit unless they are visibly contaminated with blood.

HIV is spread most efficiently through unprotected sexual contact, but can also be spread through sharing of contaminated drug paraphernalia, such as needles; and equipment used for tattooing, piercing, electrolysis or acupuncture that has not been properly sterilized. A carrier mother may also pass the virus to her baby during childbirth or breastfeeding. Blood or blood products that have not been properly screened can also pass on HIV. Having an untreated sexually transmitted infection can increase the chance of contracting HIV if exposed.

It is extremely rare for an occupational exposure to HIV, such as a needle-stick, to result in infection. A study commissioned by the Public Health Agency of Canada (PHAC) from April 2000 to March 2001, showed that, in over 1,200 high-risk exposures to HIV-infected blood, not a single health care provider contracted HIV. The risk of being infected with HIV from a needle-stick injury is considered less than 0.3 – 0.5%. An exposure to blood/body fluid on a mucous membrane, such as the eyes, nose, or mouth, on non-intact skin or through a bite has a risk of infection of 0.09%.

Even though the risk of infection is extremely low, if the worker has been exposed to blood and/or body fluid through a needle-stick injury or blood/body fluid contacting non-intact skin or mucous membranes, medical follow-up is required. Post-exposure prophylaxis for HIV must be started within two hours of exposure to be maximally effective. If taken within 2 hours of exposure, PEP can reduce the risk of HIV by 83%.

HIV testing is done by taking blood and looking for antibodies to HIV. It can take up to 12 weeks for these antibodies to develop in the body. Therefore, testing may

not be accurate until 12 weeks after exposure. This time is called the “window period.”

To prevent the spread of HIV:

- Apply the Personal Protection Strategy Model.
- Check skin for any areas that are non-intact and cover with a water-resistant dressing.
- Wear medical gloves to reduce the risk of blood/body fluid entering the body through breaks in the skin.
- If your service wears duty gloves, medical gloves should be worn over them to prevent blood and body fluid from leaking through.
- Wear eye protection and mask/respirator if blood or body fluid spray is likely.
- Clean and disinfect any surface and/or reusable equipment that may have come in contact with blood/body fluids.

Remove gloves and clean hands with ABHR or soap and water for at least 15 seconds before and after all client contact.

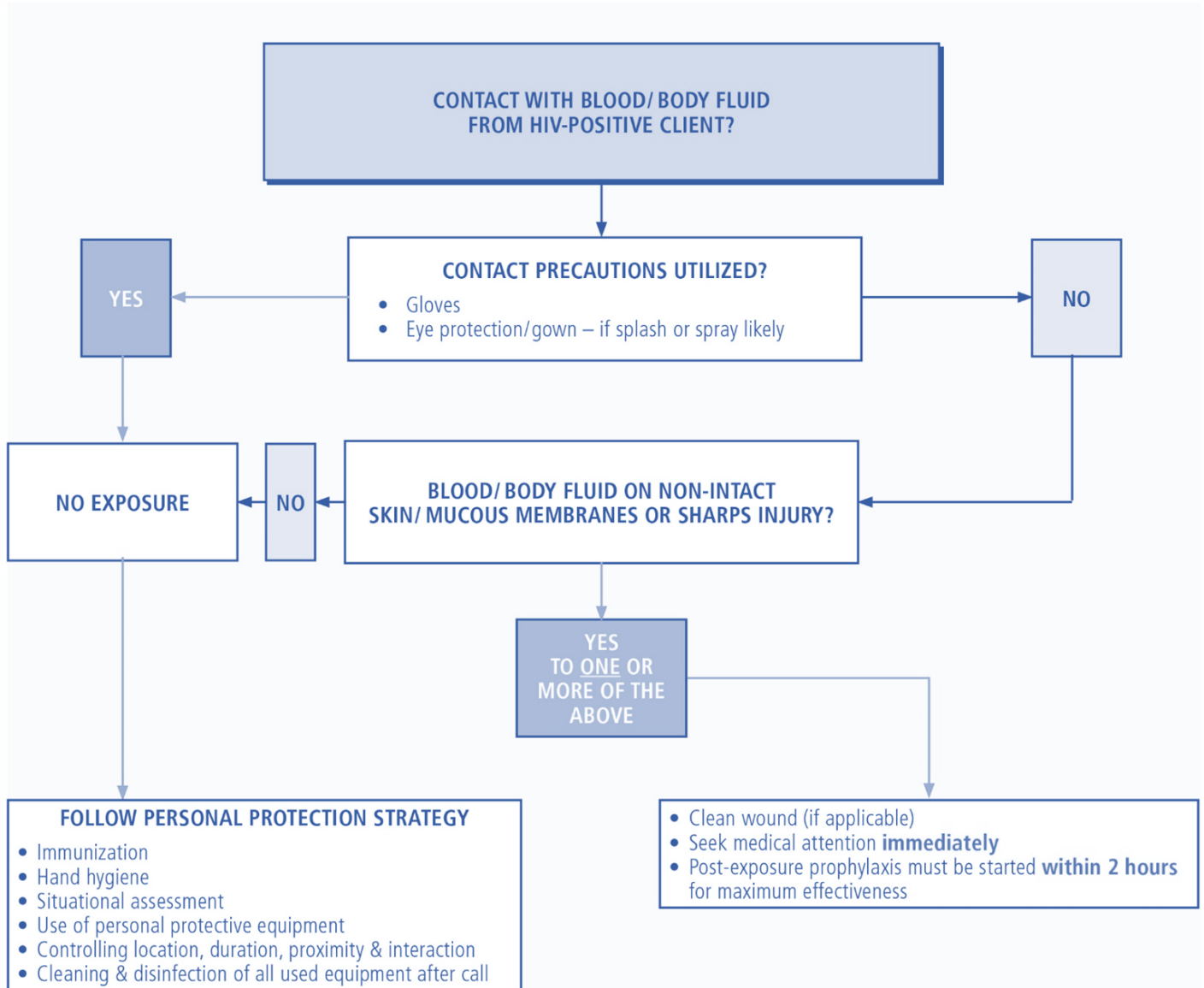
Further Information:

CATIE

<https://www.catie.ca/>

Contact your local Public Health Unit.

Human Immunodeficiency Virus (HIV)



NOTE

Contact with blood/ body fluid from an HIV+ client including sharps injury, carries a risk of infection of only 0.09 to 0.3 – 0.05%.

Influenza (the flu)

Influenza is a serious respiratory infection caused by the influenza virus. The flu spreads easily through the expulsion of infected respiratory secretions into the environment through coughing and sneezing. These heavy respiratory secretions can travel as much as two metres before landing on unprotected mucous membranes of the eyes, nose or mouth, or on surfaces, such as keyboards, tables, steering wheels or radios. When these surfaces are touched, the virus can be easily transferred to the mucous membranes of the eyes, nose and mouth when someone touches their face without cleaning their hands first. The flu can be prevented by getting vaccinated against influenza every year and by practising good hand hygiene.

While colds, stomach flu and other infections are often confused with the flu, they are not the same. Influenza can be a much more serious infection:

SYMPTOMS	COLD	INFLUENZA
Fever	Rare	Usually high (102°F/39°C-104°F/40°C), sudden onset, lasts 3-4 days
Headache	Rare	Usual, can be severe
Aches & pains	Sometimes, mild	Usual, often severe
Fatigue and weakness	Sometimes, mild	Usual, severe, may last 2-3 weeks or more
Runny, stuffy nose	Common	Common
Sneezing	Common	Sometimes
Sore throat	Common	Common
Chest discomfort, coughing	Sometimes, mild to moderate	Can become severe
Complications	Unusual	Pneumonia, respiratory failure. Can be life-threatening.

Influenza, while usually a mild-to-moderate self-limiting illness in the young and healthy, can be devastating for very young children, those with underlying medical conditions, and the elderly. As people are contagious with influenza up to 24 hours before they develop symptoms, it is very possible for emergency service or justice service workers to accidentally infect vulnerable clients who could develop severe illness or die as a consequence. It is for that reason that immunization against influenza is recommended for every emergency and justice service worker.

While antiviral medication is available to treat influenza, it is only effective within the first 48 hours of symptoms. Many types of influenza are already immune to the available antiviral medication.

To prevent the spread of Influenza:

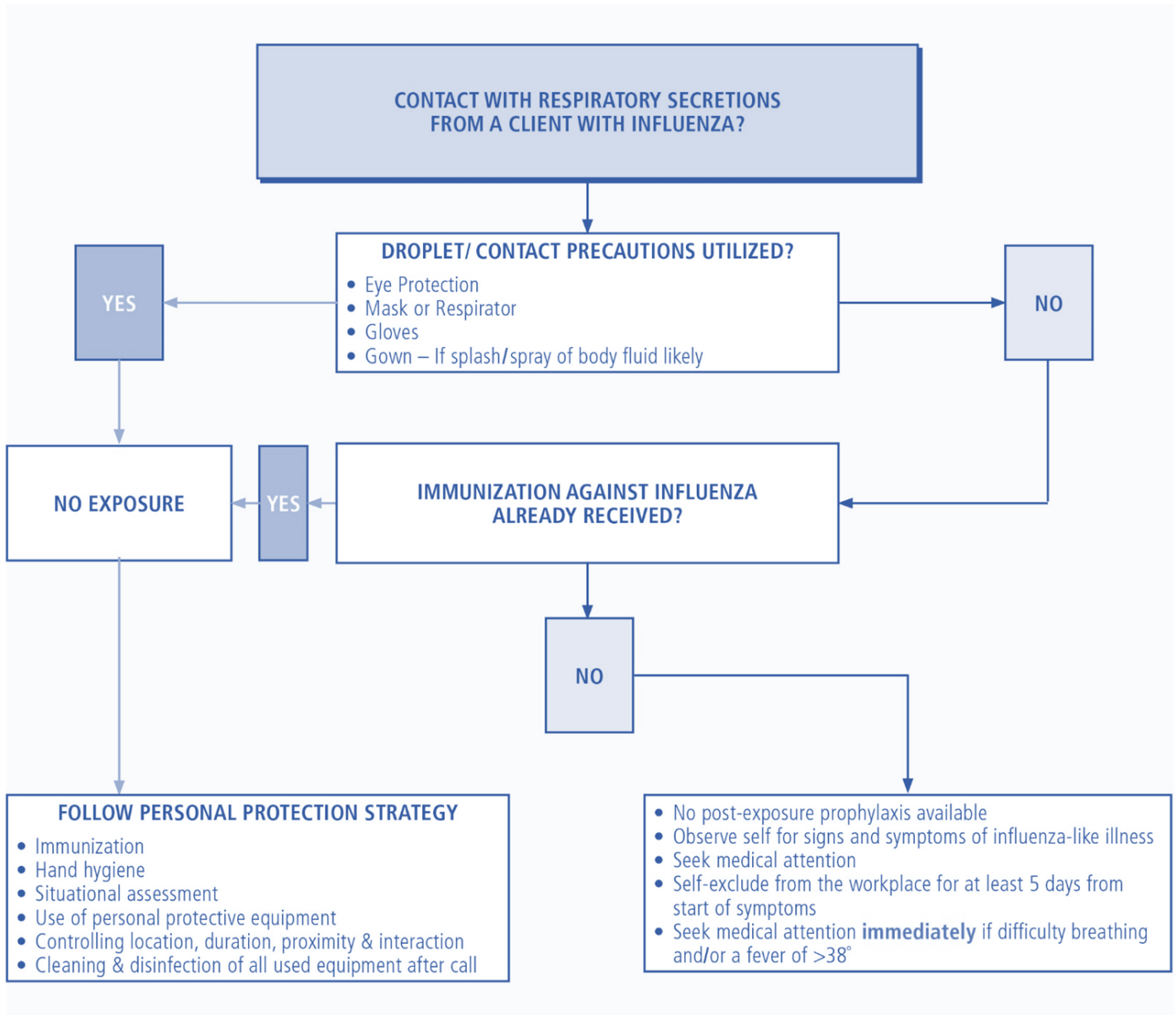
- Apply the Personal Protection Strategy Model.
- Get vaccinated against influenza every year. The influenza vaccine is available free of charge. The injection form of the vaccine contains dead virus while the nasal spray contains a live modified version of the flu virus and cannot give you the flu.
- Because the virus changes every year, and because immunity wanes from influenza vaccination after about 12 months, you need to be revaccinated every flu season.
- Control your proximity if possible by staying two metres back from the client if they have signs and symptoms of an influenza-like illness.
- If you must be within two metres of the client, wear eye protection and a surgical mask to prevent contaminated respiratory secretions from landing on your eyes, nose and mouth. If your service does not issue surgical masks, wear your fit-tested N95, PAPR or reusable (elastomeric) respirator.
- Clean and disinfect any surface and/or reusable equipment that were within two metres of the client as it may have come in contact with contaminated respiratory secretions.
- Remove gloves and clean hands with ABHR or soap and water for at least 15 seconds before and after all client contact.

Further information:

https://www.canada.ca/en/public-health/services/diseases/flu-influenza.html?utm_source=canada-ca-flu-en&utm_medium=vurl&utm_campaign=flu

Or contact your local Public Health Unit.

Influenza



Invasive Group A Streptococcal Disease (iGAS)

Group A Streptococcus (GAS) are bacteria commonly found in the throat and on the skin. People may carry these bacteria and have no symptoms of illness. When they do cause illness, the resulting disease will occur in one of 2 forms:

- invasive GAS infection; or
- non-invasive GAS infection.

The Difference between invasive and non-invasive GAS infections

Common non-invasive GAS infections include strep throat, scarlet fever, impetigo, and ear infections. These infections are less severe and more contagious than invasive GAS infections.

Invasive GAS disease may occur when bacteria get into parts of the body where bacteria usually are not found, such as the blood, muscle, or the lungs. Two of the most severe, but least common, forms of invasive GAS disease are necrotizing fasciitis and streptococcal toxic shock syndrome. Necrotizing fasciitis (commonly known as “flesh-eating disease”) is a rapidly spreading disease which destroys muscles, fat and skin tissue. Streptococcal toxic shock syndrome results in a rapid drop in blood pressure and organ failure (i.e. kidneys, liver, lungs and brain).

GAS is spread by direct contact with secretions from the nose or throat of an infected person, or through contact with an infected wound or sore on the skin. The incubation period for GAS, which is the time from when you are exposed to the bacteria until symptoms develop, is 1 to 3 days.

Activities such as open mouth kissing (“french kissing”), mouth-to-mouth resuscitation, sexual intercourse and sharing needles may put you at greater risk of becoming infected. It is rarely spread by casual contact or by touching common surfaces or shared objects.

To prevent the spread of iGAS:

- Apply the Personal Protection Strategy Model.
- Clean your hands with ABHR or soap and water for at least 15 seconds before and after any client contact.
- Use contact precautions (gloves and gown) when interacting with all clients who have signs and symptoms of a skin and/or soft tissue infection.
- Avoid contact with upper respiratory tract secretions and wear PPE to protect your mucous membranes if intubation/suctioning of the patient is required.

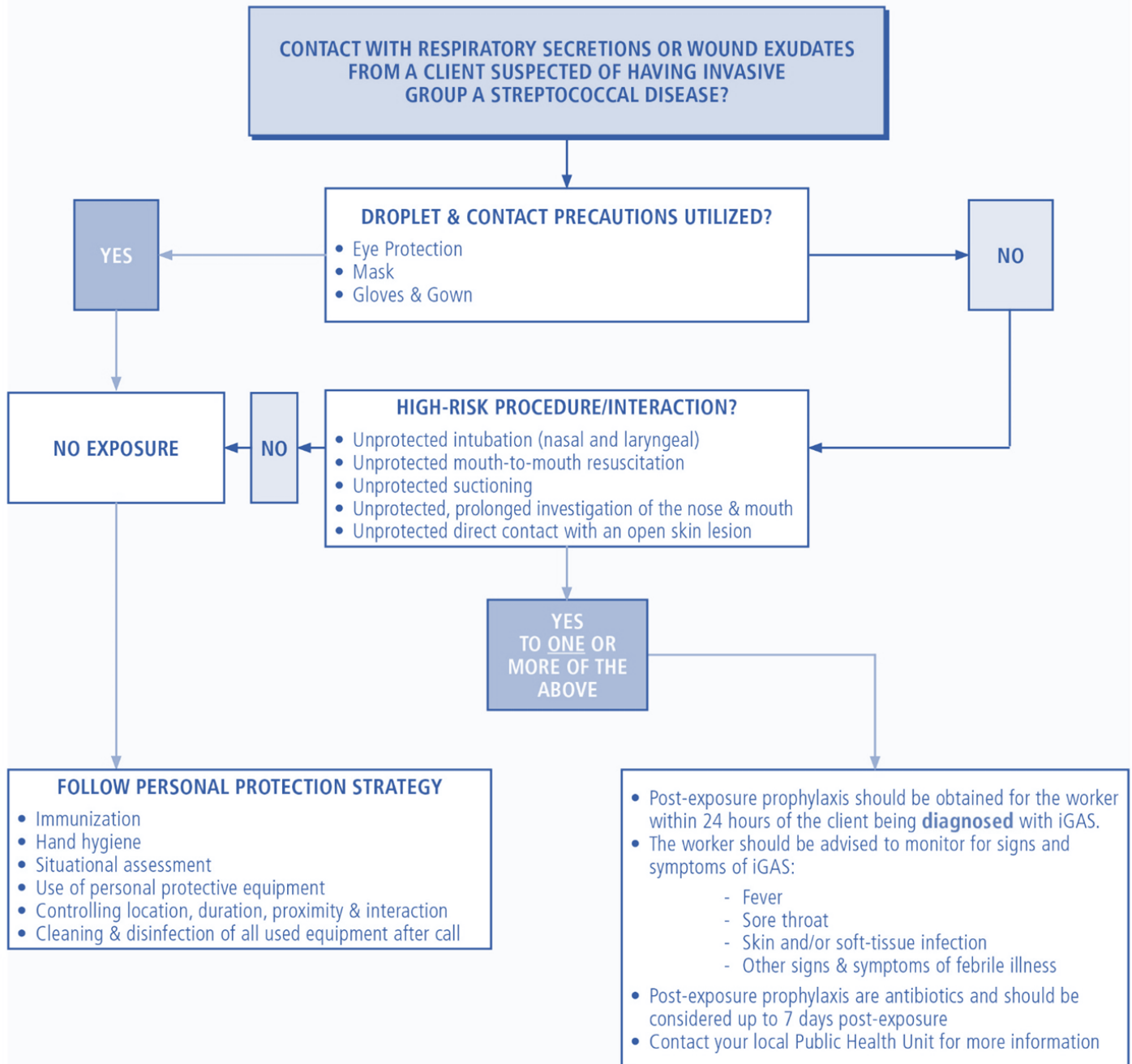
- Wrap the client in a blanket for transport, if possible, to minimize the chance of seats/stretchers becoming contaminated.

If you have any questions, contact your local Public Health Unit.

Invasive Group A Streptococcal Disease (iGAS)

AS EVIDENCED BY

Necrotizing Fasciitis, Myositis,
Gangrene, Meningitis, Pneumonia or Toxic Shock Syndrome



Methicillin-Resistant Staphylococcus aureus (MRSA)

Staphylococcus aureus (Staph aureus) is bacteria that may normally be present on the skin and in the nose of people without any sign of infection. This is known as colonization. Staph aureus can cause common infections such as impetigo, pink eye (conjunctivitis) and boils. Sometimes it causes more serious illnesses such as blood infections, surgical wound infections and pneumonia.

Methicillin-resistant Staphylococcus aureus, also called MRSA, is a Staph aureus that is resistant to several antibiotics. Illnesses caused by MRSA are no more serious or severe than those caused by non-resistant Staph aureus, however, any infection caused by MRSA is harder to treat. Due to its resistance, the number and type of antibiotics that can be used to treat MRSA are more limited.

MRSA is transmitted from person to person, mainly through direct contact. Emergency and justice service workers can become colonized by touching or rubbing their noses with their hands while caring for clients colonized with MRSA. They can also transmit MRSA to other clients if they do not clean their hands and equipment carefully between clients. Objects and surfaces can also become contaminated with MRSA and may be a source of transmission.

MRSA infections can occur anywhere on or in the body. However, the most common infections occur on the skin and in soft tissue (the layers of flesh below the skin). MRSA infection can also develop in the lungs or blood of susceptible individuals. MRSA infections can be treated, but there are less antibiotics that can be used and those antibiotics are more costly.

Even if accidentally colonized, healthy people will usually clear their MRSA colonization within six to eight months.

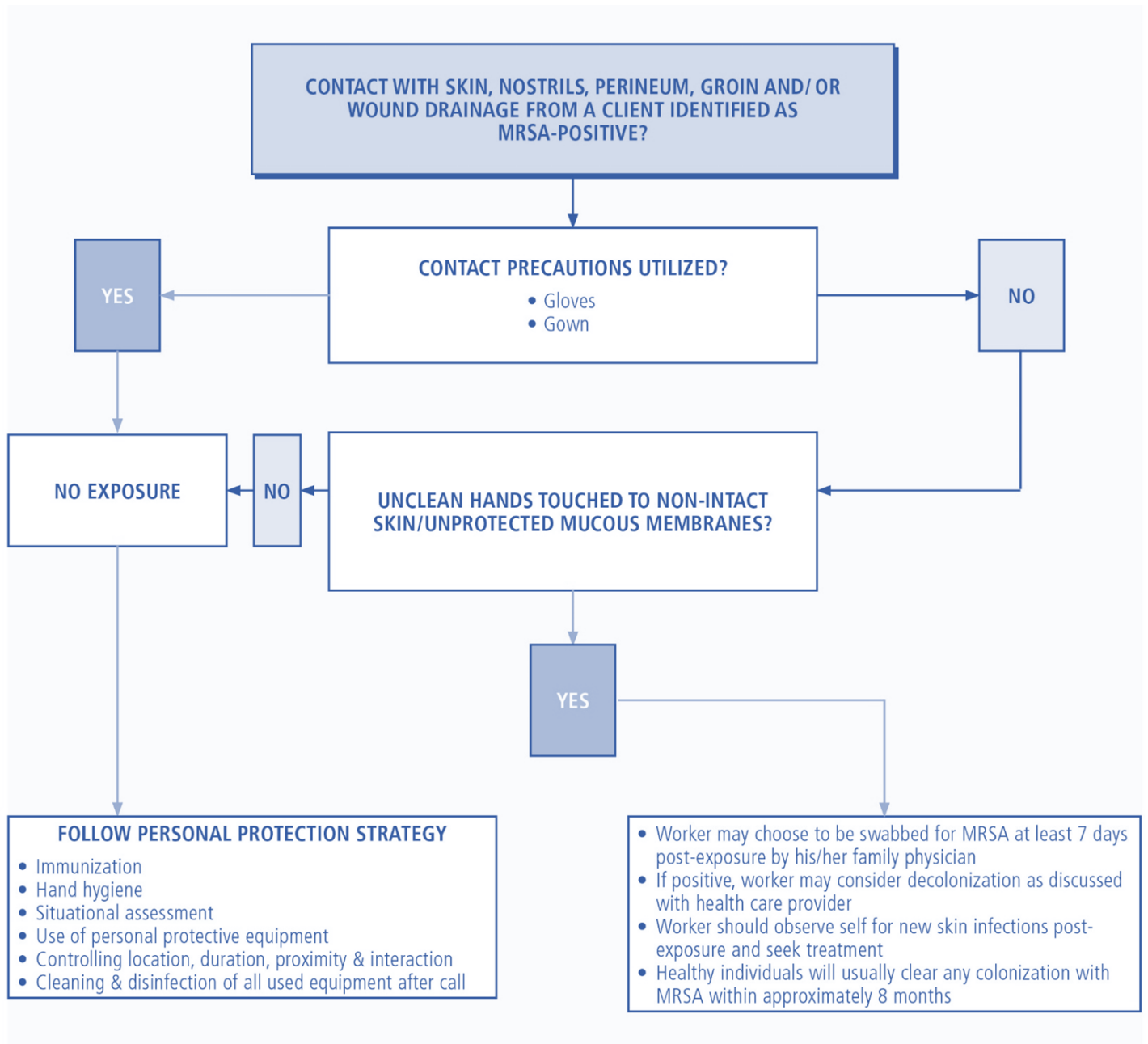
To prevent the spread of MRSA:

- Apply the Personal Protection Strategy Model.
- Clean your hands with ABHR or soap and water for at least 15 seconds before and after any client contact.
- Use contact precautions (gloves and gown) when interacting with all clients who have signs and symptoms of a skin and/or soft tissue infection or who have been identified as being colonized or infected with MRSA.
- Wrap the client in a blanket for transport, if possible, to minimize the chance of seats/stretchers becoming contaminated.

- Clean and disinfect all equipment used with the client, and all surfaces the client may have touched.
- Remember to always clean your hands before touching your nose, as that is a common area of MRSA colonization.

If you have any questions, contact your local Public Health Unit.

Methicillin-Resistant Staphylococcus aureus (MRSA)



Measles

Measles is a highly contagious viral disease. It's spread through airborne, droplet and contact transmission, which means that the virus can stay in the air long enough to be breathed in as well as be picked up on your hands through contact with infected upper respiratory tract secretions and then transferred to the unprotected mucous membranes of your eyes, nose or mouth. Five minutes of exposure to measles will cause illness in 90% of people who are not immune.



Signs & Symptoms of Measles:

- High fever
- Cold-like symptoms, such as cough, runny nose
- Sore, watery eyes
- Red rash lasting four to seven days that is usually all over the body.

Measles also weakens the immune system for months after infection, which can allow other infections, such as ear infections and pneumonia to occur. Encephalitis (inflammation of the brain) occurs in about 1 out of every 1000 cases. This severe complication can result in permanent brain damage, blindness and/or deafness. In rare cases, measles can cause the development of a fatal brain disease called SSPE that can occur years after the attack of measles.

People who are immunocompromised, children under one year of age and pregnant women are particularly at risk after exposure to measles to developing a severe or life-threatening case. A woman who is pregnant and becomes sick with measles has a higher risk of premature labour, spontaneous abortion and having a child with a low birth-weight.

Measles is a vaccine preventable disease. Measles vaccine has been used routinely in Canada since the early 1960s. Before the onset of routine immunization against measles there were 50 to 75 deaths, 5000 hospital admissions and 400 cases of encephalitis every year. Measles is given as part of the MMR (measles, mumps, rubella) vaccination and is routinely given at 12 months and again between 4 and 6 years of age. The second dose of MMR was added to Ontario's routine vaccination schedule after 1995.

Anyone born before 1970 is considered to have had a measles infection as a child and is considered immune. Those born after 1970 would have received one dose of MMR at 12 months of age, while those born after 1985 would most likely have received their second dose of MMR while still a child.

To Prevent the Spread of Measles:

- Apply the Personal Protection Strategy Model.
- If you have had only one dose of MMR talk to your health care provider about getting a second dose of MMR to ensure you are fully protected.
- If you don't know your vaccination history or are unsure of your immunity to measles, speak to your health care provider about having a blood test to check for immunity and/or arranging to receive 2 doses of MMR vaccine at least 28 days apart.
- Wear a fit-tested N95, PAPR or reusable (elastomeric) respirator, eye protection, gloves and gowns with anyone exhibiting signs and symptoms of measles.
- Clean and disinfect any surface and/or reusable equipment that were within two metres of the client as it may have come in contact with contaminated respiratory secretions.
- Remove gloves and clean hands with ABHR or soap and water for at least 15 seconds before and after all client contact.

Protection of Health Care Workers – On-the-job exposures can be prevented by having either two documented MMR vaccinations or proof of immunity obtained through a blood titre test ordered by your family physician or nurse practitioner.

Further Information:

<http://www.phac-aspc.gc.ca/im/vpd-mev/measles-rougeole-eng.php>

Contact your local Public Health Unit.

Rabies

Rabies is an infectious viral disease that affects the central nervous system of humans and other mammals. It is spread through contact with saliva and the mucous membranes of an infected animal. Humans and other mammals can become infected through a bite, cut or scratch from an animal with rabies or if the rabies virus comes into contact with the mucus membranes in their mouth, nose or eyes.

In Ontario, the animals that most often transmit rabies are foxes, skunks, bats and raccoons. Pets and humans can become infected when they come in contact with these animals.

Small rodents such as squirrels, rats, mice, hamsters, guinea pigs, gerbils, chipmunks and rabbits are almost never found to be infected with rabies. Bites by these animals are usually not considered a risk of rabies unless the animals were sick or behaving in an unusual manner and rabies was widespread in the area.

Rabies virus can be found in animal saliva days before any obvious symptoms develop. From the time of exposure, it can take from two weeks to several months for the symptoms to start showing in many animals, but they are still contagious even without obvious symptoms. Eventually, all animals that have the virus will develop symptoms and all will die of the disease. Rabies in animals can appear in two basic forms: Dumb rabies and Furious rabies.

Signs of dumb rabies:

- Some animals may become depressed and retreat to isolated places.
- Wild animals, especially skunks, may lose their fear of humans.
- Animals may show signs of paralysis such as abnormal facial expressions, drooping heads, sagging jaws or paralyzed hind limbs.

Signs of furious rabies:

- Animals may show extreme excitement and aggression.
- Animals may gnaw and bite their own limbs.
- Animals may attack stationary objects or other animals.

To prevent the spread of rabies:

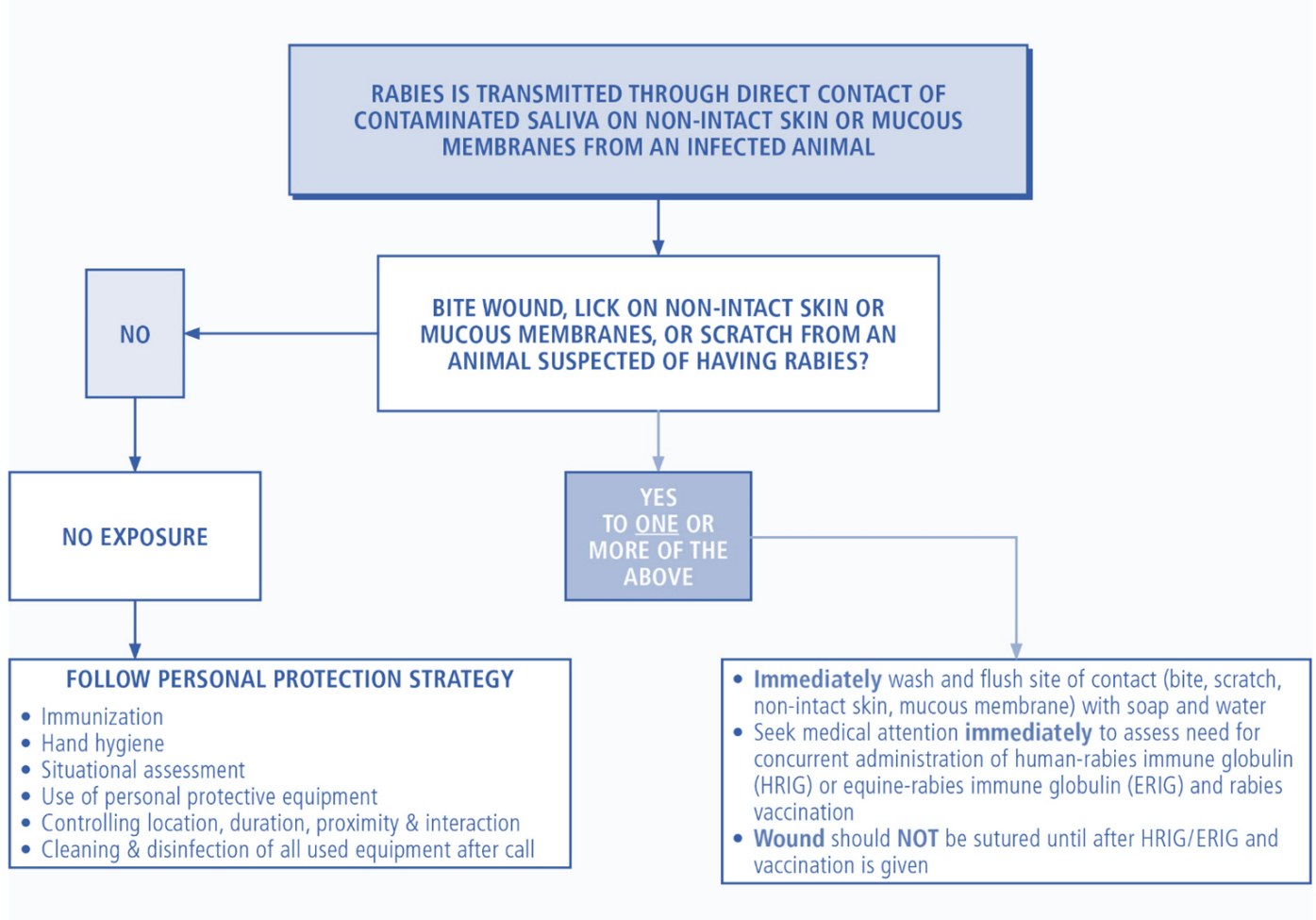
- If rabies is suspected, contact Animal Services for that municipality:
- Do not approach, interact with or handle wild or domestic animals whose rabies vaccination status cannot be verified or if that are acting strangely.
- If interaction with a wounded animal cannot be avoided, use the Personal Protection Strategy Model to control for location, duration, proximity and interaction to ensure you are not bitten or scratched.
- Wear gloves, eye protection and a respirator to prevent splash or spray of blood/body fluids contacting your eyes, nose or mouth or non-intact skin.
- Consider wearing a gown or bunker gear if contamination of your uniform is likely.
- Clean your hands with ABHR or soap and water for at least 15 seconds before and after any contact with animals.
- Clean and disinfect all equipment used with the animal (if any), and all surfaces the animal may have contacted.
- If you have been bitten or scratched by an animal that may have rabies, or suspect you have been bitten or scratched, you should:
 - Clean and wash the bite or scratch thoroughly with soap and water.
 - Seek medical attention immediately.
 - Anyone bitten by any animal, including raccoons, must immediately seek medical attention and call Public Health.

Treatment for rabies (called rabies prophylaxis) usually consists of a series of five injections given over a one-month period. Vaccination must be given as soon as possible after exposure. The treatment is safe and effective.

Further Information:

<http://travel.gc.ca/travelling/health-safety/diseases/rabies>

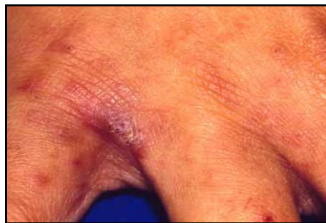
Rabies



Scabies

Scabies is a common and annoying condition caused by tiny insects (mites) that dig under the skin, causing a very itchy rash. Scabies is spread by humans through prolonged skin to skin contact, such as during sexual contact, dancing or holding hands. Other means of transmission can be through sharing clothing, bedding or towels. Scabies is not caused by lack of proper cleanliness and it can affect anyone.

Signs of scabies usually do not appear until about three weeks after mites dig under the skin.



The rash looks like curvy white threads, tiny red bumps, scratches or tiny blisters. It is very itchy, especially at night. Scabies do not spread disease, but scratching the rash can break the skin, allowing a portal of entry for infectious agents, which can cause infection.

Often the rash first appears between the fingers, around wrists, and elbow creases. It also can be found in the armpits, under the breasts, along the belt line and navel, the inner thighs, the buttocks and genitals. People, who are immunocompromised, such as with HIV infection or the elderly, may develop Norwegian or Crusted scabies, which results in a generalized dermatitis (inflammation of the skin) with scaling or crusting.

Scabies should be diagnosed by a doctor as other skin conditions can also cause a rash and itching.

To prevent the spread of scabies:

- Apply the Personal Protection Strategy Model.
- Wear gloves when in contact with the skin of a client who is complaining of itching, or who has signs and symptoms of an itchy rash.
- It takes approximately an hour for a mite to burrow into the skin. Therefore, performing excellent hand hygiene with ABHR or soap and water for at least 15 seconds before and after patient contact is highly protective against scabies.
- Keep personal items personal and do not share towels, pillows or clothing with colleagues without laundering first.
- Do not use anti-scabies medication unless scabies infestation is confirmed.

If you have scabies, you can buy medicated treatment at a pharmacy without a prescription. If you are pregnant or breastfeeding, talk to a doctor or pharmacist. Follow the instructions for treatment very carefully.

Do not have close contact with others until the treatment is finished. Any sexual partners and household contacts within the past month of scabies diagnosis need to be treated at the same time. A second treatment may be necessary.

On the same day that you use the medicated treatment, wash your bedding, towels and clothes in hot water. Place these in the dryer on the hottest cycle for 20 minutes. Dry clean anything that cannot be washed or place items in a sealed plastic bag for 3 to 7 days. Vacuum your mattress and empty out the vacuum.

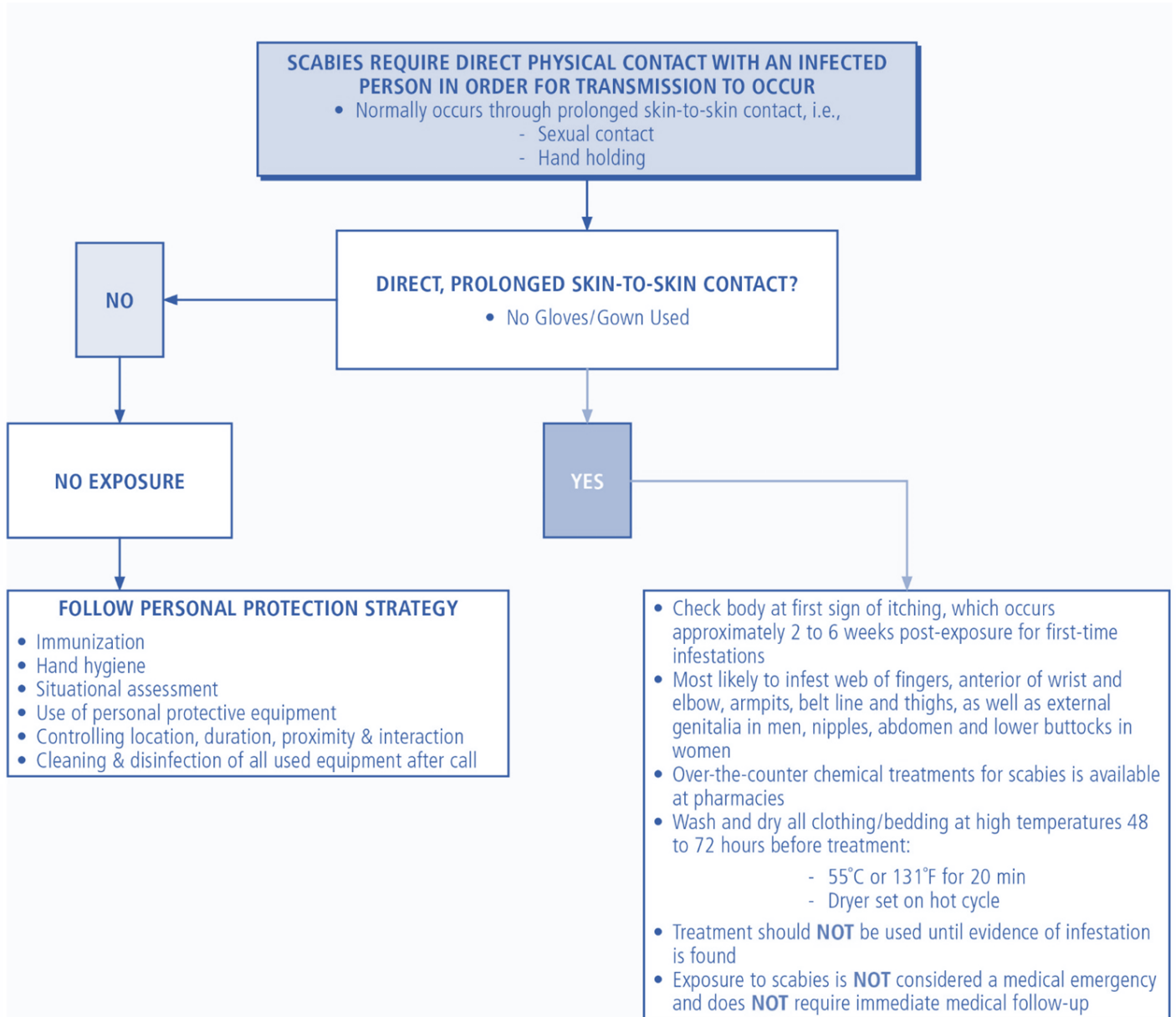
Itching can last for several weeks after treatment with the medication. Itching is due to eggs and waste materials under the skin left behind by the mites. It must be broken down by your immune system before itching will stop. Itching can also be caused by the treatment as it dries out the skin. The itching will go away with time.

Anti-scabies treatment should only be used as prophylaxis for a known or suspected scabies exposure at the recommendation of your health care provider. Treatment should only be used when scabies infection is identified.

Exposure to scabies is not considered a medical emergency and does not require immediate medical follow-up.

If you have any questions contact your local Public Health Unit.

Scabies



NOTE

Scabies take approximately one hour to burrow into the skin, therefore routine hand hygiene should prevent infestation. People with Norwegian (crusted) scabies should be considered highly contagious as prolonged contact is not required.

Tuberculosis

Tuberculosis (TB) is an infectious disease caused by the tuberculosis bacteria. TB bacteria usually cause an infection in the lungs but may travel through the blood and affect other parts of the body. The greatest risk in Ontario for developing tuberculosis is having lived in, or travelled to, countries where TB is common.

Tuberculosis is only infectious person-to-person if the disease is in the lungs or larynx. This is called active pulmonary TB and means the person is coughing the bacteria into the air. Other people can then breathe the TB bacteria into their lungs and become infected. Infection usually requires close, prolonged contact (>8 hours) with TB bacteria. People cannot get TB by sharing cutlery, dinner plates, drinking cups or toilet seats.

Tuberculosis is spread to others through airborne transmission, meaning that, after the bacteria is coughed out of the larynx or lungs, the bacteria float in the air for a prolonged period of time, allowing others to breathe it in. The risk of infection increases when:

- You have spent more than eight hours with the person.
- You have been in an area with poor ventilation where the client has been coughing for a prolonged period of time (>8 hrs.)
- You perform an intervention on the client (such as intubation) that causes the client to cough.

When a person breathes TB bacteria into their lungs, certain cells in the immune system will either destroy the TB bacteria or wall the bacteria off, rendering the bacteria inert, non-infectious and non-contagious. People may not even know they have been infected.

A [skin test](#) is able to detect TB antibodies by showing whether someone has been infected by the TB bacteria. People who have had sufficient contact with TB to become infected will have a positive skin test two to eight weeks after initial exposure. This is known as TB infection.

TB skin tests are recommended for all emergency service and justice service workers at the beginning of your employment, so that your previous skin-test status will be known if you are ever identified as having been exposed to TB.

People infected with TB, but who have no signs and symptoms of disease in their lungs, are not contagious.

Signs & Symptoms of TB:

Pulmonary tuberculosis may not produce any early symptoms until the infection in the lung has reached a size that is visible on x-ray. Symptoms in adults may include cough, loss of appetite, fatigue, weight loss, fever and night sweats. TB may be misdiagnosed as bronchitis or pneumonia. Any cough lasting longer than three weeks should be thoroughly investigated.

Sometimes, the disease is outside the lung such as in the kidney, lymph nodes and bone, causing symptoms such as pain and discomfort in those sites. TB that occurs outside the lungs (extra-pulmonary TB) is less contagious person-to-person.

People infected or actively sick with TB disease will receive free medication through their local Public Health Unit.

To prevent the spread of TB:

If you are with a client where active TB disease is suspected or confirmed, follow the Personal Protection Strategy by:

- Putting on your fit-tested N95, PAPR or reusable (elastomeric) respirator, especially when performing procedures that may induce coughing.
- Increasing ventilation in your vehicle during transport through turning on the ventilation or opening windows.
- Have the client wear a mask or cover his/her mouth when coughing.
- Minimizing the amount of time you spend with the client.

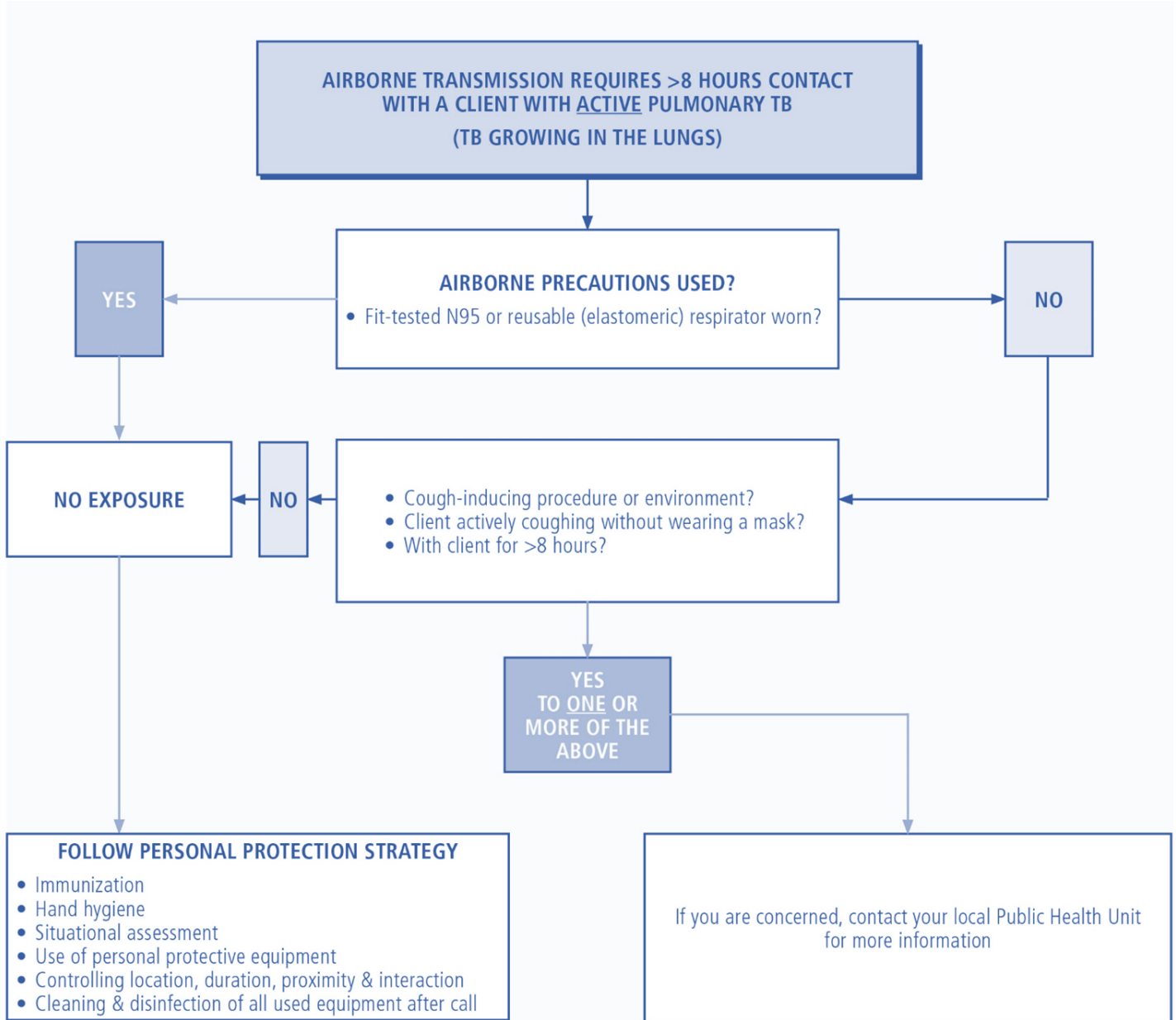
Remember: Tuberculosis is only contagious if the disease is active in the lungs or larynx. A TB skin test can determine if you have been exposed to the TB bacteria. Medication is effective in preventing and curing tuberculosis.

Further Information:

<https://www.publichealthontario.ca/en/Diseases-and-Conditions/Infectious-Diseases/Respiratory-Diseases/Tuberculosis>

Or contact your local Public Health Unit.

Tuberculosis



NOTE

Tuberculosis is NOT easily transmitted person-to-person. TB infection and TB disease are both readily treatable and curable. TB medicine is free.

Vancomycin-Resistant Enterococcus (VRE)

Vancomycin-resistant enterococcus (VRE) is a strain of enterococcus bacteria that normally lives in most peoples' bowels and has developed resistance to many commonly used antibiotics, specifically an antibiotic called Vancomycin.

VRE is found in feces, and spread through the oral-fecal route, meaning that the bacteria must be eaten. Commodes, bathing tubs and rectal thermometers are examples of items that become contaminated by tiny, non-visible particles of feces and therefore, may spread VRE person-to-person when touched. Clients and workers can become infected by touching items that are contaminated with feces and then touching their mouths, allowing them to swallow the bacteria. Clients can also become infected by health care workers whose hands are contaminated with VRE and do not clean their hands properly before providing care.

There are very few antibiotics that can be used to treat VRE infections. Clients who are very sick from diseases that decrease their ability to fight infections are at highest risk for getting an infection with VRE. Healthy people with intact immune systems are not at risk from VRE.

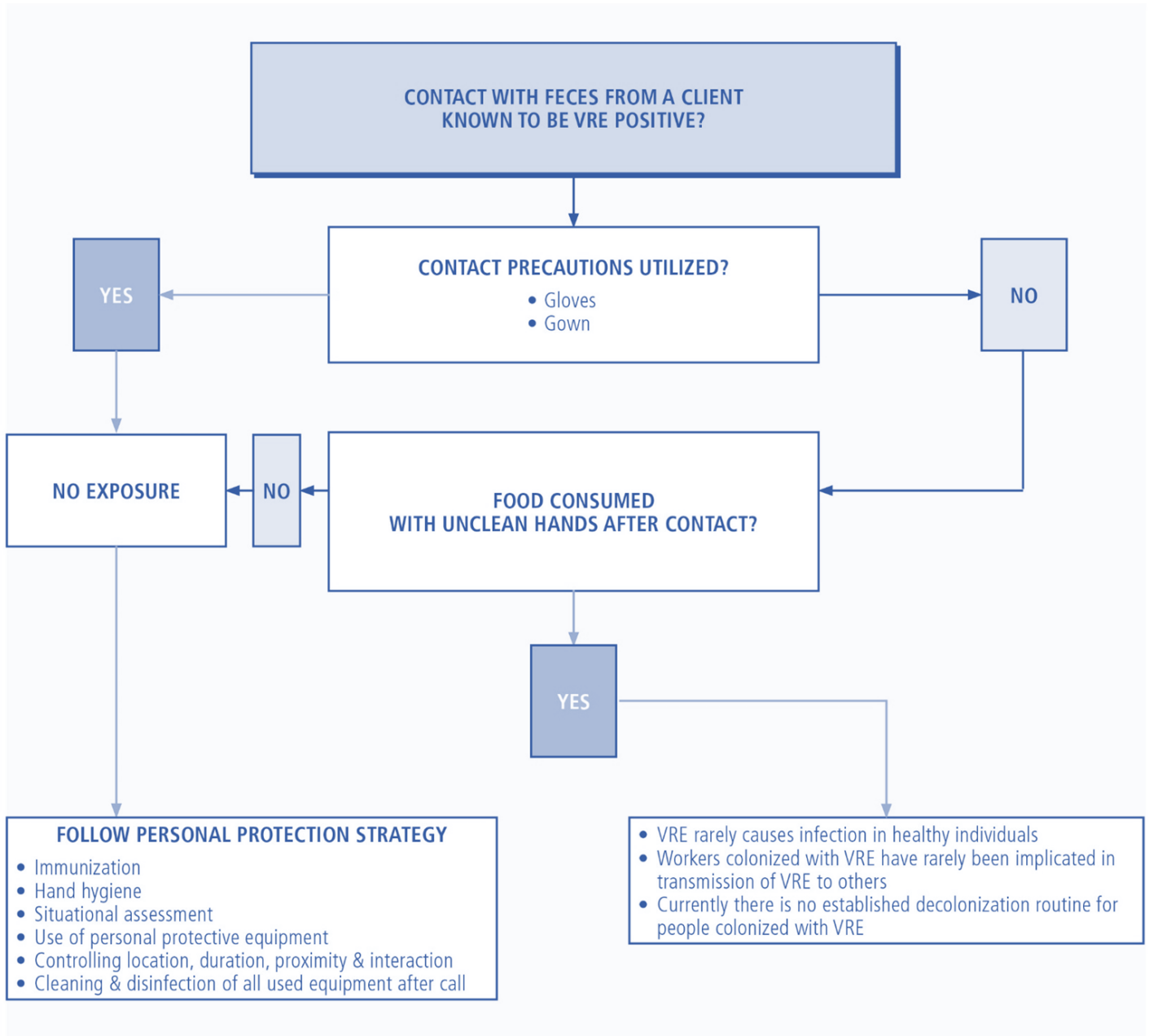
VRE is a concern in the acute care setting as there is a risk that the resistance that VRE has developed to Vancomycin could be shared with other bacteria and therefore cause greater antibiotic resistance overall. This is the rationale for why certain health care institutions may place a client who is colonized or infected with VRE (VRE positive) on contact precautions while they are in hospital.

To prevent the spread of VRE:

- Apply the Personal Protection Strategy Model.
- Clean your hands with alcohol-based hand sanitizer or soap and water for at least 15 seconds before and after any client contact.
- Use contact precautions (gloves and gown) when interacting with all clients who have signs and symptoms of diarrhea.
- Wrap the client in a blanket for transport, if possible, to minimize the chance of seats/stretchers becoming contaminated.
- Clean and disinfect all equipment used with the client, and all surfaces the client may have touched.
- Remember to always clean your hands before eating!

If you have any questions, contact your Designated Officer or your local Public Health Unit.

Vancomycin-Resistant Enterococcus (VRE)



Appendix B: Designated Officer Incident Assessment Form

How did the exposure occur?

- Needlestick/punctured by sharp object
- Splashed in the eye by _____(type of body fluid)
- Laceration of the skin splashed in the mouth by _____ (type of body fluid)
- Non-intact skin exposed to _____(type of body fluid)
- Close contact with someone with a cough, possibly TB
- Close contact with someone suspected of having meningococcal disease
- Confined in an enclosed area (e.g. vehicle, aircraft) with someone who was coughing
- Giving mouth to mouth resuscitation to someone without using a mouthpiece
- Human, animal or insect bite
- Shared drinking glasses and other utensils other (describe in detail)
- Other, please describe_____

What is the worker's immune status? Are his/her immunizations up to date for:

- Tetanus and Diphtheria
- Rubella
- Polio
- Measles
- Tuberculosis

Has he or she received a full course of hepatitis B vaccine?

- Yes
- No

When did he or she receive the last dose of hepatitis B vaccine?

Was serology testing done to determine and he or she responded to the vaccine?

- Yes
- No

When was the last testing done for antibody?

What barrier precautions did the worker wear or use during the incident?

- Goggles
- Mask
- Gloves
- Apron or protective clothing
- Others (describe in detail): _____

Were the barriers intact? (E.g. were the gloves torn?)

- Yes
- No

Did any body fluids soak through?

What body fluids were the worker exposed to?

- Blood
- Saliva
- Wound Drainage
- Vomitus
- Faeces
- Urine

How long was the contact/exposure? (e.g., the worker was in the same aircraft or vehicle for # ____hours, the worker was soaked with (type of body fluid) for at least (length of time) before washing it off.

Did a significant exposure occur?

- Yes
 - Blood borne
 - Respiratory
- No

What other information is available that will help assess exposure? (E.g. suspected diagnosis of the contact, location of the exposure, such as a crack house, shooting gallery, homeless shelter, center for the developmentally challenged, animal shelter or place with pets, school for children, rock concert hall)

Was the Medical Officer of Health contacted?

Yes

Medical Officer Name and Phone number: _____

No

What advice was given to the worker?

- Reassurance
- Reinforce infection control procedures
- Informed that an exposure has occurred
- If an exposure has occurred to follow-up with family physician
- To seek medical attention at nearest hospital emergency

Other _____

Signature of Designated Officer

Date: _____

Appendix C: Legislative/Regulatory Requirements

The Occupational Health and Safety Act sets out the responsibilities of employers, supervisors and workers for workplace safety. Among other obligations the Act requires employers to “take every precaution reasonable in the circumstances for the protection of a worker” and to “acquaint a worker or a person in authority over a worker with any hazard in the workplace and in the handling, storage, use, disposal and transport” of biological agents.

Sample Board Policy

Board Policy # _____

It is the policy of the _____ Police Services Board with respect to communicable diseases that the Chief of Police will:

- a) develop and maintain procedures that are consistent with the most recent edition of the Ministry of Health and Long-Term Care’s Preventing and Assessing Occupational Exposures to Selected Communicable Diseases – An Information Manual for Designated Officers;
- b) designate and train one or more members as a Communicable Disease Coordinator(s);
- c) ensure that each Communicable Disease Coordinator is provided with a copy of the most recent edition of the Ministry of Health and Long-Term Care’s Preventing and Assessing Occupational Exposures to Selected Communicable Diseases – An Information Manual for Designated Officers; and
- d) work, where possible, with the local medical officer of health, to develop a post exposure plan that addresses roles and responsibilities, reporting protocols, medical evaluation, intervention, confidentiality, access to treatments and follow-up support for workers who have suffered a high-risk occupational exposure to a communicable disease.

Police Service Guidelines

Coordination

1. Every Chief of Police should designate and train one or more members as a Communicable Disease Coordinator(s) who would be responsible for:
 - a) receiving reports from members who believe they may have been exposed to a communicable disease;
 - b) assessing, given the situation and circumstances, whether an exposure could have occurred;
 - c) if an exposure could have occurred, liaising with the local medical officer of health; and
 - d) following liaison with the local medical officer of health, providing information and advice to the member about the possible exposure.
2. Every Chief of Police should ensure that each Communicable Disease Coordinator is provided with a copy of the most recent edition of the Ministry of Health and Long-Term Care's Preventing and Assessing Occupational Exposures to Selected Communicable Diseases - An Information Manual for Designated Officers.
3. Every Chief of Police should work, where possible, with the local medical officer of health, to develop a post-exposure plan that addresses roles and responsibilities, reporting protocols, medical evaluation, intervention, confidentiality, access to treatments and follow-up support for workers who have suffered a high-risk occupational exposure to a communicable disease.

Procedures

4. Every police service's procedures should:
 - a) be consistent with the most recent edition of the Ministry of Health and Long-Term Care's Preventing and Assessing Occupational Exposures to Selected Communicable Diseases - An Information Manual for Designated Officers;
 - b) set out procedures to be followed by a member who believes that he or she may have been exposed to a communicable disease.
 - c) require that all police officers and civilian members who may be exposed to blood/bodily fluids in the workplace are offered a voluntary Hepatitis B vaccination at no cost to the worker;
 - d) set out the workplace controls for minimizing and preventing the risk of occupational exposure, including:

- i) the handling and storage of contaminated forensic exhibits, in accordance with the police service's procedures on the collection, preservation and control of evidence and property;
 - ii) undertaking search of persons or premises;
 - iii) the custody and transportation of prisoners, in accordance with the police service's procedures on prisoner care and control and prisoner transportation, including the implementation of special precautions for dealing with prisoners with a known or suspected communicable disease;
 - iv) the handling of sharps, including syringes; and
 - v) practices around blood/bodily fluid;
- e) set out the workplace procedures and controls for post-exposure management, including the requirement that:
- i) potential exposures are managed promptly, in collaboration with the local medical officer of health;
 - ii) the appropriate first aid measures are delivered immediately;
 - iii) the role of supervisors in managing exposure incidents is clearly defined and communicated to all workers;
 - iv) the role of the Communicable Disease Coordinator(s) is clearly defined and communicated to all workers;
 - v) the established protocol for assessing and reporting a possible exposure is followed;
 - vi) follow-up planning is undertaken for each individual who has experienced a potential exposure, based on a reasonable assessment of their needs; and
 - vii) a record keeping procedure is established for the following purposes: training; maintaining confidential records for affected workers; and problem identification, resolution and evaluation; and
- f) set out the workplace procedures and controls that address general infection control, including:
- i) the cleaning of unprotected skin;
 - ii) hand washing procedures;
 - iii) the removal and disposal of anti-microbial gloves;
 - iv) handling contaminated work clothing;
 - v) disinfection methods for surfaces and police vehicles, both interior and exterior;
 - vi) disinfection of holding facilities;

- vii) handling and disinfection of non-disposable equipment; and
- viii) handling and disposal of biological waste and non-reusable equipment.

Training

5. Every Chief of Police should ensure that police officers and civilian members who may be at risk of exposure to communicable diseases receive training on communicable diseases and their prevention, including information on:

a) bloodborne diseases, including, at minimum, Hepatitis B (HBV), Hepatitis C (HCV) and HIV/Aids, including:

- i) overview, incidence and prevalence of disease in the population;
- ii) sero-conversion rates for HBV, HCV and HIV;
- iii) modes of transmission and incubation period;
- iv) the risk of infection when exposed to infected blood/bodily fluids;
- v) assessing and reducing the risks;
- vi) identification and symptoms; and
- vii) post-exposure management; and

b) airborne infections, including, at minimum, Meningitis, Tuberculosis (TB) including:

- i) overview, incidence and prevalence of disease in the population;
- ii) modes of transmission and incubation period;
- iii) risk of acquiring the disease;
- iv) differentiation between what is TB infection versus the disease;
- v) reducing the risks;
- vi) identification and symptoms; and Policing Standards Manual (2000) Communicable Diseases November 2000 AI-004 4/5
- vii) post-exposure management.

6. Every Chief of Police should ensure that all police officers and civilian members who may be at risk of exposure to communicable diseases are provided with current information, including information on emerging trends.

7. Every Chief of Police, in cooperation with the local medical officer of health, should ensure that there is a mechanism to share information on a regular basis and to ensure that the staff training being provided is current, accurate and sufficient.

Monitoring and Evaluation

8. Every Chief of Police should periodically monitor and evaluate the effectiveness of the police service's procedures on communicable diseases.

Equipment

9. Every Chief of Police should ensure that every police officer and civilian members who may be at risk of exposure to communicable diseases have available to them the personal protective equipment set out in the Ministry's designated equipment list on communicable diseases.

Equipment

10. Every Chief of Police should also ensure that police officers and civilian members who may be at risk of exposure to communicable diseases are trained on the use of the personal protective equipment set out in the Ministry's designated equipment list on communicable diseases, and where appropriate, are properly fitted and sized for the protective equipment.

MINISTRY'S DESIGNATED EQUIPMENT LIST

Communicable Diseases - Equipment and Facilities List

The following minimum equipment should be contained in biohazard kits that are made available to police officers and appropriate civilian members of a police service.

PERSONAL ISSUE

- disposable medical grade non-sterile examination gloves, preferably non-latex, usually nitrile, to avoid the problem of latex sensitivity
- waterless antiseptic hand wipes
- a disposable one-way air valve for cardio-pulmonary resuscitation
- a device to secure the items to the officer's person

MOBILE KITS

- goggles
- disposable moisture-resistant cone masks (NIOSH approved N95 respirator) for tuberculosis protection, and has boomerang nose sealing
- heavy gauge gloves
- moisture-resistant disposable clothing
- biohazardous waste disposal products
- spatulas
- evidence tubes

- biohazard labels
- biohazard bags
- antiseptic hand wipes
- waterless antiseptic hand cleaner
- to be in a container designed to hold such items

STATIONARY KITS

- disposable medical grade non-sterile examination gloves, preferably non-latex, usually nitrile, to avoid the problem of latex sensitivity
- biohazard waste disposal products
- heavy gauge gloves
- moisture-resistant disposable protective clothing
- spatulas
- biohazard bags
- germicidal cleaner
- sharps containers
- waterless antiseptic hand cleaner
- to be in a container designed to hold such items

Appendix D: Mandatory Blood Testing Act, 2023

To access the most recent version of the Mandatory Blood Testing Act, please use the link or QR Code below

https://www.ontario.ca/laws/statute/O6m26?_ga=2.81047639.1738393038.1633375080-1838246539.1590431742



Glossary

Enhanced Surveillance Directive: PHO may issue enhanced surveillance directives for reportable diseases in response to a variety of circumstances including, but not limited to:

- Increased case reports of reportable disease(s);
- Reports of emerging disease(s);
- Diseases with seasonal variation (e.g., West Nile Virus); and
- Food contamination alerts.

Each enhanced surveillance directive will include the following:

- Situation background and current status;
- Start and end dates (if known);
- Detailed data requirements;
- Step-by-step guide for data entry into iPHIS;
- Data field definitions;
- Screenshots of data field locations; and
- Information on whom to contact for assistance.

Facility: In this protocol, facility has the same meaning as defined in the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current) which describes facilities in the following two categories:

- Facilities that are under the authority of the HPPA and/or its regulations, including:²
 - O. Reg. 568/90 (Recreational Camps);¹¹
 - O. Reg. 554/90 (Camps in Unorganized Territories);¹² and
 - HPPA, Section 10. (2)2 (Premises used or intended for use as a boarding house or lodging house).²
 - Other facilities that are not regulated under the HPPA, as follows:²
 - Ice arenas;
 - Seasonal farm workers' housing;
 - Schools;
 - Child care centres (as defined in the *Child Care and Early Years Act, 2014*) and other child care facilities;⁵ Long-term care homes; Group homes; and Other facilities as instructed by the ministry.

Health Hazard: In this protocol, health hazard has the same meaning as Section 1 of the HPPA.² “Health hazard” means,

- a) a condition of a premises,
- b) a substance, thing, plant or animal other than man, or
- c) a solid, liquid, gas or combination of any of them, that has or that is likely to have an adverse effect on the health of any person; (“risque pour la santé”)

Infection Prevention and Control (IPAC) Lapse: A lapse is defined as a deviation from IPAC standard of care, based on current IPAC standard of care documents from the Provincial Infectious Diseases Advisory Committee (PIDAC), Public Health Ontario (PHO), or the ministry, where available, that the medical officer of health or designate believes on reasonable and probable grounds has or may result in infectious disease transmission to the premises' clients, attendees or staff through exposure to blood, body fluids and/or potentially infectious lesions.

Infectious diseases of public health importance: Infectious diseases of public health importance include, but are not limited to, those specified reportable diseases as set out by O. Reg 559/91 (as amended) under the HPPA and include zoonotic diseases.^{13, 2} Emerging infectious diseases may be considered of public health importance based on a variety of criteria, including their designation as an emerging disease by international, federal, and/or provincial health authorities; their potential for preventability or public health action; and the seriousness of their impact on the health of the population and potential spread.

Reportable event: In this protocol, reportable event has the same meaning as Section 38 of the HPPA.²

Sporadic Cases: A sporadic case is an instance of disease which appears to be unrelated to a community or institutional outbreak. It can be one or more cases that do not share an epidemiological link.

Surveillance: The ongoing systematic collection, analysis, and interpretation of health data, essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know. The final link in the surveillance chain is the application of these data to prevention and control. A surveillance system includes a functional capacity for data collection, analysis, and dissemination linked to public health programs.¹⁴

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