**Canberra Hospital and Health Services**

**ClinicalProcedure**

**Blood Borne Virus: Occupational Risk Exposure Management**

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| Purpose |

To provide guidelines for the management of a health care worker (HCW) following an occupational risk exposure (ORE) to a potential blood borne virus (BBV).

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| Scope |

This procedure applies to all HCWs. Compliance with the requirements of this procedure is **mandatory**.

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| Section 1 – Introduction |

An ORE is an incident that occurs during the course of a HCW’s employment and involves contact with blood or other body fluids. Such exposures may put the HCW at risk of acquiring a BBV.

An ORE may involve a:

* Needlestick injury or other sharps exposure – including hollow bore needles
* (e.g. venepuncture needle) and non-hollow bore sharps (e.g. scalpel).
* Mucous membrane splash.
* Non-intact skin exposure, scratch or bite.

HIV, HBV and HCV may be transmitted by significant exposure to blood or other body fluids.

**Prevention** of exposure to blood or other body fluids by adherence to standard precautions, as well as HBV immunisation, remains the first line of protection against OREs to HIV, HBV and HCV.

PEP is available to reduce the risk of HIV or HBV following a high risk exposure.

Knowledge regarding treatment of exposure to HIV, HBV and HCV is evolving rapidly so, in addition to following the guidelines included in this procedure, the advice of an appropriate medical specialist should always be sought prior to the commencement of PEP.

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| Section 2 – Responsibilities of ACT Health |

The ACT Health *Work Health and Safety Management System* (WHSMS), supported by the ACT Health *Work Health and Safety* policy, outlines the specific roles and responsibilities, governance arrangements and processes for managing work health and safety risks in the organisation.

It is the responsibility of ACT Health to ensure that:

* All HCWs whose work places them at risk have been offered appropriate screening and immunisation, in accordance with the ACT Health *Occupational Assessment, Screening and Vaccination* procedure.
* All HCWs are aware of, and must comply with, the infection prevention and control policies, standard operating procedures and/or guidelines relevant to their work area to reduce the risk of transmission of the specified infectious diseases.
* An efficient local system is maintained for the reporting and managing of OREs to blood or other body fluids.
* The confidentiality of exposed HCWs is maintained.
* Exposed HCWs are able to obtain the support to which they are entitled, including workers’ compensation, if appropriate.

ACT Health acknowledges that the parts of this procedure which deal with blood test results contain complex language. If you are not familiar with medical terminology, support can be provided to ensure all parts of the procedure are understood.

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| Section 3 – Immediate Care after an ORE |

## Immediate First Aid

After exposure to blood or other body fluids, the exposed HCW should follow the advice in **Table 1**.

**Table 1**

*Immediate First Aid After an ORE*

|  |  |
| --- | --- |
| **Type of Injury** | **Action Required** |
| Needlestick and other sharps**\*** | Allow active bleeding, clean with soap and water and rinse well. Cover with a waterproof dressing. |
| Non-intact skin**\*** | Clean with soap and water and rinse well. Cover with a waterproof dressing. |
| Eye | Irrigate eyes (remove contact lenses) with water or saline. |
| Mucous membrane (mouth or nose) | Spit out or blow nose. Irrigate mouth or nose with water. |
| Intact skin**\*** | Clean with soap and water and rinse well. |
| Clothing - contaminated | Remove clothing and shower if necessary. |

**\*** Where soap and water is not available, use of an alcohol based hand rub is an acceptable alternative for washing cuts or punctures of the skin or intact skin.

Depending on the nature of the injury, further assessment and management by an appropriate medical specialist may be required, for example, suturing after a scalpel injury.

## Accessing ORE Risk Assessment

After attending to ‘immediate First Aid’, the exposed HCW must inform his or her supervisor of the ORE. The supervisor is responsible for:

* Relieving the exposed HCW from duty to seek ORE management as soon as possible.
* Ensuring the exposed HCW is aware of how to access ORE management.
* Checking in with the exposed HCW after the ORE risk assessment.

The exposed HCW is responsible for seeking management of his or her ORE, as set out in **Figure 1**.

**Figure 1**

*Contact Details for the Management of an Exposed HCW After an ORE*

|  |  |  |
| --- | --- | --- |
| **Site** | **Contact Details** | |
| **Canberra Hospital** | **Weekdays – Working Hours**  Monday to Friday  0730 – 1530 | ***OMU Registered Nurse***  ✆ 6244 2321 or 6244 2323  or page 50296 or 50280 or mobile  via switch |
| **Weekdays – After Hours**  Monday to Friday  1530 – 0730 | ***After Hours Clinical Nurse Consultant***  ✆ Switchboard: Dial 9 or ext. 42222  or page 50479 |
| **Weekends and Public Holidays**  All times | ***After Hours Clinical Nurse Consultant***  ✆ Switchboard: Dial 9 or ext. 42222  or page 50479 |
| **Calvary Health Care Bruce (CHC Bruce)** | **Weekdays – Working Hours**  Monday to Friday  0800 –1730 | ***CHC Bruce Staff Health Department***  ✆ 6201 6174 or 6264 7076 or via  CHC switch |
| **Weekdays – After Hours**  Monday to Friday  1730 – 0800 | ***After Hours Coordinator***  ✆ 6201 6896 |
| **Weekends and Public Holidays**  All times | ***After Hours Coordinator***  ✆ 6201 6896 |

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| Section 4 – Risk Assessment of an ORE |

The risk assessment of the ORE should begin as soon as possible after the exposure. Risk assessment of an ORE is essential to ensure the timely administration of PEP, as required.

## Risk of Infection after Exposure

**HIV** The average risk after needlestick or sharps to HIV-infected blood is 0.3%. The risk is believed to be higher for exposures involving an increased volume of blood and/or high viral load.[[1]](#footnote-1),[[2]](#footnote-2)

**HBV** For non-immune people, the risk after needlestick or sharps to HBV-infected blood ranges from 1-40% and depends on the HBV viral load and e-Antigen status of the source (1-6% for e-Antigen negative blood and 22-40% for e-Antigen positive blood).[[3]](#footnote-3),[[4]](#footnote-4)

**HCV** The risk after needlestick or sharps injury to HCV-infected blood has been estimated at 0-7% (average 1.8%).[[5]](#footnote-5) The risk of transmission is negligible if the source is HCV PCR-negative. The risk following blood exposure to the eye, nose or mouth is unknown, but believed to be very small.

## Persons Responsible for Completing the Risk Assessment

All OREs are to be risk assessed and managed by trained staff only, and not by the exposed HCW. ACT Health staff trained in ORE risk assessment include Occupational Medicine Unit Registered Nurses (OMU RNs) and After Hours Clinical Nurse Consultants (AH CNCs). The attending OMU RN or AH CNC is responsible for:

* Appropriately documenting all information obtained during the risk assessment.
* Working through the contents of the ORE Pack with the exposed HCW and, as required, the source person.

## ORE Pack

ORE Packs are located in the OMU and the Emergency Department at Canberra Hospital and the Emergency Department at CHC Bruce. Each ORE Pack contains a set of Blue Forms for the exposed HCW (E1-E8) and a set of Yellow Forms for the source person (S1-S3). See **Table 2**.

**Table 2**

*Contents of the ORE Pack*

|  |  |  |  |
| --- | --- | --- | --- |
| **Contents** | |  | |
| ***Blue Forms – Exposed HCW Forms*** | | ***Yellow Forms – Source* *Person Forms*** | |
| **E1** | Information Sheet | **S1** | Information Sheet |
| **E2** | ORE Risk Assessment | **S2** | ORE Risk Assessment |
| **E3** | ACT Pathology Request for Occupational Risk Exposure Baseline Testing | **S3** | ACT Pathology Request for Occupational Risk Exposure Baseline Testing |
| **E4** | HBV Information Sheet |  |  |
| **E5** | HBiG Information Sheet |  |  |
| **E6** | Accident and Incident Report (AIR) |  |  |
| **E7** | ORE to a BBV Procedure |  |  |
| **E8** | ACT Pathology Request for Occupational Risk Exposure Follow-Up Testing |  |  |

## Elements Comprising the Risk Assessment

Risk assessment of the ORE includes assessment of the:

* Type and significance of the exposure.
* Status of the exposed HCW with respect to BBVs, including immunisation history.
* Status of the source with respect to BBVs.

### Determining the Type and Significance of the Exposure

The OMU RN or AH CNC will provide the exposed HCW with ***Form*** ***E1*** *Information Sheet*, and document the exposure using ***Form******E2*** *ORE Risk Assessment*, which seeks information about the:

* Type of exposure (i.e. hollow bore, other sharps (non-hollow bore), mucous membrane splash, non-intact skin splash, scratch or bite).
* Body substance
* Blood.
* Blood stained fluid (i.e. fluid containing visible blood).
* Other potentially infectious fluids (e.g. semen and vaginal secretions and cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids).
* Non-blood stained fluid (e.g. sweat, tears, nasal secretions, sputum, saliva, vomitus, urine, stool).
* Volume of body substance.
* Extent of injury (e.g. site depth, presence of bleeding post trauma, need for further injury care - suturing).
* Place, time and date of injury.
* Details of procedure being performed, including where and how the exposure occurred;
* Factor(s) which may have contributed to the injury.
* Time elapsed since the exposure.
* Presence of personal protective equipment (e.g. face mask, safety glasses, gloves).

The OMU RN or AH CNC will undertake further assessment of the source and exposed HCW with baseline blood testing. OREs that involve exposure to non-blood stained fluids (sweat, tears, nasal secretions, sputum, saliva, vomitus, urine, stool) do not generally need further assessment apart from review of Hepatitis B immunisation status, with commencement of Hepatitis B immunisation if the exposed HCW is not immune. Further counselling will be offered to all source persons and all exposed HCWs, the extent of which will be determined according to individual circumstances.

### Support Organisations in the ACT

If required, the following organisations can provide assistance and support:

**Hepatitis ACT**

Address 36 David Street Turner ACT 2612 (Opposite the O’Connor Shops)

Telephone 02 6230 6344 or 1300 301 383

**AIDS Action Council of the ACT**

Address Westlund House - 16 Gordon Street Acton ACT 2601

Telephone 02 6257 2855

**Carers ACT**

Address 2/80 Beaurepaire Crescent Holt ACT 2615

Telephone 02 6296 9900

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| Section 5 – Baseline Testing and Management of the Exposed HCW |

The OMU RN or AH CNC is responsible for advising the exposed HCW of the need to confirm his or her baseline HIV, HBV and HCV status, including immunity to HBV, with appropriate discussion and consent, after an ORE.

ACT Health will not cover the costs of baseline testing and management for agencies/locums or contractors. This will need to be determined between the HCW and agency/locum or contractor.

## Baseline Testing of the Exposed HCW

The exposed HCW must be offered baseline HIV antigen/antibody, HBV surface antigen and surface antibody testing and HCV antibody blood testing as soon as possible.

HIV antigen/antibody, Hepatitis B surface antigen and surface antibody and HCV antibody screening tests for exposed HCWs can be performed 24 hours a day, 7 days a week by the immunoassay laboratory at Canberra Hospital. ***Form E3*** *ACT Pathology Request for Occupational Risk Exposure Baseline Testing* must be used for all baseline blood test requests. A gold top serum tube should be used for collection.

HCWs who disclose their own HIV, HBV or HCV infection at the time of ORE assessment will be advised that care in relation to their existing BBV infection is covered by the ACT Health *Blood Borne Virus Infection in Health Care Workers: Determination and Management of Scope of Clinical Practice and Chief Health Officer’s Role* procedure. They will also be encouraged to have appropriate baseline testing in relation to the ORE.

### Obtaining Informed Consent for Baseline Testing of the Exposed HCW

The OMU RN or AH CNC must obtain consent from the exposed HCW before proceeding with any baseline testing. Pre-test discussion should be provided as part of seeking consent and before blood is taken for HIV, HBV and HCV testing. Consent should be documented using ***Form*** ***E2*** *ORE Risk Assessment.*

The extent of pre-test discussion may vary according to the exposed HCW’s level of knowledge and understanding about HIV, HBV and HCV and his or her risk of exposure.

The source person should **not** be present at the pre-test discussion or while the exposed HCW is being tested.

## Pre-Test Discussion with the Exposed HCW

A relevant history will be obtained using ***Form E2*** *ORE Risk Assessment*. Pre-test discussion should consider whether the exposed HCW is possibly in a “window period” for infection relating to any other recent occupational or non-occupational exposure. The HCW should be informed that baseline testing for the ORE will not detect very recent infection from other occupational or non-occupational exposure.

Pre-test discussion will also include the provision of information about:

* The testing to be performed.
* Obtaining test results.
* Accessing further counselling and support*.*

## Notification of Exposed HCW Baseline Test Results

Negative HIV and HCV antibody and Hepatitis B surface antigen (HBsAg), as well as detected or undetected Hepatitis B surface antibody (HBsAb) results will be automatically available on the pathology computer system (CIS). The laboratory will **not** notify these results. The OMU RN or AH CNC is responsible for checking test results and conveying these to the exposed HCW. When results are received after a shift change, it is the responsibility of the incoming staff to check all test results and convey these to the exposed HCW.

If the HCW has a baseline HBsAb < 10mIU/mL **and** the HCW has no documentation of prior immunity (i.e. does not have HBsAB ≥ 10mIU/mL following a course of 3 Hepatitis B vaccinations) **and** the source is HBV positive or unknown, the HCW should be informed as soon as possible to allow for HBV PEP.

All positive and indeterminate HCW HIV test results will be phoned through to the ordering clinician by the Clinical Microbiologist (or delegate).

Positive and indeterminate HCW HBV and HCV results will be available to the OMU RN or AH CNC electronically via the hospital pathology system (and hard copy) once the report is authorised.

The OMU RN or AH CNC must discuss all positive and indeterminate HCW results with the Infectious Diseases Physician on-call for advice on the immediate management of the exposed HCW, including timeframes for contacting the exposed HCW and appropriate referral for ongoing management.

## Post-Test Discussion with the Exposed HCW

Post-test discussion will depend on the HCW’s test results and, if known, the source’s test results.

### Negative HCW Baseline Test Results

If all HCW baseline results are negative, post-test discussion should refer back to window periods that may apply in relation to other occupational or non-occupational exposures identified during the pre-test discussion, with recommendations for further testing as appropriate.

When further testing is indicated, post-test discussion may include the provision of advice until follow-up serology is finalised, including:

* Not to donate plasma, blood or blood products, body tissue, breast milk or sperm.
* To protect sexual partners by practicing safe sex.
* Not to share injecting equipment.
* To seek medical advice regarding pregnancy and/or breastfeeding.

### Positive and Indeterminate HCW Baseline Test Results

If a HCW has one or more positive or indeterminate baseline test results, post-test discussion will occur in the context of individualised assessment and care, under the guidance of the Infectious Diseases Physician on-call.

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| Section 6 – Baseline Testing and Management of the Source |

Every effort should be made to ascertain the HIV, HBV and HCV status of the source after an ORE. Testing of the source for HIV, HBV and HCV should occur as soon as possible, so that initial results are available within 4 hours.

When the identity of a source is known, the source is commonly referred to as a source person. A source person: may be a current patient; may have been discharged; may not be contactable; and/or may decline a request for contact. When there is no identifiable source person, for example, an injury from a discarded hollow bore needle, attempts should be made to establish when the sharp or other object may last have been used, and if possible, on whom.

## Baseline Testing of a Source Person

If the status of a source person is unknown at the time of the ORE, informed consent and baseline testing should be performed to determine the infectious status of the source for HIV, HBV and HCV.

If the source is known to have HIV, HBV or HCV, a recent viral load may be available. If not:

* If a source is known to have HIV, baseline testing should include HIV PCR.
* If a source is known to have HBV, baseline testing should include HBV e-Antigen and HBV PCR.
* If a source is known to be HCV antibody positive, baseline testing should include HCV PCR.

HIV, HBV and HCV **screening tests**[[6]](#footnote-6) can be performed 24 hours a day, 7 days a week by the immunoassay laboratory at Canberra Hospital. PCR testing is performed during normal business hours. ***Form*** ***S3*** *ACT Pathology Request for Occupational Risk Exposure Baseline Testing* must be used for all baseline blood test requests. A gold top serum tube should be used for collection. If HCV, HBV and/or HIV PCR testing is needed, a purple top 10mL EDTA tube (or two pink top 5mL EDTA tubes) is required in addition to the gold top serum tube.

## Interpreter Services

In traumatic or emotionally charged situations and times of crisis, a person’s second language competency may significantly decrease. The CHHS *Interpreter Services* procedure requires the use of an interpreter where there is any likelihood of misunderstanding due to language differences. Generally, a source person’s medical record will already indicate if an interpreter is needed and include the language or dialect required. However, there may also be circumstances where the source person’s medical record does not indicate an interpreter is needed and, if there are concerns about any likelihood of misunderstanding due to language differences, the OMU RN or AH CNC **must** offer and encourage use of an interpreter or telephone interpreter.

As per the CHHS Interpreter Services procedure, the OMU RN or AH CNC must accompany an interpreter liaising with a source person at all times, and the source person must be present during all interactions between the OMU RN or AH CNC and interpreter.

## Obtaining Informed Consent for Baseline Testing

Without the consent of a source person, the OMU RN and AH CNC **cannot** take blood (or add on tests to blood previously collected from the source person) for serology testing solely for the purpose of assessing and treating an exposed HCW. This means that, if a patient is unconscious, the treating medical officer cannot give consent for a blood test, except if the patient has provided consent in the *Consent to Treatment* form (see Part 6.3.2 below). Relevantly, the ACT Health WHSMS provides:

*7.6.11 Occupational Risk Exposure (ORE) Management*

*There are no legal requirements for a patient, client or consumer to declare their infectious status to health care institutions. ACT Health must obtain oral consent for testing for blood borne viruses and also provide pre and post test counselling to a patient, client or consumer involved in an occupational risk exposure (ORE).*

### When a Source Person Provides Consent

Consent must be documented using ***Form*** ***S2*** *ORE Risk Assessment*. The OMU RN or AH CNC must then complete the pre-test discussion using ***Form*** ***S2*** *ORE Risk Assessment*.

### When a Source Person is Unable to Provide Consent

When a patient is admitted to hospital for a procedure or treatment, he or she completes a *Consent to Treatment* form (attached to the *General Conditions of Admission* form). Dot Point 5 of the *Consent to Treatment* form provides: “... I consent to my blood being tested for any disease, including hepatitis and HIV antibody if any hospital staff member is exposed to my blood or body fluids.”

Sometimes a source person will be unable to provide consent for baseline testing after an ORE because he or she is unconscious. If an unconscious source person has been admitted to hospital for a procedure or treatment, the *Consent to Treatment* form will provide information as to whether or not he or she has consented to baseline testing.A source person tested for HBV, HCV or HIV while unconscious should be provided his or her results as soon as possible, with appropriate discussion.

Sometimes a source person will be unable to provide consent for baseline testing after an ORE because he or she is a child or young person under the age of 18 years or an adult aged 18 years or older whose decision-making capacity is impaired by therapeutic or other drugs, alcohol, delirium or dementia. In these circumstances, the *Consent to Treatment* form may provide information as to whether or not the source person has consented to baseline testing. For further information, refer to the ACT Health *Consent and Treatment* policy, the ACT Health *Consent and Treatment: Children or Young People* procedure and the ACT Health *Consent and Treatment: Capacity and Substitute Decision Makers* procedure. If the source person is unable to provide consent, informed consent must be obtained from the responsible parent or guardian, using ***Form*** ***S2*** *ORE Risk Assessment*.

### When a Source Person Refuses Consent

A source person has the right to refuse consent for baseline testing. Refusal of consent must be documented in the source person’s clinical record. If a source person refuses consent, the exposed HCW should be managed as set out in **Part 7.1 Source Status Unknown for HIV, HBV and HCV**.

## Pre-Test Discussion with a Source Person

Pre-test discussion should be provided before blood is taken for HBV, HCV and HIV testing. The OMU RN or AH CNC should explain to the source person that pre-test discussion will include some questions about sexual partners and injecting drug use. The source person should be reassured that these questions are helpful to assess risk of infection and assist with the interpretation of their results, and that their answers will remain confidential within the OMU. The exposed HCW should **not** be present at the pre-test discussion or while the source person is being tested.

Pre-test discussion may include:

* Exploration of the source person’s history, including a discussion about whether the source person is possibly in a “window period” for infection relating to a recent exposure.
* Exploration of whether a source person has a BBV but has not disclosed to his/her treating team.
* Provision of information about testing to be performed.
* Provision of information about obtaining test results.
* Provision of information about accessing further counselling and support.

### When a Source Person is Not a Current Inpatient

If the source person is no longer a patient, the OMU RN or AH CNC may contact the source person to:

* Explain that an ORE has occurred and, if the source person agrees to further discussion, ***Form*** ***S2*** *ORE Risk Assessment* will be completed over the phone.
* If the source person agrees to blood testing, decide how this will be done, either:
* If a suitable blood specimen from the source person’s admission is still available at ACT Pathology, tests can be requested on this specimen. **OR**
* Source person returns to the OMU for testing and counselling. The OMU will advise the source person that **this is the preferred option** if a suitable blood specimen from their admission is not available at ACT Pathology. ACT Health will cover all costs of testing performed by the OMU but will not reimburse testing performed outside of the OMU. **OR**
* OMU to fax pathology request form to closest pathology collection centre. The OMU will request that the source person provides the test results to the OMU. If consent is provided, the OMU is responsible for contacting the source person by telephone to obtain the test results. **OR**
* If the source person prefers to see his or her GP, the OMU will call or fax the GP to outline what tests are required and why. The OMU will request that the source person provide his or her consent for the GP to make the test results available to the OMU RN or AH CNC. If consent is provided, the OMU RN or AH CNC is responsible for contacting the GP by telephone to obtain the test results.

### When a Source Person is Not Contactable or Declines a Request for Contact

If the source person is not contactable or declines a request for contact, the relative risk of the source being positive for HIV, HBV or HCV must be inferred.

## Notification of Source Person Baseline Test Results

Negative HIV and Hepatitis C antibody and Hepatitis B surface antigen (HBsAg), as well as detected or undetected Hepatitis B surface antibody (HBsAb) results will be automatically available on the pathology computer system (CIS). The laboratory will **not** notify these results. The OMU RN or AH CNC is responsible for checking test results. OMU RN or AH CNC (or treating Medical Officer) will convey test results to the source person as soon as possible. This may, by prior agreement with the source person, be in the morning following an After Hours ORE.

The Clinical Microbiologist (or delegate) will, via telephone, directly notify the OMU RN or AH CNC of any positive or indeterminate HIV and Hepatitis B surface antigen results. These initial tests are only **screening** tests and require further confirmatory testing which may take several days. They should not be considered as final results until all confirmatory tests are available but will be used when assessing the risk of the exposure and need for PEP in the exposed HCW. Positive HCV results will not be phoned through but will be available on CIS.

The OMU RN or AH CNC will discuss all positive and indeterminate test results with the Infectious Diseases Physician on-call. Where possible, the Infectious Diseases Physician on-call will speak to the source person and, as required, make an appointment to discuss the results, the implications and a follow-up plan. The Infectious Diseases Physician on-call will also liaise with the source person’s treating Medical Officer.

## Post-Test Discussion with a Source Person

Post-test discussion will depend on the results.

### Negative Baseline Test Results

If all baseline results are negative, post-test discussion should refer back to window periods that may apply in relation to other potential exposures identified during the pre-test discussion. If there have been potential exposures within window periods, further testing will be recommended.

When further testing is indicated, post-test discussion may include the provision of advice until follow-up serology is finalised, including:

* Not to donate plasma, blood or blood products, body tissue, breast milk or sperm.
* To protect sexual partners by practicing safe sex.
* Not to share injecting equipment.
* To seek medical advice regarding pregnancy and/or breastfeeding.

By request, the OMU can provide test results to another nominated heath care provider. Consent must be documented.

### Positive and Indeterminate Baseline Test Results

If a source person has one or more positive or indeterminate baseline test results, post-test discussion will occur in the context of individualised assessment and care, under the guidance of the Infectious Diseases Physician on-call.

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| Section 7 – Treatment of the Exposed HCW |

**Table 3** overleaf summarises the recommended schedule of baseline testing after an ORE.

**Table 3**

*Recommended Schedule of Baseline Testing After an ORE*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HCW status** | **Baseline Tests (see *Note for Tests* below)** | | | **Post exposure prophylaxis (PEP)** |
| ***HCW immune to HBV*** | HIV  HBV  HCV**A** | | | HIV PEP**B** |
| ***HCW non-immune to HBV or HBV status uncertain*** | HIV  HBV  HCV**A** | | | HIV PEP**B**  HBV PEP**C,D** |
| 1. If HCW is known to be HCV antibody positive, add HCV PCR. 2. By risk assessment if the source is known to be HIV positive or source status is unknown. If HIV PEP indicated, add baseline FBC, EUC and LFTs. If the source is known to be HIV positive, aim to commence HIV PEP within 1-2 hours. HIV PEP may be considered for higher risk exposures where the source status is unknown or source is negative but discloses risk exposures in the last 6 weeks. HIV PEP should **not** be offered more than 72 hours after exposure.[[7]](#footnote-7) 3. If the source is known to be HBV sAg positive, or source status is unknown,HBV PEP (vaccination + HBIG) is most effective when commenced within 24 hours. Where the HCW is non-immune, HBV PEP may be considered for higher risk exposures where the source is negative but discloses risk exposures in the last 3 months. 4. HBV PEP should be offered in accordance with the **HBV Management** table below. | | | | |
| **Exposed HCW Status** | | **Source Status** | **Exposed HCW Management** | |
| HBsAb **positive** (immune) | | Not relevant | No HBV PEP. | |
| HBsAg and HBsAb **negative** (non-immune) | | HBsAg **negative** | Recommend HBV vaccination. | |
| HBsAg and HBsAb **negative** (non-immune) | | HBsAg **positive** or **unknown** | Recommend HBIG and HBV vaccination. | |
| HBsAg screening test **positive** and  HBsAb **negative** (HBV infection or false positive HBsAg) | | HBsAg **negative** | No HBV PEP. Await full HBV results. Discuss with Clinical Microbiologist and/or Infectious Diseases Physician on-call for further management. | |
| HBsAg **positive** or **unknown** | Discuss with Clinical Microbiologist and/or Infectious Diseases Physician on-call. Assess likelihood of HCW having false positive HBsAg as HBIG and HBV vaccination may be indicated. | |

ACT Health will not cover the costs of treatment for agencies/locums or contractors. This will need to be determined between the HCW and agency/locum or contractor.

## Source Status Unknown for HIV, HBV and HCV

If the infectious status of a source is uncertain after every effort has been made to ascertain the HIV, HBV and HCV status, the relative risk of the source being positive for HIV, HBV or HCV must be inferred. If there is thought to be a low risk of the source being infected with HIV, HBV or HCV, the exposed HCW should be managed as set out in **Parts 7.2 and 7.5**. If there is thought to be a high risk of the source being infected with HIV, HBV or HCV, the exposed HCW should be managed as set out in **Parts 7.4, 7.5 and 7.6**.

## Source Negative for HIV, HBV and HCV and Unlikely to be in the Window Period for Infection

HIV PEP is not recommended. HCWs non-immune to Hepatitis B should be managed as outlined in **Part 7.5**. Follow-up testing to exclude HIV, HBV and HCV is as set out in **Part** **8**.

## Source Negative for HIV, HBV and HCV but Discloses Risk Exposures in the Window Period for Infection

The OMU RN or AH CNC must discuss disclosures of risk exposures within the window period for infection with the Infectious Diseases Physician on-call. The exposed HCW will be treated as appropriate to the level of risk.

For **HIV**, PEP may be considered for higher risk exposures where the source discloses risk exposures in the last 6 weeks. Follow-up source testing should be offered to try to clarify the source status.

For **HBV**, where the HCW is non-immune, PEP may be considered for higher risk exposures where the source discloses risk exposures in the last 3 months. Follow-up source testing should be offered to try to clarify the source status.

## Source HIV Positive or Indeterminate on HIV Testing (or Unknown as per Part 7.1)

HIV PEP is a **4-week course** of HIV antiretroviral medication. Early initiation of PEP, as soon as possible after exposure, is recommended as part of this procedure. If the source is known to be HIV positive, aim to commence HIV PEP within 1-2 hours. If the source blood tests suggest previously undiagnosed HIV, commence HIV PEP within 1-2 hours of the test results being available. PEP should **not** be offered more than 72 hours after exposure.[[8]](#footnote-8)

**Monday to Friday 00730 – 1530 CHHS**

The OMU RN must seek immediate advice from the Infectious Diseases Physician on-call or Canberra Sexual Health Centre (CSHC) to determine the need for HIV PEP. Where possible, information concerning the source’s stage of HIV infection, viral load and history of HIV therapy should be provided. If the Infectious Diseases Physician on-call or Sexual Health Physician recommends PEP, the OMU RN will refer the exposed HCW directly to the CSHC for counselling and initiation of PEP. Baseline test results (for the exposed HCW and source person) and copies of the completed ***Form E2*** *ORE Risk Assessment* and ***Form S2*** *ORE Risk Assessment* from the ORE Pack should be available to the CSHC.

**Weekdays After Hours 1530 – 0730 or on a Public Holiday or Weekend**

The AH CNC must seek immediate advice from the Infectious Diseases Physician on-call to determine the need for HIV PEP. Where possible, information concerning the source’s stage of HIV infection, viral load and history of HIV therapy should be provided. If recommended, a 5-day three drug PEP starter pack is available in the Emergency Department at Canberra Hospital and the Emergency Department at CHC Bruce.

**The exposed HCW should attend the CSHC the next working day for ongoing PEP management.** This will provide a further opportunity to assess the appropriateness of the initial PEP regimen, including the number and combination of drugs prescribed. Baseline test results (for the exposed HCW and source person) and copies of the completed ***Form E2*** *ORE Risk Assessment* and ***Form S2*** *ORE Risk Assessment* from the ORE Pack should be available to the CSHC.

Three drug PEP starter pack treatment will be reviewed in accordance with **Table 4.** It may be possible to simplify three drug treatment to two drug treatment, particularly if further information such as source viral load is available at review.

**Table 4**

*PEP Recommendations After an ORE to a Known HIV Positive Source Following Assessment at CSHC*

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of exposure with known HIV positive source** | **Estimated**  **risk of HIV transmission per exposure** | **PEP Recommendation** | |
| **Source viral load**  **undetectable** | **Source not on treatment or on treatment with detectable viral load** |
| Needlestick injury (NSI) or other sharps exposure | 1/440 **a** | 2 drugs | 3 drugs |
| Mucous membrane and non-intact skin exposure | < 1/1000 | Consider 2 drugs | 3 drugs |

***N.B.*** This table is sourced from the *National Guidelines: Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV.* Australasian Society for HIV Medicine (ASHM, 2013). See Table 5 (p.10) of the National Guidelines.

**a** For example, PEP may be recommended if needle and syringe contained fresh blood and sufficiently penetrated the skin.

There is no direct evidence to support the greater or lesser efficacy of 3 over 2 drug preventive regimens. The recommendation for the number of antiretroviral drugs is based on an extrapolation of the possible benefit conferred by increased numbers/classes of drugs for HIV treatment.[[9]](#footnote-9)

## Source HBV Positive or Indeterminate on HBV Testing (or Unknown as per Part 7.1)

For all OREs where the HBV status of the source is unknown or HBV positive or indeterminate on HBV testing, the exposed HCW will be treated as for a positive source.

HBV PEP is most effective when taken within 24 hours and should be offered in accordance with **Table 3**.

If an exposed HCW is unvaccinated or incompletely vaccinated, the OMU RN or AH CNC will commence or complete the course of HBV vaccination and advise the exposed HCW about his or her vaccination requirements. When required, the OMU RN or AH CNC will offer a single dose of Hepatitis B specific immunoglobulin (HBIG) 400 IU IM injection ideally within 24 hours (but up to 72 hours) of the exposure.

## Source HCV Positive or Indeterminate on HCV Testing (or Unknown as per Part 7.1)

For all OREs where the source is unknown, HCV positive or in the window period for HCV, the exposed HCW will be advised and followed-up as for a positive source.

At present, there is no PEP proven to be effective following exposure to HCV.

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| Section 8 – Follow-Up Testing and Appointments |

**Table 5** below summarises the recommended schedule of follow-up testing. **Appointments will be scheduled by the OMU or CHC Bruce SH at 6 weeks, 3 months and 6 months after exposure.**

**Table 5**

*Recommended Schedule of Follow-Up Testing After an ORE*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HCW status** | **Tests (see *Note for Tests* below)** | | | **Immunisation** |
| **6 weeks \*** | **3 months** | **6 months** |
| ***HCW immune to HBV*** | HIV | HIV  HCV | HCV | Nil required. |
| ***HCW non-immune to HBV*** | HIV | HBV + LFTs  HIV  HCV | HBV + LFTs  HCV | HBV vaccine at  4 weeks (dose 2) and  6 months (dose 3). |
| **\* 6 week follow-up is optional if the source is HIV, HBV and HCV negative and no disclosed window period risks. Follow-up at 3 months is recommended.** | | | | |
| **Additional follow-up:**  **If HIV PEP has been commenced:** *add* HIV PEP review at 5-10 days including repeat full blood count, renal & liver function tests.  **If exposure to HCV positive source**: *add* HCV PCR and LFTs at 6 weeks and 3 months.  **If a HCW is HCV Ab positive, PCR negative at baseline:** *add* HCV PCR and LFTs at 6 weeks and 3 months. HCV Ab testing is not required. | | | | |

|  |  |
| --- | --- |
| **Note for Tests** | |
| **HIV** | means HIV Ag/Ab |
| **HBV** | means HBV sAg, sAb, cAb |
| **HCV** | means HCV Ab |

***Form*** ***E8*** *ACT Pathology Request for Occupational Risk Exposure Follow-Up Testing* must be used for all follow-up blood test requests scheduled by the OMU.

An exposed HCW may not consent to follow-up management by the OMU. It is then the responsibility of the OMU to clarify follow-up arrangements with the exposed HCW, for example, his or her GP or Canberra Sexual Health Centre.

ACT Health will not cover the costs of follow-up testing for agencies/locums or contractors. This will need to be determined between the HCW and agency/locum or contractor.

## Source HIV Positive, Unknown or Negative with Window Period Risk Factors

HCWs should be informed of symptoms of acute HIV infection, with advice to present if these occur. Routine follow-up testing will be at 6 weeks and 3 months from the date of the ORE.[[10]](#footnote-10) If the HCW has commenced HIV PEP, follow-up includes PEP review at 5-10 days with repeat full blood count, renal and liver function tests. HBV and HCV follow-up testing may also be required.

## Source HBV positive, Unknown or Negative with Window Period Risk Factors

HCWs with evidence of previous immunity to hepatitis B (HBsAb positive) require no further HBV testing. Non-immune exposed HCWs should be informed of symptoms of acute hepatitis, with advice to present if these occur.[[11]](#footnote-11) Routine follow-up for non-immune exposed HCWs who have received initial immunisation with or without HBIG includes further immunisation at 4 weeks and 6 months *and* sAg, sAb and cAb and LFTs testing at 3 months and 6 months. HIV and HCV follow-up testing may also be required.

## Source HCV Positive, Unknown or Negative with Window Period Fisk Factors

HCWs should be informed of symptoms of acute hepatitis, with advice to present if these occur.**8** Routine follow-up testing will include HCV antibody at 3 months and 6 months. If the source person is HCV positive, additional testing is indicated with HCV PCR and LFTs at 6 weeks and 3 months.

If the HCW is HCV antibody positive at baseline, HCV Ab is not required. Routine follow-up testing includes HCV PCR and LFTs at 6 weeks and 3 months*.* HIV and HBV follow-up testing may also be required.

## Source HIV, HBV and HCV Negative without Disclosed Risk Factors for Window Period

For a HCW exposed to a source person who is **negative** for BBVs and is considered **low risk** to be in the window period of infection (did not disclose a window period risk), the infection risk in the exposed HCW is extremely low but follow-up testing at 3 months is recommended to definitively exclude infection occurring as a result of the ORE. This would include HIV, HCV and if non-immune, HBV. Follow-up at 6 weeks is optional.

Preventive behaviours during follow-up must be discussed with all HCWs. This includes safe sexual and injecting behaviours as well as the HCW preventing exposing others to their body fluids through other means such as accidents or body tissue donation. This includes discussion about conception/pregnancy, the risk of mother to child transmission and contraception. Specialist advice is recommended for a HCW who is pregnant or trying to conceive at the time of ORE.

For more information, see the:

* National Hepatitis B Testing Policy at <http://testingportal.ashm.org.au/hbv>
* National Hepatitis C Testing Policy at <http://testingportal.ashm.org.au/hcv>
* National HIV Testing Policy at <http://testingportal.ashm.org.au/hiv>
* National Guidelines for Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV at: <http://www.ashm.org.au/pep-guidelines/NPEPPEPGuidelinesDec2013.pdf>

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| Section 9 – Managing Injury and Illness in ACT Public Sector Workplaces |

Workers’ compensation arrangements for ACT Public Sector (ACTPS) workers are provided under the *Safety, Rehabilitation and Compensation Act (1988)*. The Return-to-Work program is managed by the ACT Government’s Chief Minister and Treasury Injury Management & Safety Team (CMTDIM) on behalf of ACT Health. Refer to the ACT Government *Managing Injury and Illness in the Workplace Policy* forguidance on managing and supporting workers who experience injury or illness in the workplace.

## Reporting Work Related Injuries – Accident/Incident Report (AIR) Notification

The ACT Government Accident/Incident Report (AIR) must be used to report all work related accident/incidents which resulted in a workplace injury to a person and all circumstances which may result in the risk of harm. The attending OMU RN or AH CNC will ensure that Parts A-D of the AIR form are completed. The OMU will scan the AIR form to the Workplace Safety inbox. Workplace Safety staff will enter the AIR data into Riskman and distribute the Riskman notice to the exposed HCW’s manager for comment and investigation. The manager will complete Part E of the AIR form. Workplace Safety staff will also distribute the Riskman notice to the OMU RN for comment.

The exposed HCW can request a hard copy of the Riskman report by email: [workplacesafety@act.gov.au](mailto:workplacesafety@act.gov.au)

## Compensation Claims

If compensation is to be claimed, a copy of the completed AIR should be included with the *Compensation Claim Packs and Injury Management Support Request Forms*, which can be obtained from the Workplace Health Advisory Unit (WHAU), located at 123 Carruthers Street in Curtin, telephone 6205 1432. The WHAU provides initial advice and guidance on injury management issues for supervisors, managers and injured workers. All Injury Management Services are managed by the CMTDIM, through a whole-of-Government Improvement Plan.

## Leave Applications

If the exposed HCW is unable to return to work, he or she must apply for leave in accordance with his or her enterprise agreement (or employment contract) and, as required, produce relevant documentary evidence.

Exposed HCWs who perform EPPs as part of their employment should refer to the *Australian National Guidelines for the Management of Health Care Workers Known to be Infected With Blood Borne Viruses* and the ACT Health *Blood Borne Virus Infection in Health Care Workers: Determination and Management of Scope of Clinical Practice and Chief Health Officer’s Role* procedure for more information. The exposed HCW may be restricted from performing EPPs following a high risk exposure pending the results of follow-up testing.

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| Implementation |

This procedure will be incorporated into existing training programs and orientation.

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| Related Policies, Procedures, Guidelines and Legislation |

**Related Legislation**

***ACT Legislation***

Available at: <http://www.legislation.act.gov.au/>

*Occupational Health and Safety Act* 1989

*Health Records (Privacy and Access) Act* 1997

*Medicines, Poisons and Therapeutic Goods Act* 2008

*Public Health Act* 1997

*Humans Right Act* 2004

***Commonwealth Legislation***

Available at: <http://www.comlaw.gov.au/>

*Quarantine Act* 1908 (Clth)

**Standards**

Australian Commission on Safety and Quality in Health Care (2012). *Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections*.Sydney, Australia: ACSQHC.

<http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard3_Oct_2012_WEB.pdf>

Australian Commission on Safety and Quality in Health Care (2012). *Safety and Quality Improvement Guide Standard 7: Blood and Blood Products*.Sydney, Australia: ACSQHC. <http://www.safetyandquality.gov.au/publications/safety-and-quality-improvement-guide-standard-7-blood-and-blood-products-october-2012/>

**Related ACT Health Policies and Standard Operating Procedures**

Available at: <http://acthealth/c/HealthIntranet?a=&did=5004883>

*Blood Borne Virus Infection in Health Care Workers: Determination and Management of Scope of Clinical Practice and Chief Health Officer’s Role* Procedure

*Consent and Treatment* Policy

*Consent for a Child or Young Person* Procedure

*Consent Capacity and Substitute Decision Maker* Procedure

*Occupational Assessment, Screening and Vaccination* Procedure

Risk Management Guidelines

**National Guidelines**

Australian National Guidelines for the Management of Health Care Workers Known to be Infected with Blood Borne Viruses (2012). Communicable Diseases Network Australia (CDNA). <http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdna-bloodborne.htm>

Australian Immunisation Handbook (10th Edition) (2014). National Health and Medical Research Council (NHMRC). <http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home>

Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010). NHMRC. <http://www.nhmrc.gov.au/guidelines-publications/cd33>

National Hepatitis B Testing Policy (2012). HBV Expert Reference Committee – A Joint Working Party of the BBVSS and MACBBVS. <http://testingportal.ashm.org.au/hbv>

National Hepatitis C Testing Policy (2012). HCV Expert Reference Committee – A Joint Working Party of the BBVSS and MACBBVS. <http://testingportal.ashm.org.au/hcv>

National HIV Testing Policy (2011). HIV Expert Reference Committee – A Joint Working Party of the BBVSS and MACBBVS. <http://testingportal.ashm.org.au/hiv>

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| Definition of Terms |

**ACT Health** includes ACT Health and CHC Bruce health care facilities.

**AEFI** means Adverse Event Following Immunisation and is an unwanted or unexpected event following immunisation.

**AH CNC** means After Hours Clinical Nurse Consultant.

**BBV** means Blood Borne Virus and includes HIV, HBV and HCV.

**BBV-Infected HCWs** means HCWs who are infected with a BBV and includes HCWs infected with HIV, HBV and/or HCV.

**CHC Bruce** means Calvary Health Care Bruce (previously Calvary Public Hospital).

**CHC Bruce SH** means Calvary Health Care Bruce Staff Health Department.

**CHHS** means Canberra Hospital and Health Services.

**Clinical Area** is an area or health facility where patients are assessed and clinically managed.

**Contractor** is any company, partnership, other entity, or individual that does not have a direct employment relationship with ACT Health and has an agreement to provide ACT Health with services or product or, in relation to ACT Health infrastructure, carry out construction, alteration, improvement, refurbishment, demolition or other works.

**DDG-CHHS** means Deputy Director-General – CHHS.

**EPPs** meansexposure prone procedures. EPPs are invasive procedures where there is potential for direct contact between the skin (usually finger or thumb of the HCW) and sharp surgical instruments, needles or sharp tissues, spicules of bone or teeth in body cavities or in poorly visualised or confined body sites, including the mouth of the patient.

**Expert Advisory** means the *Expert Advisory Committee for Health Care Workers*

**Committee** *Infected with a Blood Borne Virus* that determines the potential infectivity of a BBV-infected HCW and the degree of risk of transmission of the infection, for the provision of advice to ACT Health on modifying the work practices of BBV-infected HCWs.

**Exposure** meanscontact between blood or other body fluids with the eyes, skin or mucous membranes of the exposed HCW.

**Exposed HCW** means the HCW exposed to blood or other body fluids.

**HCW** means health care workerand is inclusive of the following personnel:

* Clinical and non-clinical personnel working in a health care facility who are employed by ACT Health on a permanent, temporary or casual basis.
* Volunteers.
* Students (including tertiary and secondary school students).
* Other clinical and non-clinical personnel (persons not permanently, temporarily or casually employed by ACT Health) who are contracted to work (e.g. Honorary and Visiting Medical Officers) and persons providing other services under separate employment arrangements (e.g. agency/locum personnel, including Contracted Domestic and Environmental Staff).
* Any other personnel where an agreement is in effect to undertake clinical placements.
* For CHC Bruce, HCWs who are permanently, temporarily or casually employed by CHC Bruce.

**Health Care Facility**  refers to a defined service location such as a hospital, community health centre or other location where health services are provided.

**Hepatitis A** means Hepatitis A Virus (HAV).

**Hepatitis B** means Hepatitis B Virus (HBV).

**Hepatitis C** meansHepatitis C Virus (HCV).

**HBIG** means Hepatitis B specific immunoglobulin.

**HCV Status** is the presence or absence of Hepatitis C infection and/or active disease.

**HIV** means Human Immunodeficiency Virus.

**HIV Status** is the presence or absence of HIV infection and/or active disease.

**OMU** means the Occupational Medicine Unit at CHHS.

**OMU RN** means Occupational Medicine Unit Registered Nurse.

**PEP** means Post Exposure Prophylaxis, medication administered after an ORE that may reduce the risk of acquiring an infection.

**Risk Assessment** means the overall process of estimating the magnitude of risk following an ORE in order to determine appropriate management.

**Source** meansthe blood or other body fluids to which the HCW is exposed.

**Source Person** means the person whose blood or body fluids are involved in an exposure.

**Student** means a student enrolled in a program of study at a tertiary or secondary educational institution. Secondary school students include students undertaking vocational education delivered by the Canberra Institute of Technology (CIT) and NSW Technical and Further Education (TAFE) Institutes as well as the Technical and Vocational Education and Training (TVET).

**Volunteer** is an individual who undertakes work in an ACT Health operated facility that is not paid or remunerated (except out of pocket expenses) and works to fulfil a charity or community service good.

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| Search Terms |

Blood Borne Virus, Occupational Risk Exposure, Sharp Exposure, Splash Exposure, needle stick injury, HIV, infected health care worker, occupational screening, BBV, post exposure prophylasix (PPE)

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| Attachments |

Attachment 1: Occupational Risk Exposure Pack (accessible from the Policy Register <http://inhealth/PPR/default.aspx>)

Attachment 2: Occupational Risk Exposure Testing Summary

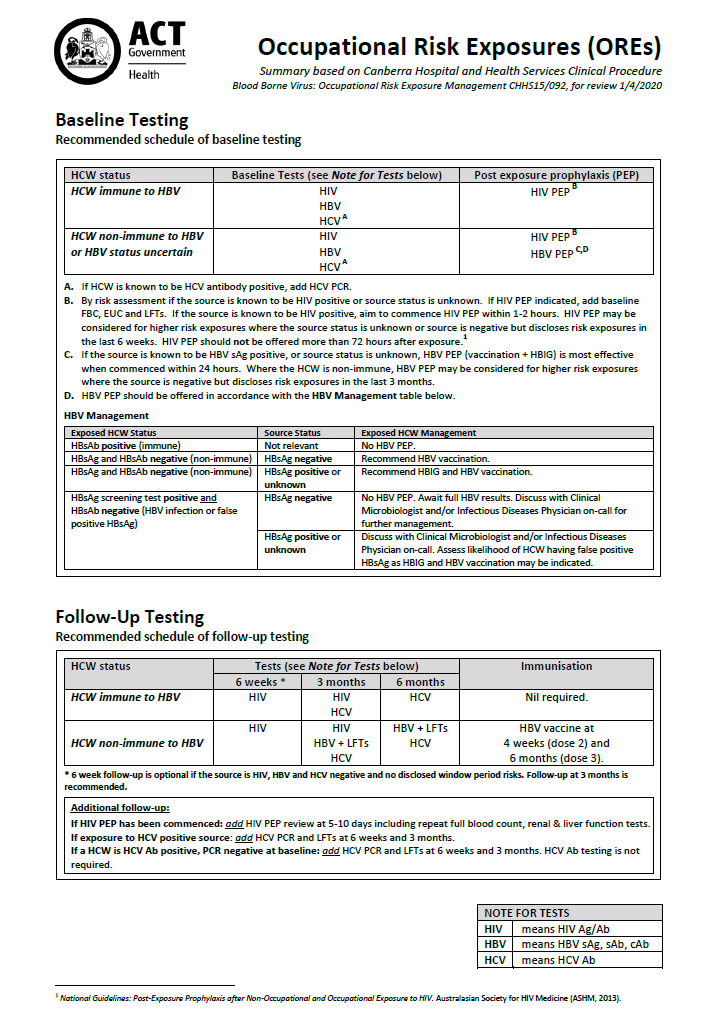
**Disclaimer**: *This document has been developed by ACT Health, Canberra Hospital and Health Service specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Health Directorate assumes no responsibility whatsoever.*

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| --- | --- | --- |
| Date Amended | Section Amended | Approved By |
| *18/11/2016* | *Attachment 2 added* | *CSQU Policy Team Manager* |
|  |  |  |

## Attachment 1: Occupational Risk Exposure Pack

The complete pack can be accessed from the Policy and Plans Register at: <http://inhealth/PPR/default.aspx>

## Attachment 2: Occupational Risk Exposure Testing Summary



1. Bell, D.M. (1997). Occupational risk of human immunodeficiency virus infection in healthcare workers: An overview. *The American Journal of Medicine, 102*(5) (Suppl. 2), 9-15. [↑](#footnote-ref-1)
2. Kuhar, D.T., Henderson, D.K., Struble, K.A., Heneine, W., Thomas, V., et al. (2013). Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. *Infection Control and Hospital Epidemiology, 34*(9), 875-892. [↑](#footnote-ref-2)
3. ## CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management - Recommendations and Reports (2013). *MMWR* ***62*(RR10); 1-19.**

   [↑](#footnote-ref-3)
4. Werner, B.G., & Grady, G.F. (1982). Accidental hepatitis-B-surface-antigen-positive inoculations: use of e antigen to estimate infectivity. *Annals of Internal Medicine, 97,* 367–9. [↑](#footnote-ref-4)
5. Centers for Disease Control and Prevention. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. *MMWR 2001*;50 (No. RR-11). [↑](#footnote-ref-5)
6. HIV, HBV and HCV screening tests include HIV antigen/antibody testing, HBV antigen and antibody testing and HCV antibody testing. [↑](#footnote-ref-6)
7. *National Guidelines: Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV.* Australasian Society for HIV Medicine (ASHM, 2013). [↑](#footnote-ref-7)
8. *National Guidelines: Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV.* Australasian Society for HIV Medicine (ASHM, 2013). [↑](#footnote-ref-8)
9. *National Guidelines: Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV.* Australasian Society for HIV Medicine (ASHM, 2013). [↑](#footnote-ref-9)
10. Follow-up HIV testing is no longer recommended at 6 months *National Guidelines: Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV.* Australasian Society for HIV Medicine (ASHM, 2013). [↑](#footnote-ref-10)
11. NHMRC (2010) *Australian Guidelines for the Prevention and Control of Infection in Healthcare*. Commonwealth of Australia. [↑](#footnote-ref-11)