Blood Borne Virus (BBV) Exposure – Clinical Management NT Health Guideline

Document Metadata			
Target Audience	All Employees;		
Jurisdiction	NT Health;		
Jurisdiction Exclusions	N/A;		
Document Owner	Co-Director Infectious Diseases, RDPH		
Approval Authority	Chief Medical Officer		
Author	Infectious Diseases Department, RDPH		
PGC/SharePoint ID: HEALTHINTRA-1880-2535		**Content Manager ID:** EDOC2021/209470	
Version Number: | Version: 59.0 |	Approved Date: 07/09/2021	Review Date: 07/09/2025	
This is a NT Health Policy Guidelines Centre (PGC) Approved and Controlled document. Uncontrolled if printed.			

Purpose

This guideline is a reference document containing the rationale and extended information regarding the clinical management of potential occupational and non-occupational exposures to blood borne pathogens. This document should be used in conjunction with the Healthcare Worker Occupational Exposure Incident Management NT Health Guideline.

A potential blood borne virus (BBV) exposure occurs when broken skin, conjunctiva or mucosa (oral or genital) is exposed to the blood or body fluids of another person. These include needle stick punctures, scalpel cuts, human bites, scrapes and cuts where the integrity of the skin or mucous membranes have been compromised, sexual contact and splashes of blood or body fluids including amniotic fluid.

The purpose of this guideline is to ensure the prompt and appropriate assessment, management, reporting and follow-up of people who have been potentially exposed to BBV and other blood borne pathogens such as syphilis.

Guideline

General Information

The immediate management of the incident, including first aid, risk assessment and consideration of post exposure prophylaxis is considered a medical emergency in terms of timeliness and resource allocation. Appropriate follow-up should be advised for all people with significant potential exposures regardless of place of employment or nature of exposure.

Procedure

A. First Aid Following Potential BBV Exposure

Immediately perform basic first aid:

- For exposure of skin to blood or body fluids, excretions or secretions wash the area well with soap and water. If the exposure has involved skin penetration, bleed gently, wash thoroughly as above and apply a waterproof dressing. (do NOT squeeze or rub, as this will increase blood circulation in injured area an could increase risk of potential infection)
- For exposure of eyes or conjunctiva to blood or body fluid, excretions or secretions, remove any contact lenses (if applicable) and with eyes open, irrigate with copious amounts of water or normal saline for at least 30 seconds.
- For exposure of mouth to blood or body fluids, excretions or secretions, spit out and rinse mouth with plain water several times.
- If required, remove soiled clothes as soon as appropriate and place in a plastic bag. Wash affected skin area thoroughly with soap and water.
- *Do not* inject antiseptics or disinfectants into wounds.
- *Do not* douche the vagina or rectum after sexual exposure.

B. Risk Assessment of Exposure

The significance of the injury or exposure should be assessed with respect to blood borne pathogens transmission risk;

1. The nature and extent of the injury or anatomical site of the exposure
2. The nature of the item that caused the injury (e.g. type and gauge of the needle)
3. The nature of the body fluid, secretion or tissue involved
4. The volume of blood and body substances to which the person was exposed

Body fluids that pose a potential risk for BBV transmission include:

- Blood, serum, plasma and all biological fluids visibly contaminated with blood
- Pleural, amniotic, pericardial, peritoneal, synovial and cerebrospinal fluids
- Uterine/vaginal secretions or semen
- Laboratory specimens that contain concentrated virus

Significant Exposures *Requiring* Assessment and Management

A potential significant BBV exposure occurs if one of the above body fluids comes in contact with another person in either an occupational or non-occupational setting via:

- Percutaneous injury e.g. needle stick or scalpel, intravenous drug use (IVDU)
- Non intact skin. Skin integrity is considered compromised if there is evidence of chapped skin, dermatitis, abrasion or open wound
- Eye splash
- Mucous membrane splash
- Vaginal or anal sexual contact

Non-Significant Exposures *Not Requiring* Assessment and Management

The following exposures are considered non-significant and do not require any specific follow-up or testing:

- Any injury sustained from a clean (i.e. unused) sharp
- Mucous membrane exposure to non-blood stained body fluids other than blood or semen
- Intact skin exposed to blood or any other body fluid or substance

C. Serology Testing of a Known *Source*

The source person is defined as the person from which the blood or body fluids originated in the event of an exposure. If a **significant exposure** has occurred the source person should be tested and assessed to determine known or probable BBV infection where possible.

Agreement to undergo testing is **voluntary**. The source person is under no legal obligation to comply with this request. Where the incident occurs during a procedure for which consent has been previously obtained (e.g. intra-operatively or during the anaesthetic recovery period) the bloods can be collected immediately with the source person informed and given appropriate information at a suitable time post procedure.

If the source is contactable then serological testing should be performed as soon as possible after exposure, ideally within 24 hours of exposure. If the source is unknown or not contactable their risk of having a blood-borne pathogen should be assessed on the basis of any demographic or epidemiological information known at the time of assessment.

See Healthcare Worker Occupational Exposure Incident Management NT Health Guideline for further information around responsibility for testing of the source patients

In *Darwin* if the following day is a weekend or public holiday the on-call Infectious Diseases (IFD) Physician/Registrar should call the microbiologist on-call to facilitate serological testing within 24 hours. The HRN and identification details of both source and exposed person will be required by the on-call IFD Physician/Registrar.

For *Alice Springs* Hospital Staff. High Risk exposure on weekends and Public Holidays where immune status is unknown. The ED MO is to advise the exposed person to present to ED after 3pm the following day for results and treatment if required. The person must attend the ED to have a record of the consultation. Results will not be provided over the phone.

For *Gove* District Hospital staff the treating MO in the Emergency Department must liaise with IFD and pathology to ensure that serology is processed within an acceptable timeframe. The ED MO is to advise the patient to represent to ED within a suitable timeframe to receive results of serology testing.

Source Person Assessment:

- Assess clinical risk for BBV according to demographic and epidemiological factors. The following groups are considered higher risk:
    - Men who have sex with men (HIV, HBV)
    - People born in high prevalence countries or who have had sex with someone born in a high prevalence country (HIV, HBV, HCV)
    - People who inject drugs (HBV, HCV)
    - Indigenous Australians (HBV)
    - Indigenous Australians, especially those from communities west and south of Alice Springs (HTLV-1)
- Ask about current sexually transmitted infection (STI), hepatitis B, hepatitis C and Syphilis status
    - When a source is known to have infection with any blood-borne pathogens an urgent attempt should be made to establish current and prior treatment history, along with the most recent viral load result, and discuss with IFD on-call.

- If the source person is known to be HIV positive then obtain information regarding:
  - Date of last plasma viral load test and results
  - Anti-retroviral treatment history
  - Whether there have been concerns about resistant HIV
- If a source person has had a significant exposure *themselves* occurring within the 3 month window period for serological testing then further advice should be sought from IFD on-call.

Source Person Testing:

- If consent from the source has been obtained (as discussed above) then blood should be collected in two gold top tubes for:
  - HIV Ab; HBsAg; HBsAb; HCV Ab (if positive then RNA PCR); HTLV I Ab (Biohazard and percutaneous exposures); Syphilis serology
  - Request HCV PCR be performed in the event HCV serology positive. LFT's may also be requested if not recently attended.
- The pathology request should be marked urgent and blood samples delivered to the laboratory as soon as possible.

D. Medical Management of the Exposed Person

(*Refer to Site Specific Reporting and Procedure guidelines for detailed local procedures*). The exposed person is defined as the person exposed to blood or body fluids.

General Information for All Significant Exposures

For all possible, definite and massive exposures where the source is either known to be infected or reports risk factors for blood-borne pathogens, the exposed person should be advised to:

- Not donate plasma, blood, body tissue, breast milk or sperm
- Protect sexual partners by adopting safe sexual practices (e.g. use of condoms)
- Seek expert medical advice regarding pregnancy and/or breastfeeding
- Be aware of their responsibilities under the Australian National Guidelines for the Management of Health Care workers known to be infected with blood-borne viruses
- Continue these precautions until follow-up serology is available at 12 weeks post-exposure, at which time they can be ceased if a BBV was not acquired

Specific Information for Individual Pathogens

1. Hepatitis B Virus (HBV)

Risk of Transmission

Risk of HBV transmission from a percutaneous blood exposure from a needle is 30% if the source is HBeAg and HBsAg positive and 1-6% if the source is only HBsAg positive.

- Immune competent people who have previously mounted an effective immune response to Hepatitis B immunisation (documented HBsAb greater than10 mIU/mL on any occasion) maintain long-term immunity regardless of their current HBsAb level. Immune compromised and dialysis dependent patients potentially exposed to BBV should be discussed with IFD on-call.

Post Exposure Prophylaxis (PEP)

For *non-immune* people:

- HBV vaccination provides significant protection if given within 7 days post exposure. The first dose of Hepatitis B vaccine should be given as soon as practical following exposure and a further 2 doses should be given at 1 month and 6 months after the first dose, generally by referral to a primary care provider.
- Hepatitis B Immunoglobulin provides a small additional benefit if given within 72 hours post exposure; ideally it should be given as soon as practical after exposure.

Immediate Management

Table 1, on the next page, outlines the actions which should be performed at the point of initial assessment following a possible HBV exposure:

Table 1. Immediate Management of Exposed Persons in Relation to Hepatitis B Virus Risk:

	Exposed person known to be immune (documented HBsAb greater than 10mIU/mL at any point)	Exposed person unvaccinated	Exposed person vaccinated, but immune response unknown	Exposed person vaccinated, but known vaccine non-responder‡
Source already known to be HBsAg positive **OR** Source is from a high risk group† AND serology testing results likely to be delayed greater than 24 hours **OR** Source is unknown (for percutaneous or discrete high risk sexual exposure)	No treatment required	Give first dose Hepatitis B vaccination (give to all people regardless of source risk) **AND** Give Hepatitis B Immunoglobulin (HBIG) 400 IU intramuscular injection for adults	Give Hepatitis B vaccination if serology result is likely to be delayed greater than 24 hours. Otherwise await exposed person's HBsAb level then manage accordingly.	Give Hepatitis B Immunoglobulin (HBIG) 400 IU intramuscular injection for adults **AND** Re-vaccination should be attempted if the exposed person has previously failed only one immunisation course. Hepatitis B vaccination should be given immediately.

†Regarding HBV risk, high-risk groups are considered to be men who have sex with men (MSM), IVDU, people from high-prevalence countries and Indigenous persons. ‡ A non-responder is someone without HBV infection who has a documented history of a primary course of Hepatitis B immunisation, but with a recorded HBsAB level less than10 mIU/mL

Further management following baseline source serology results:

If Source is HBsAg positive:

If the exposed person is not known to have responded to vaccination (never had HBsAb above 10 mIU/mL) they should receive HBIG (if not already given) and commence/complete a full vaccination course unless they have failed 2 vaccination courses in which case they should receive a second dose of HBIG at 1 month following exposure.

If the exposed person is known to have previously responded to vaccination (HBsAb greater than10 mIU/mL) no further action is required.

If Source is HBsAg negative:

Complete Hepatitis B immunisation course if exposed person is non-immune.

If Source is unknown:

If exposed person is not immune (HBsAb less than 10 mIU/ml) complete Hepatitis B immunisation course.

If source was from a high-risk group[†] also give exposed person HBIG within 72 hours (if not already done).

2. HIV

Risk of Transmission

- The estimated total risk of HIV transmission is calculated by risk of transmission per exposure times risk of the source being HIV positive.
- The estimated seroprevalence of different groups and the estimated risk of transmission according to each type of exposure is shown in Table 2.
- Factors that affect the risk of transmission include viral load of the source, type of exposure and other factors such as co-existent STIs or breaches in the skin and mucosa.

Post Exposure Prophylaxis (PEP)

- HIV PEP using a 4-week regimen of anti-retroviral agents reduces the risk of HIV transmission by an estimated 90% if given within 72 hours of exposure, preferably within 24 hours, the earlier the better. HIV PEP should generally not be started later than 72 hours following an exposure.
- The following recommendations can be made based on transmission risk:
  - High Risk (greater than 1/1000): recommend 3 drug PEP regimen
  - Intermediate Risk (less than 1/1000 but greater than 1/10,000): consider 2 drug PEP regimen
  - Low Risk (less than 1/10,000): do not routinely recommend PEP
- Table 1 outlines the recommendations for specific exposures; however where there are individual factors altering either the severity of exposure or estimated risk of the source being HIV positive advice should be sought from IFD on-call prior to initiating or refusing PEP.

Immediate Management

- **Following IFD consultation PEP should be commenced at the point of initial assessment for high risk exposures according to the recommendations in** Table 2 **without waiting for source HIV test results.**
- In cases where the source person has had a significant exposure *themselves* occurring within the 3 month window period for serological testing, discuss with the IFD registrar/consultant regarding need for PEP despite serological testing.
- In all other cases serological testing of the source should occur first if possible and the decision to give PEP determined on the basis of these results. Testing should occur within 24 hours for any significant exposure wherever practical.
- Baseline blood tests required prior to commencing HIV PEP are outlined in Table 3.
  - **Due to the risk of inducing resistance, all exposed persons commencing HIV PEP require baseline HIV serology, regardless of whether they have been previously tested.**
- Prior to commencing HIV PEP informed consent should be obtained. The following points need to be covered when discussing PEP:
  - The exposed person's risk of pre-existing infection.

- HIV PEP is unproven in randomised trials but data from animal studies and human retrospective studies estimate it to be approximately 80-90% effective, therefore precautions should be taken to avoid transmission to others even if PEP is taken.
- 10-20% of people do not complete the 4 week course due to side effects, although this is more likely with lower-risk exposures and the higher-risk pack.
- Completion of the entire 4 week course is required for effectiveness.
- Mild side effects such as nausea, headache, diarrhoea and fatigue are common but self-limiting. More serious side effects are rare but may include hepatotoxicity and reversible renal impairment.

- The recommended **intermediate-risk** starter pack contains 3 days of fixed dose combination tenofovir disoproxil fumarate 300mg and emtricitabine 200mg one tablet daily PO.
- The recommended **high-risk** starter pack contains 3 days of tenofovir disoproxil fumarate 300mg and emtricitabine 200mg plus dolutegravir 50mg daily PO.
- As both starter packs now contain all necessary medications, only one or the other should be given to the patient. If follow-up is unlikely to occur within 3 days then provide two of the same type of starter packs.
- HIV PEP is available in all emergency departments, hospital pharmacies, Clinic 34s and larger Remote Health Clinics.

Further Management

- If the source person returns a positive HIV result the exposed person must be urgently referred to IFD or a Clinic 34 doctor for consideration of PEP initiation or adjustment.
- For any exposed person commencing on HIV PEP, ongoing management and access to the remainder of the 4 week regimen must be arranged via the on-call IFD consultant/registrar for occupational exposures and Clinic 34 for sexual and other non-occupational exposures.
- Exposed non-staff members not requiring any further management other than the 3 month follow-up blood tests should be advised to attend a general practitioner.
- For all significant exposures where the source person is found to be HIV infected or is believed to be at high risk and possibly in the window period, the exposed person should undergo HIV serology at 6 weeks and 3 months post exposure.

3. Hepatitis C Virus (HCV)

Risk of Transmission

- The risk of transmission following parenteral exposure to blood is approximately 3% (range 1-10%)
- Sexual transmission is very uncommon.
- The risk of transmission correlates with the source HCV RNA level.

Post Exposure Prophylaxis

- No PEP is available for HCV.
- New treatments are now available for HCV that are greater than 95% successful at curing infection and can be offered to those infected with HCV.

Immediate Management

- For all significant **parenteral** exposures where the source person is known to have HCV or is at higher risk of HCV (IVDU, from a HCV high prevalence country) ensure the exposed person is aware of benefit of treatment and the need for attending follow-up.

Further Management

- For all significant **parenteral** exposures where the source person is found to be anti-HCV positive HCV PCR should be performed immediately, preferably on stored blood taken at the time of initial management.
- If source person has a positive HCV viral load the exposed person should undergo PCR at 4-6 weeks and 3 months, and serological testing at 3 and 6 months post exposure.

4. HTLV-1

Risk of Transmission

- HTLV-1 is transmissible through blood exposures. While transmission through blood transfusions has been documented there are no reports of transmission through the small amount of blood involved in most occupational and non-occupational blood exposures. This may be due to the fact that HTLV-1 is cell-associated and there are relatively few cells infected in most patients.
- Adult HTLV-1 prevalence exceeds 40% in some Central Australian Indigenous communities and rates are also high in some patient groups in the Katherine region and the north-west of WA. The virus is rare in Arnhem Land and prevalence has not been studied elsewhere in Australia. Because of patient mobility and occasional sporadic HTLV-1 infection outside normal risk populations, exposure to HTLV-1 should be considered and tested for in all NT occupational exposure injuries.
- The infection of host cells during acute HTLV-1 infection is through an infectious life-cycle that requires reverse transcription, thereafter clonal proliferation predominates and currently available antiretroviral agents are ineffective.

Post Exposure Prophylaxis

- There is no clinical data demonstrating effective PEP for HTLV-1.
- In-vitro testing and the virology of HTLV-1 suggests some anti-retroviral medication used for HIV may be effective.
- It is likely drugs would be more effective when given early similar to the situation with other viruses.
- HTLV-1 PEP should generally not be started more than 72 hours following an exposure.

Immediate Management

- Following a **significant parenteral exposure** to a source known to be HTLV-1 positive, PEP using 28 days of once daily tenofovir 300mg/emtricitabine 200mg plus dolutegravir 50mg daily PO should be offered to the exposed person. Due to unproven efficacy and the unknown but likely very low risk of transmission, any use of PEP should be accompanied by a detailed explanation.

Further Management

- If the source person returns a positive HTLV-1 result the exposed person must be urgently referred to IFD or a Clinic 34 doctor for consideration of PEP initiation as soon as possible, within 72 hours.
- For any exposed person commencing on HTLV-1 PEP ongoing management and access to the remainder of the 4 week regimen must be arranged via the on-call IFD consultant.

5. Syphilis

Risk of Transmission

- Syphilis is potentially transmissible via parenteral blood exposure.
- Transmission is more likely during untreated early primary syphilis, secondary syphilis and early latent syphilis (ie if the source is within the first 2 years of contracting syphilis and remains untreated).
- Most asymptomatic people with positive syphilis serology have either treated or latent syphilis and thus are extremely unlikely to transmit syphilis via blood exposure.
- Acute infectious syphilis, once a rare condition, is quite common now in the NT and thus routine testing for occupational exposures is recommended.

Post Exposure Prophylaxis

- Benzathine benzylpenicillin 2.4 million units IM given as a single dose at any time in the first 2 years following exposure will reliably cure syphilis infection. If given extremely early it might prevent the development of antibodies. Benzathine benzylpenicillin is long acting; do not confuse with benzylpenicillin, which is short acting.
  - In the event of clinically significant penicillin allergy, use doxycycline 100mg twice daily for 2 weeks.
  - Azithromycin should not be used due to widespread resistance.

Immediate Management

- Following a **significant exposure** to untreated early primary syphilis, secondary syphilis or early latent syphilis (likely acquisition within 2 years) give 2.4 million units IM benzathine benzylpenicillin stat (or alternative – see above).

Further Management

- If the source person returns a positive syphilis serological result, it must be ascertained whether the person has early, late or treated infection. This can be done by contacting the NT syphilis registry through the CDC or discussion with either IFD or Clinic 34.
- If the source has evidence of acquisition within the preceding 2 years and has not received appropriate treatment (or treatment has occurred within the past 5 days), then post exposure prophylaxis with benzathine penicillin should be offered to the exposed person.

- If source has evidence of late latent or adequately treated syphilis the exposed person should be followed up with repeat syphilis serology at 3 months. If source has been previously treated, RPR is expected to have fallen 4-fold, by 6-12 months of treatment. If this has not occurred, or if there is a recent increase in RPR, discuss with IFD. Treatment of the exposed person is relatively risk-free and should be considered on a case-by-case basis.

E. Test Results And Follow-Up Of Incidents

See Healthcare Worker Occupational Exposure Incident Management NT Health Guideline for details regarding follow up of occupational exposures.

Follow up of sexual exposures should occur at Clinic 34

Recipient/Exposed Person

- In the event of the exposed person having an initial positive test the following referrals should be made:
  - HIV positive: referral to Clinic 34
  - Hepatitis B or C: referral to viral hepatitis clinic
  - HTLV 1: Referral to IFD clinic

Table 2: HIV PEP Recommendations According to Source and Exposure Type

	HIV Prevalence Estimate	Receptive Anal Sex	Insertive Anal Sex (Circumcised)	Insertive Anal Sex (Uncircumcised)	Shared Injecting Equipment	Receptive Vaginal Sex	Insertive Vaginal Sex	Needle Stick Injury or other sharps exposure	Mucous membrane/non-intact skin Blood	Receptive or insertive Oral intercourse	Discarded Needlestick Injury
Risk Per Exposure		1/70 (ejaculation)-1/155 (withdrawal)	1/900	1/160	1/125	1/1250	1/2500	1/440	less than 1/1000	Not measureable	Not Measurable
Known HIV Positive Undetectable Viral Load > 6 months	100%	None*	None*	None*	None*	None*	None*	Consider 2 drugs if occupational exposure	Consider 2 drugs if occupational exposure	None	None
Known HIV Positive Detectable or Unknown Viral Load	100%	3-Drug	3-Drug	3-Drug	3-Drug	3-Drug	3-Drug	3-Drug	3-Drug	None^	None
Men Who Have Sex With Men, Sydney, Brisbane And Melbourne	8.5-11.2%	2-Drug	2-Drug	2-Drug	2-Drug	Consider 2-Drug	NA	2-Drug	None	None	None
Men Who Have Sex With Men Other Areas, Including Darwin	4-8.3%	2-Drug	Consider 2 drugs, particularly if STI, trauma or blood	2-Drug	2-Drug	Consider 2 drugs	NA	2-Drug	None	None	None

	HIV Prevalence Estimate	Receptive Anal Sex	Insertive Anal Sex (Circumcised)	Insertive Anal Sex (Uncircumcised)	Shared Injecting Equipment	Receptive Vaginal Sex	Insertive Vaginal Sex	Needle Stick Injury or other sharps exposure	Mucous membrane/non-intact skin Blood	Receptive or insertive Oral intercourse	Discarded Needlestick Injury
People Who Inject Drugs (IDU), Australia	0.5%	2-Drug	None	None	None	None	None	None	None	None	None
Female Commercial Sex Workers[1], Australia (CSW)	<0.1%	NA	None	None	None	NA	None	None	None	None	None
Men Who Have Sex With Men In South East Asia	2-26%%	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	NA	2-Drug	2-Drug	None	None
People Who Inject Drugs In South East Asia	2-29%	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	None	None
Female Commercial Sex Workers1 In South East Asia	less than 1-15-20%	NA	2-Drug	2-Drug	2-Drug	NA	2-Drug	2-Drug	2-Drug	None	None
Cambodia (Heterosexual)[2]	0.8%	2-Drug	None	None	2-Drug	None	None	None	None	None	None
Indonesia (Heterosexual	0.4%	None	None	None	2-Drug	None	None	None	None	None	None
Papua New Guinea (Heterosexual)	0.5%	None	None	None	2-Drug	None	None	None	None	None	None

	HIV Prevalence Estimate	Receptive Anal Sex	Insertive Anal Sex (Circumcised)	Insertive Anal Sex (Uncircumcised)	Shared Injecting Equipment	Receptive Vaginal Sex	Insertive Vaginal Sex	Needle Stick Injury or other sharps exposure	Mucous membrane/non-intact skin Blood	Receptive or insertive Oral intercourse	Discarded Needlestick Injury
Philippines (Heterosexual)	less than 0.1%	None	None	None	2-Drug	None	None	None	None	None	None
Thailand (Heterosexual)	1.1%	2-Drug	None	None	2-Drug	None	None	None	None	None	None
Vietnam (Heterosexual)	0.4%	None	None	None	2-Drug	None	None	None	None	None	None
Sub-Saharan Africa3 (Heterosexual)	0.5-26%	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	2-Drug	None	None

1. Commercial sex workers should be broadly defined to include massage and other entertainment workers such as bar attendants
2. Selected overseas estimates, see http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/ for other countries
3. Sub-Saharan Africa contained both higher and lower prevalence countries, contact IFD if uncertain, assume high prevalence if unknown

* Provided the source history is reliable, they are compliant with medication, attend regular follow-up and have no inter-current STIs

^ PEP may be recommended for receptive oral intercourse with ejaculation if the exposed person has a breach in their oral mucous membrane.

Note: 2 drug = standard risk pack; 3-d

Table 3: HIV PEP Baseline Testing and Follow-up Recommendations

Time	Actions	Person responsible
Baseline	HIV, Hep B and C*, syphilis serology, FBC, UEC, LFT If Hepatitis B immune then no further testing required. If not immune then needs vaccination +/- HBIG and follow-up (up to 6 months) Pregnancy test (for women) if sexual exposures and PEP prescribed STI if sexual exposures.	HCW, in consultation with IFD/SH
Within 3 days	Reassess level of risk, correct regimen (if any) and consent for HIV PEP Review source (if available) and exposed person's baseline results	Clinic 34 if sexual exposure All other - IFD, either directly or via advice to another HCW
2 weeks	Review compliance, adverse effects and repeat STI screen if sexual exposure Check CK and urinary myoglobin in patient who report myalgias or weakness on raltegravir in consultation with IFD/SH	Clinic 34 if sexual exposure All other - IFD, either directly or via advice to another HCW
4-6 weeks	Perform HIV testing and syphilis serology for sexual exposures LFT, EUC if clinically indicated Check CK and urinary myoglobin in patient who report myalgias or weakness on raltegravir, in consultation with IFD/SH Pregnancy test if sexual exposure	Clinic 34 if sexual exposure All other - IFD, either directly or via advice to another HCW
3 months	Perform HIV, syphilis, Hep B and C serology*. (Hep B not required if recipient immune at baseline) and STI screen/ Syphilis serology for sexual exposures	Clinic 34 if sexual exposure All other - IFD, either directly or via advice to another HCW
*HCV can be omitted for sexual exposures if no prior risks are identified.		

Abbreviations

BBV	Blood Borne Virus
CDC	Centre for Disease Control
CSW	Commercial Sex Worker
HBV	Hepatitis B Virus
HBsAb	Hepatitis B Surface Antibody
HBsAg	Hepatitis B Surface Antigen
HBeAg	Hepatitis B e Antigen
HBIG	Hepatitis B Immunoglobulin
HCW	Healthcare Worker
HCV	Hepatitis C Virus
HCAb	Hepatitis C Antibody
HIV	Human Immunodeficiency Virus
HPC	High Prevalence Country
HMO	House Medical Officer
HRN	Hospital Reference Number
HTLV	Human T-Cell Lymphotropic Virus
IFD	Infectious Diseases
IDU/ IVDU	Intravenous Drug User
MSM	Men Who Have Sex With Men
SH	Sexual Health
STI	Sexually Transmitted Disease

Quality Assurance		
	Method	**Responsibility**
Implementation	Document will be available for all staff via the PGC. A broadcast email of new and reviewed policy documents will be sent to all staff by the Clinical Excellence and Patient Safety Unit each month Safety & Quality Managers will be made aware of this policy and are responsible for dissemination in their areas.	PGC Administrators Clinical Excellence and Patient Safety Unit Safety & Quality Mangers
Review	Review in four years, or earlier if practice changes	Infection Prevention and Control Advisor
Evaluation	Document will be evaluated at time of review	Director Clinical Excellence & Patient Safety DoH
Compliance	Incidents will be reported via RiskMan and managed by the appropriate Unit Manager, Work Health Safety Units and Safety & Quality teams Audit via IPMU	All staff IPMU

Key Associated Documents	
Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents	National Health and Medical Research Council. (2010). *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010)*. Retrieved from http://www.nhmrc.gov.au/guidelines/publications/cd33 National Health and Medical Research Council. (2014). *Australian Immunisation Handbook* (10 ed.). Retrieved from http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home Healthcare Worker Occupational Exposure Incident Management NT Health Guideline
References	Australian National Council on Aids, Hepatitis C and Related Diseases (ANCAHRD). (2002). *Management of exposure to blood/body fluids in a health care setting*. Retrieved from http://smah.uow.edu.au/content/groups/public/@web/@health/documents/doc/uow025471.pdf Australian Society for HIV Medicine (2016). *National guidelines for post-exposure prophylaxis after non-occupational and occupational exposure to HIV (Revised)*. Retrieved from https://ashm.blob.core.windows.net/ashmpublic/PEP_Literature_Review_2016.PDF Bartlett, J.G., & Weber, J.G. (2012). *Management of healthcare personnel exposed to HIV*. Retrieved from http://www.uptodate.com/contents/management-of-healthcare-personnel-exposed-to-hiv *Remote Health Atlas: Biohazard Exposure Management*. Retrieved from http://system.prompt.org.au/download/document.aspx?id=9418156&code=8F289CF63F69EF3D1E885FCA173EB443 Weber, D.J., Rutala, W.A., & Eron, Joseph. (2012). *Management of healthcare workers exposed to hepatitis B virus or hepatitis C virus*. Retrieved from http://www.uptodate.com/contents/management-of-healthcare-workers-exposed-to-hepatitis-b-virus-or-hepatitis-c-virus

Definitions, Acronyms and Alternative Search Terms	
Term	Description
Source person	The person from which the blood or body fluids originated in the event of an exposure
Exposed person	The person exposed to blood or bodily fluids. Also referred to as the "injured person" or "the recipient".
Significant exposure	Any exposure of non-intact skin or mucosa to bodily fluids likely to carry pathogens (see section B)
PEP	Post exposure prophylaxis
HB	Hepatitis B virus
Alternative Search items	Biohazard, occupational exposure, needlestick, sharps, Hepatitis, HIV, PEP

National Safety and Quality Health Service Standards							
Clinical Governance	Partnering with Consumers	Preventing and Controlling Healthcare Associated Infection	Medication Safety	Comprehensive Care	Communicating for Safety	Blood Management	Recognising & Responding to Acute Deterioration
☐	☐	☒	☐	☐	☒	☐	☐