



## OPERATIONAL DIRECTIVE

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**Subject:**      **Management of Occupational Exposure to Blood and Body Fluids in the Health Care Setting**

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### INTRODUCTION

The purpose of this document is to provide Health Care Workers (HCW) with guidelines for the management of an exposure to another person's blood or body fluids in healthcare settings.

Human immunodeficiency virus (HIV), hepatitis B (HBV) and hepatitis C (HCV) may be transmitted by significant exposure to blood or other body fluids.

Occupational exposure is defined as an incident that occurs during the course of a person's employment and involves contact with blood or other body substances. Such exposures may put the person at risk of acquiring a blood borne virus.

Adherence to standard infection control practices remains the first line of protection for health care workers against occupational exposure to HIV, HBV or HCV. Knowledge regarding treatment of exposures to HIV, HBV and HCV is evolving rapidly, so the advice of an appropriate medical specialist should always be sought following any exposure with a known positive or high risk source.

The risk of transmission of blood borne viruses (BBV) following an occupational exposure is dependent on the type of injury sustained, the extent of the exposure and the current viral status of the source of the exposure. A thorough risk assessment of each exposure is required to determine the risk of disease transmission.

Health care facilities (HCF) shall encourage the reporting of all exposures in a non-punitive manner and analyse the cause of exposures to address areas where improvements can be made, either by a change in work practice or introduction of safety designed devices to prevent occupational exposures occurring.

Health care facilities shall have a nominated person, who is appropriately trained to coordinate the management of all occupational exposures, and ensure procedures are in place to manage exposures occurring 24 hours a day.

**Any exposure of a HCW from a Source positive for a BBV (or likely to be positive) shall be referred immediately to an Infectious Disease Physician or Clinical Immunologist for counselling, management and ongoing follow up (See Appendix 2).**

Confidentiality of both the Recipient and Source details shall be maintained at all times.

## 1. MANDATORY BBV TESTING

Currently, there is no mandatory requirement in Western Australia to test a HCW for BBV status prior to employment. However, the HCW who undertakes exposure-prone procedures should be advised that it is their ethical responsibility to know their own BBV status, to follow recommended procedures to prevent BBV transmission, and to report BBV exposure incidents.

## 2. RISK TO HEALTH CARE WORKERS

Generally, a HCW who sustains an occupational exposure to blood or body fluids has a low risk of contracting a BBV. The highest risk of BBV acquisition results from exposure to a HBV positive source (10-40%). However, with near universal uptake of hepatitis B vaccination amongst HCWs, there has been a sharp decline in occupationally acquired HBV.

The risk of occupationally acquired hepatitis C is relatively low in comparison to HBV. The average incidence of seroconversion after accidental percutaneous exposure is estimated at 1.8% (Range: 1-10%). Transmission rarely occurs from mucous membrane exposures.

The risk of acquiring HIV infection is extremely low and is estimated at 0.3% following percutaneous exposure and 0.09% after mucous membrane exposure from a positive source. The highest risk of transmission for any BBV is associated with:

- Deep injury with a device visibly contaminated with blood.
- Injuries associated with contaminated hollow bore needles.
- Source patient with late stage HIV infection or high viral load.
- Source patient with HBV who is HBeAg positive/HBV DNA detectable/high viral load.
- Source patient with HCV who is HCV RNA PCR detectable.

## 3. HEALTH CARE FACILITIES

Each HCF shall have resources and protocols in place to ensure the HCW who has been exposed to blood or body fluids is treated appropriately. Health Care Facilities are responsible for:

- 3.1 Nominating an appropriately trained and qualified Health Care Provider (HCP) to coordinate the management of exposure incidents.
- 3.2 Having written protocols available for the management of an exposure, which includes information about:
  - the HCP that the HCW should inform immediately following an exposure;
  - the after-hours management of exposures;
  - the BBV tests that should be performed and the name and telephone number of the laboratory that will perform these tests;
  - accessing hepatitis B vaccine and HBIG;
  - the testing of the Source and Recipient for BBV;
  - the name and contact details of suitably qualified Physicians for the management of the HCW, who has an exposure from a source that is positive or likely to be positive for a BBV; and

- the name and contact details of physicians specialising in HIV Medicine, who will authorise the release of PEP for HIV exposures, and of the pharmacy that stocks the PEP drugs.
- 3.3 Supporting the HCW with appropriate information, counselling, testing and work allocation.
  - 3.4 Maintaining confidentiality for the HCW and for the Source.
  - 3.5 Encouraging the reporting of all exposure incidents within a few hours of exposure.
  - 3.6 Ensuring that any exposure incident reported by a HCW is fully documented and filed permanently with any relevant information relating to the incident.
  - 3.7 Documenting interventions designed to prevent the recurrence of that type of exposure (e.g. training, changes to work practices, new equipment).
  - 3.8 Monitoring all exposures and implementing interventions that may prevent further exposures.

#### 4. HEALTH CARE PROVIDERS

All occupational exposures to blood or body fluids shall be reported to the nominated HCP for the HCF. **The nominated HCP shall:**

- 4.1 Ensure that appropriate counselling is provided to the HCW following a reported exposure and prior to, and following, any testing for BBV.
- 4.2 Conduct an evaluation and risk assessment (Refer Appendix 1) of the exposure that includes defining:
  - the nature and extent of the injury/exposure;
  - the nature of the object causing the exposure;
  - the volume of blood or body fluid that the HCW was exposed to;
  - the vaccination and immune status of the HCW;
  - the BBV status of the Source; and
  - the likelihood of an unidentified source being HBV, HCV or HIV positive.
- 4.3 Obtain informed consent from the HCW to perform baseline serology to determine current HBV, HCV and HIV status.
- 4.4 Assess the HCW for HBV vaccination status and, if not immunised, commence the HCW on a vaccination schedule. The need to provide Post-Exposure Prophylaxis HBIG (PEP) in the non-immune HCW shall be assessed.
- 4.5 Assess the HCW for any potential risk for other diseases (e.g. tetanus) and offer PEP as appropriate.
- 4.6 Make every effort to identify the Source of the exposure.
- 4.7 Obtain informed consent from the Source to perform serology testing for HBV, HCV and HIV status. In some instances, the Source may have provided the HCF with written consent at time of admission for BBV testing in the event of an exposure to a

HCW. If written or verbal consent is unable to be obtained then attempts should be made to obtain consent from the next-of-kin. The Medical Practitioner responsible for the Source must be informed that BBV testing has been undertaken. In the event that consent can not be obtained at the time of the incident, delayed testing of the Source should be considered and the matter discussed with the responsible senior medical officer (Head of Infection Control or Infectious Diseases Physician/Immunologist) in the Health Care Facility.

- 4.8 Ensure HCV-RNA testing is ordered, if the Source is positive for antibody to HCV, and HBeAg and HBV quantitative PCR (or HBV DNA), if the Source is positive for HBsAg. This person will need a separate blood sample specifically for HCV-RNA or HBV quantitative PCR.
- 4.9 Ensure prompt reporting of BBV test results to the HCW and to the Source.
- 4.10 Document results of all exposure-related tests.
- 4.11 Coordinate administration of Post Exposure Prophylaxis, which includes provision of **verbal and written** information about the treatment and any possible adverse drug reactions.

## 5. IMMEDIATE MANAGEMENT OF EXPOSURES

After exposure to blood or body fluids, the HCW shall, as soon as possible:

- 5.1 **Sharps injury:** Wash the skin thoroughly with soap and water and apply a waterproof dressing. Alcohol-based hand rinses, gels or foams, that are 60% . 90% alcohol by weight, should be used if water is not available.
- 5.2 **Splash:** Wash the skin well with soap and water irrespective of whether there are cuts or abrasions. If blood or body fluids splash into the eyes, rinse the eyes gently and thoroughly with running water or with normal saline. If blood or body fluids are sprayed into the mouth, spit out the blood or body fluid and then rinse the mouth thoroughly with running water.
- 5.3 Remove contaminated clothing and shower if necessary.
- 5.4 Baseline BBV testing of the HCW should be performed (HIV antibody, HBsAg and HCV antibody) after counselling is provided and informed consent obtained, even if the Source is known to be negative for BBV or it is a low risk exposure.
- 5.5 Refusal by the HCW for BBV testing shall be documented.

## 6. MANAGEMENT OF SOURCE

- 6.1 **Source negative for BBV:** If the Source is found to be HBV, HCV and HIV negative, further testing of the Source is generally not required unless there is reason to suspect that the Source was high risk for BBV infection. Follow-up can be undertaken through the Source's GP.
- 6.2 **Source likely to be positive for BBV:** In the situation where it is suspected that the Source is in the ~~the~~ window+period for a BBV, the Source should receive appropriate counselling and be asked to consent to follow-up at appropriate intervals (usually 6 weeks and 12 weeks) to ascertain whether or not they develop a BBV. Much earlier

follow-up testing than 6 weeks may be appropriate if, for example, there is suspicion that the source patient has recently been infected with HIV. Testing should include HIV antibody, HBsAg and HCV antibody.

## **7. MANAGEMENT OF THE EXPOSED HEALTH CARE WORKER**

### **7.1 Source Negative for HBV, HCV and HIV**

When the Source is confirmed negative for BBV, the HCW should be offered follow up serology testing at 3 months for reassurance. No further follow up of the Source is required. No behavioural or work practice modifications are required by the HCW.

### **7.2 Source Unknown or Unable to be Tested**

7.2.1 If after every effort has been made to ascertain the HBV, HCV, and HIV status of the Source or if the Source remains unknown, the probable risk of the source being positive for a BBV must be inferred when considering management of the exposed HCW. The probable risk of the Source being positive and the risk to the HCW must be assessed from epidemiological and historical information and the HCW treated as appropriate. This is dependent on the type of exposure, the probability that the Vehicle (e.g. sharp) was contaminated with blood/body fluid and the prevalence of HBV, HCV and HIV in the community from which the Source came.

7.2.2 If it is considered there is a high risk of the Source being infected with a BBV, then the HCW shall be managed in accordance with the sections relating to a Source positive for BBV.

7.2.3 Testing of needles or other sharp objects implicated in an exposure is not recommended. The reliability and interpretation of findings in such circumstances are unknown and poses an additional hazard to the persons handling these items.

### **7.3 Source Positive for HBV (or likely to be positive)**

7.3.1 If the HCW is immune to HBV, no further treatment or special precautions need to be taken.

7.3.2 If the HCW is non-immune, the schedules listed in Table 1 shall be followed.

**TABLE 1:** Recommended post-exposure prophylaxis for exposure to HBV

Vaccination and antibody response status of exposed HCW *	Status of Source	
	HBsAg-Positive	Unknown or not available for Testing
<b>Unvaccinated</b>	<ul style="list-style-type: none"> <li>Give HBIG<sup>†</sup> (1 dose) and initiate hepatitis B vaccination- <b>preferably</b> within 24 hours* of exposure. *Refer to AIH for time-frames.</li> </ul>	<ul style="list-style-type: none"> <li>Initiate hepatitis B vaccination . <b>preferably</b> within 24 hours* of exposure</li> <li>*Refer to AIH for time-frames.</li> </ul>
<b>Previously vaccinated</b> <ul style="list-style-type: none"> <li>Known responder**</li> <li>Known non-responder<sup>‡</sup></li> <li>Response unknown</li> </ul>	<ul style="list-style-type: none"> <li>No treatment</li> </ul>	<ul style="list-style-type: none"> <li>No treatment</li> </ul>
	<ul style="list-style-type: none"> <li>Give HBIG (2 doses<sup>‡</sup>) or else HBIG (1 dose) <b>and</b> initiate re-immunisation . preferably within 24 hours of exposure</li> </ul>	<ul style="list-style-type: none"> <li>If suspected high-risk source, treat as if source were HBsAg-positive.</li> </ul>
	Test exposed person for anti-HBs <ul style="list-style-type: none"> <li>If inadequate, give 1 dose HBIG<sup>†</sup> <b>and</b> vaccine booster dose <sup>#</sup></li> <li>If adequate, no treatment</li> </ul>	Test exposed person for anti-HBs <ul style="list-style-type: none"> <li>If inadequate vaccine booster dose <sup>#</sup></li> <li>If adequate, no treatment</li> </ul>
<p>* Persons who have been previously infected with HBV are immune to reinfection and do not require post exposure prophylaxis.</p> <p><sup>†</sup> Dose of HBIG, 0.06 mL/kg, intramuscularly.</p> <p>** A responder is a person with adequate levels of serum antibody to HBsAg (i.e. anti-HBs is <math>\geq</math> 10 iu/ml) after receiving a full 3 dose primary course of vaccination.</p> <p><sup>‡</sup> Persons known NOT to have responded to a 3-dose vaccine series and to reimmunisation with 3 additional doses should be given 2 doses of HBIG (0.06 mL/kg), one dose as soon as possible after exposure and the second 1 month later. If non-response to primary 3-dose course of vaccination only, give 1 dose of HBIG and re-initiate a further 3-dose course of immunisation. *Refer to AIH.</p> <p><sup>#</sup> The person should be evaluated for antibody response after the vaccine booster dose. For persons who received HBIG, anti-HBs testing should be done when passively acquired antibody from HBIG is no longer detectable (e.g. 4-6 months); if they do not receive HBIG, anti-HBs testing should be done 1-2 months after the vaccine booster dose. If anti-HBs is inadequate (&lt;10mIU/mL) after the vaccine booster dose, 2 additional doses should be administered to complete a 3-dose reimmunisation course.</p>		

\*Refer to the 9<sup>th</sup> Edition of the Australian Immunisation Handbook (AIH) (2007) for more detailed information

#### 7.4 Source Positive for HCV (or likely to be positive)

7.4.1 Currently, there is no known treatment that can alter the likelihood of transmission of HCV.

7.4.2 If the Source is found to be HCV RNA PCR positive, then the HCW should be referred to an Infectious Diseases Physician, Clinical Microbiologist or Hepatologist with expertise in managing HCV infection.

7.4.3 If source HCV RNA positive, HCW baseline and follow-up HCV serology shall include:

- HCV RNA PCR and ALT at 4, 8, and 12 weeks post exposure, and
- HCV antibody at 12 and 26 weeks.

7.4.4 Ongoing counselling and support for the HCW must be continued for the duration of post exposure follow up. Support and counselling must be extended to significant contacts of the HCW.

## 7.5 BEHAVIOURAL COUNSELLING FOR HCW EXPOSED TO HBV OR HCV

7.5.1 Any HCW exposed to a HBV (excluding HBV immune HCW) or HCV positive source should be reviewed and counselled by an Infectious Disease Physician with expertise in viral hepatitis as soon as possible following confirmation of the positive status of the Source.

7.5.2 Generally, the HCW exposed to HCV infected blood does not need to take any special precautions to prevent secondary transmission during the follow up period; however, they should refrain from donating blood, plasma, organs, tissue or semen. The exposed person does not need to modify sexual practices or refrain from becoming pregnant. If an exposed woman is breast feeding, she does not need to discontinue.

7.5.3 No modifications to exposed HCW patient care responsibilities are required to prevent transmission to patients based solely on exposure to HBV or HCV positive blood.

7.5.4 In the event a known non-immune or non-responder to hepatitis B vaccine is exposed to HBV positive blood, then an individual risk-assessment should be conducted and any recommendations for precautions and patient care responsibilities given. The risk-assessment should take into consideration the receipt of timely HBIG by the exposed non-responder HCW and HBV immune status of breastfed infants or sexual partner and exposure prone work practices. The HCW should refrain from donating blood, plasma, organs, tissue or semen.

7.5.5 If an exposed HCW becomes acutely infected with HBV or HCV, then measures outlined in the DoH Operational Directive . Policy for HCWs with Blood-borne Virus Infections+must be followed.

## 7.6 SOURCE POSITIVE FOR HIV (OR LIKELY TO BE POSITIVE)

7.6.1 If the Source is found to be HIV positive, then the HCW shall be **referred immediately** to a medical specialist with expertise in managing HIV infection for consideration of initiation of prophylactic treatment (Refer Appendix 2 for 24 hour on call availability).

7.6.2 The decision to commence HIV PEP is based on the type of exposure and on the characteristics of the Source. HIV PEP may be recommended, considered but not actively recommended, or recommended against (Refer Appendix 3).

- 7.6.3 The interval within which PEP should be initiated for optimal efficacy is not known. However, where HIV PEP is indicated, it should be commenced as soon as possible following exposure after appropriate counselling (within 24 hours post exposure wherever possible).
- 7.6.4 Prior to commencement of HIV PEP, counselling and consent for treatment shall include the following information:
- The risk of HIV infection following exposure.
  - The natural history of HIV infection, including the symptoms, signs and serology.
  - The benefits of HIV PEP given within 72 hours after exposure has been shown to reduce the risk of HIV transmission by about 79% and is recommended for high risk exposures.
  - Side effects of HIV PEP (e.g. Nausea, headaches, fatigue and gastro-intestinal upset) may occur in up to one-third of individuals. There is no evidence of long-term toxicity from short courses of antiretroviral drugs in humans, but this cannot be discounted. The HCW should be monitored closely for adherence to the regimen and for adverse drug reactions.
  - The use of HIV PEP in known or suspected pregnancy; pregnancy does not preclude the use of optimal HIV PEP regimes.
  - **Compliance with HIV PEP:** Physicians should stress to the HCW the importance of strict compliance with the PEP regime.
- 7.6.5 The HCW shall be evaluated within hours after their exposure and the evaluation must include information about medications the HCW might be taking and any current or underlying medical conditions or circumstances (i.e. pregnancy, breast feeding, or renal or hepatic disease) that might influence PEP drug selection.
- 7.6.6 Limited data indicates that combination therapy may prevent HIV replication following a significant occupational exposure. The optimal duration of PEP is unknown, however duration of four weeks is supported in the literature.
- 7.6.7 The HCW shall have baseline testing for HIV antibodies at the time of exposure and at six weeks, three months and six months after exposure.
- 7.6.8 Ongoing counselling and support for the HCW must be continued for the duration of PEP or, if the HCW chooses not to have PEP, for the duration of post-exposure follow-up. Support and counselling must be extended to family and other intimate contacts of the HCW.
- 7.6.9 The patient care responsibilities of an exposed person do not need to be modified, based solely on an HIV exposure, to prevent transmission to patients.

7.6.10 The exposed HCW shall be advised to seek medical attention for any acute illness that occurs during the follow up period. Such an illness, particularly if characterised by fever, rash, myalgia or lymphadenopathy, may be indicative of acute HIV infection but also might be indicative of a drug reaction or another medical condition.

7.6.11 During the period of surveillance for HIV seroconversion (i.e. up to 6 months), the HCW should be advised to:

- Refrain from donating body tissue, breast milk or semen unless approved by the attending physician. Refrain from donating plasma or blood (for a period of 12 months as per Australian Red Cross Blood Service).
- Provide risk-based counselling and recommend sexual abstinence or protection of sexual partners from contact with blood, semen or vaginal fluids by using condoms for a period of 3 months.
- Avoid pregnancy until the surveillance period is completed and the HIV status is known.
- Discontinue breast feeding.
- Not share drug injecting equipment, razors, toothbrushes, or other possible sources of BBV transmission.
- Cover open cuts and wounds with a waterproof dressing.

## **8 AVAILABILITY OF ANTIRETROVIRAL STARTER PACKS**

8.1 Area Health Services and private hospitals are responsible for ensuring that the recommended HIV PEP starter pack containing Truvada® (300mg tenofovir and 200mg emtricitabine) are available to enable administration of the drugs within 72 hours of an exposure. Starter packs should contain sufficient drugs for 7 days treatment.

8.2 It is the responsibility of public and private hospital pharmacies to obtain their own supplies of Truvada® from the manufacturers. Repacking into smaller starter packs must be done by a pharmacist. For further information about Truvada® supply, contact the drug manufacturer. It will be the responsibility of hospital pharmacies to have a process in place to ensure that in-date stock is available and accessible, according to the needs of their Area Health Service and in compliance with the Operational Directive.

Dr Neale Fong  
**DIRECTOR GENERAL**

**RISK CLASSIFICATION**

Risk assessment of occupational exposure to blood or body fluids is conducted on the basis of the type of exposure and the amount of infectious material involved.

<b>Non Exposure:</b>	Intact skin visibly contaminated with blood or any body substance.
<b>Doubtful Exposure:</b>	<ul style="list-style-type: none"> <li>(i) Intradermal (superficial) injury with a needle considered <u>not</u> to be contaminated with blood or body substance.</li> <li>(ii) Superficial wound not associated with visible bleeding, caused by an instrument considered <u>not</u> to be contaminated with blood or body substance.</li> <li>(iii) Prior wound or skin lesion contaminated with a body substance other than blood, e.g. urine.</li> <li>(iv) Mucous membrane or conjunctival contact with a body fluid other than blood.</li> </ul>
<b>Possible Exposure:</b>	<ul style="list-style-type: none"> <li>(i) Intradermal (superficial) injury with a needle contaminated with blood or body substance.</li> <li>(ii) A wound <u>not</u> associated with visible bleeding, produced by an instrument contaminated with blood or body substance.</li> <li>(iii) Prior wound or skin lesion contaminated with blood or body substance.</li> <li>(v) Mucous membrane or conjunctival contact with blood or body substance.</li> </ul>
<b>Definite Exposure: (Moderate Risk)</b>	<ul style="list-style-type: none"> <li>(i) Skin penetrating injury with a needle contaminated with blood or body substance.</li> <li>(ii) Injection of blood/body substance &lt; 1ml.</li> <li>(iii) Laceration or similar wound which caused bleeding, and is produced by an instrument that is visibly contaminated with blood or body substance.</li> <li>(iv) In laboratory settings, any direct inoculation with HIV tissue or material likely to contain HIV, HBV or HCV not included above.</li> </ul>
<b>Massive Exposure: (High Risk)</b>	<ul style="list-style-type: none"> <li>(i) Transfusion of blood.</li> <li>(ii) Injection of large volume of blood/body substance (&gt;1ml).</li> <li>(iii) Parenteral exposure to laboratory specimens containing high titre of virus.</li> </ul>

**HIV Specialist Contact Details**

**Contact advice on using antiretrovirals**

Facility	Telephone Number	Who to Contact
Royal Perth Hospital . Clinical Immunology	(08) 9224 2899 (Monday-Friday)  (08) 9224 2244 (Weekends, low activity days, public holidays and after hours)	Clinical Immunology Registrar (Monday-Friday)  Page Immunology Registrar on call (Weekends, low activity days, public holidays and after hours)
Fremantle Hospital . Infectious Diseases Department	(08) 9431 3333	Infectious Diseases Physician
Sir Charles Gairdner Hospital . Microbiology Department	(08) 9346 3333	Clinical Immunology Registrar (Monday-Friday)  Page Immunology Registrar on call (Weekends, low activity days, public holidays and after hours)

**HIV Specialists are available on call - 24 hours a day via Hospital switchboards**

## Guidelines for PEP FOR HIV

**NB: Referral to an HIV Specialist must be provided in all cases of HIV exposure.**

EXPOSURE	TREATMENT	COMMENCEMENT OF TREATMENT	FURTHER POINTS TO CONSIDER
Percutaneous	Recommended	Within hours ( $\leq 72$ )  Truvada® (300mg tenofovir and 200 mg emtricitabine)  (once daily for 4 weeks)	<b>Starter packs contain sufficient drugs for 7 days treatment.</b>
Ocular, mucous membrane or non-intact skin	Offered but not actively recommended		
Non-blood stained urine, saliva, faeces	Not offered		

## REFERENCES

1. Communicable Diseases Network Australia. Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting. 2004.
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6. Centres for Disease Control and Prevention (CDC). Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis. *MMWR* 2001;50 (No RR-11):1-54.
7. New South Wales Health Department. Management of health care workers potentially exposed to HIV, hepatitis B and hepatitis C. Circular Number:2003/39.
8. Queensland Health . Infection Control Guidelines November 2001. Appendix P: Management of blood and body fluid exposure.
9. Charles PG, Angus PW, Sasadeusz JJ and Grayson ML. Management of healthcare workers after occupational exposure to hepatitis C virus. *MJA* 2003; 179:153-157

## GLOSSARY

<b>ALT</b>	Alanine aminotransferase
<b>Anti-HBs</b>	Antibody to hepatitis B surface antigen
<b>Blood Borne Virus (BBV)</b>	Hepatitis B virus (HBV), Hepatitis C virus (HCV), Human Immunodeficiency virus (HIV).
<b>Exposure</b>	Contact with blood or any body fluids, e.g. blood, semen, vaginal fluid.
<b>Exposure Prone Procedure (EPP)</b>	Any situation where there is potentially a high risk of transmission of BBV from the HCW to a patient.
<b>HBIG</b>	Hepatitis B immunoglobulin
<b>HBsAg</b>	Hepatitis B surface antigen
<b>HBeAg</b>	Hepatitis B e antigen
<b>HBV</b>	Hepatitis B virus
<b>HCV</b>	Hepatitis C virus
<b>HCV RNA PCR</b>	Detects HCV viraemia
<b>Health Care Worker (HCW)</b>	A person whose activities involve contact with patients or with the blood or other body fluids from patients in a health care or laboratory setting e.g. nurses, doctors, scientists, students, volunteers.
<b>Health Care Facility (HCF)</b>	Any facility providing a health care service, private or public including Ambulance Services in Western Australia
<b>Health Care Provider (HCP)</b>	An appropriately trained and qualified HCW responsible for the management of occupational exposures to blood or body fluids
<b>HIV</b>	Human Immunodeficiency Virus
<b>PCR</b>	Polymerase chain reaction
<b>Post Exposure Prophylaxis (PEP)</b>	Administration of drugs or vaccines after exposure to a blood borne virus, e.g. HIV or HBV, in an attempt to prevent seroconversion.
<b>Recipient</b>	The person who is exposed to another person's blood or body fluids.
<b>Source</b>	The person to whom the HCW was exposed.
<b>Sharp</b>	Any object capable of inflicting a penetrating injury.
<b>Window Period</b>	The time from exposure to seroconversion when the source may be asymptomatic, experiencing seroconversion illness, and when routine Ab testing may be negative.