



THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

School of Medicine, Fremantle

GUIDELINES FOR INFECTION CONTROL

Purpose:	To outline infection control practices to prevent or reduce risk of transmission of infectious disease
Contact:	Associate Dean (Clinical)
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OBJECTIVES

It is mandatory that all medical students are aware of infection control guidelines in order to:

- understand the way the chain of infection works (source of infection, mode of transmission, susceptible host);
- identify potential risks for transmission of infection between themselves and their patients;
- decide what measures they should implement to prevent or reduce risk of infection; and
- be aware of what guidelines and procedures to follow if exposed to a BBV while on clinical practice.

When undertaking clinical experience with patients within Western Australia, interstate or overseas, medical students are expected to adhere to the following infection control guidelines and to familiarise themselves with the infection control protocols in each rotation they undertake.

REDUCING THE RISK OF INFECTIOUS DISEASE

STANDARD PRECAUTIONS

When working with patients, it must be assumed that **ALL blood, body secretions and tissue are potentially infectious**. As a first line approach to infection prevention, standard precautions minimise the risk of transmission between student and patient, even in high risk situations.

Infectious agents may include bacteria, viruses and parasites. Standard precautions are as follows:

1. Practice good hand hygiene as most infections are transmitted by hand. Use soap or alcohol based hand rubs (between 60% and 80% v/v ethanol) before and after every episode of patient contact. All Notre Dame medical students are required to complete the [Five Moments of Hand Hygiene](#) modules at the beginning of each academic year.
2. Wear Personal Protective Equipment (PPE) such as surgical masks, eye protection wear, latex rubber gloves, and full body gowns at all times when working with patients who require contact precautions during procedures which generate sprays of blood or bodily secretions. Students are advised to double glove in situations which carry a risk of BBV exposure as this provides additional protection.
3. Safely use and dispose of sharps (includes scalpels, needles, lancets). Do not recap needles (or bend or cut) but dispose of them directly into puncture proof containers which should not be more than three quarters full. Sharps injuries are predominately caused by needle devices associated with venepuncture, administration of medication via intravascular lines and recapping needles.
4. Spills of blood or other potentially infectious material should be promptly cleaned as follows: wear gloves and other PPE; clean spill area with paper towels and detergent or a chemical disinfectant and dispose of in appropriate waste container.
5. If common use of equipment for multiple patients is unavoidable, sterilize or clean the equipment and leave to dry before re use.

6. Wear respiratory protective equipment e.g. particulate filter mask/ P2 respirator when an airborne-transmissible infectious agent is known or suspected.
7. Remove PPE and perform hand hygiene before leaving the patient care area.

For further information, see APPENDIX 2.

ADDITIONAL PRECAUTIONS – TRANSMISSION BASED

As well as adhering to the standard precautions outlined above for all patients, additional precautions should be used for patients known or suspected to be infected with infective pathogens. Transmission-based precautions are additional work practices for specific situations where standard precautions are not sufficient to interrupt transmission. These precautions are tailored to the particular infectious agent and its mode of transmission:

- (a) Air (*Mycobacterium tuberculosis*, measles, chickenpox)
- (b) Droplet (influenza, pertussis, mumps, rubella)
- (c) Direct/indirect contact with skin (MRSA) or with contaminated surfaces

Transmission based precautions are additional precautions which may include one or any combination of the following:

- continued implementation of standard precautions;
- appropriate use of PPE (including gloves, apron or gowns, surgical masks or P2 respirators, and protective eyewear);
- patient-dedicated equipment;
- allocation of single rooms;
- appropriate air handling requirements; and
- enhanced cleaning and disinfecting of the patient environment.

Source: [The Australian Guidelines for the Prevention and Control of Infection in Healthcare 2010](#)

NEEDLESTICK/SHARPS INJURY GUIDELINES

1. The risk of transmission of blood borne viruses (BBV) following an occupational exposure is low and dependent on the:
 - (a) type of injury sustained;
 - (b) extent of the exposure; and
 - (c) current viral status of the source of the exposure.
2. A thorough risk assessment of each exposure is required to determine the risk of disease transmission. Accidental injection of BBVs, although uncommon, is the major hazard of needlestick injuries.
3. The risk if transmission of HBV after a sharps injury from a HBV positive source has been calculated to be at least 6-30% in non-immune recipients with higher rates if the source is

HBeAg positive. HCV rate of transmission from needlestick has been calculated to be 1.8% with range from 0-7%. (CDNA 2012)

Note: There is obviously no risk of a BBV from a needlestick injury if the source is clear of BBVs.

Procedures for sharps/needlestick and splash injuries at clinical sites

General advice

- Apply first-aid to the injured body part.
- Immediately report the biohazard injury to your Clinical Supervisor or the Nurse Manager in your department. If you wait until the next day to report the injury it could be too late to receive retroviral drugs.
- Prevention and safe practice is better than cure. Practice standard precautions at all times. Do not recap needles – ever! Wear PPE.
- Complete the University's Incident/Injury Report and Needlestick/Sharps Injury or Exposure to Body Fluid Report Forms (available from the student portal, your Hospital Admin staff member and APPENDIX 3). Report the incident and deliver the completed forms to the Placement Coordinator.

Students should be aware of hospital protocols for infection control when on clinical placements.

General Practice placement

- Report any injury / incident to the supervising GP. Although students may have their own GP it is strongly advisable to seek medical attention from one of the practice GPs. GP preceptors have been advised of this potential occurrence.
- The Discipline Leader of General Practice should also be notified at the earliest opportunity.

What constitutes a significant BBV exposure?

The risk of BBV transmission is dependent on a number of factors. Exposures associated with high risk of infection include:

- (a) a needle stick injury that was used to cannulate a blood vessel in the source patient;
- (b) a deep needlestick; and
- (c) visible blood on the surface of the instrument.

Protocol after an occupational exposure to a BBV

Most exposures are not serious. Knowledge regarding treatment of exposures is evolving rapidly, so the advice of an infectious diseases specialist should always be sought following any exposure with a known positive or high risk source.

However, if exposed you must seek immediate qualified advice by a specialist practitioner or infection control nurse. If the source is known or inferred to be infected with HIV, taking immediate action and starting HIV post exposure prophylaxis (PEP) within an hour or two and

within 72 hours can significantly reduce your risk of acquiring the infection. Take note of what, when and how the exposure occurred.

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. If mucous membrane exposure has occurred, flush the area with copious amounts of water or saline.
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.
3. Remove contaminated clothing and shower if necessary.
4. Assess the HIV status of the source if possible. Baseline BBV testing should be performed (HIV antibody, HBsAg and HCV antibody). If the antibody test result is positive, assume it is a true positive. If the source is unknown or unable to be tested, it is inferred that the source is positive.
5. Seek qualified infectious disease consultant /nurse evaluation **IMMEDIATELY** for assistance in assessing risk and advice on managing exposures to HIV and other BBV pathogens.
6. Once management of the exposure is underway, fill in the appropriate Notre Dame form, *Needlestick/Sharps Injury or Exposure to Body Fluid Report Form* (available on student portal) and contact Associate Dean (Clinical) or the Domain Chair of Communication and Clinical Practice for advice.
7. People with occupational exposure to HIV should receive HIV antibody testing by enzyme immunoassay as soon as possible after exposure as a baseline, with follow-up testing at 6 weeks, 3 months and 6 months. In addition to HIV baseline testing, assessment for immunity to HBV and HCV is warranted.
8. Exposed individuals are advised to use precautions (avoid blood donations, breastfeeding or pregnancy) to prevent secondary transmission especially during the first 6-12 weeks after exposure.
9. Ensure you seek medical evaluation on return from an overseas elective even if the source is known to be negative for BBV or it is a low risk exposure
10. Post exposure counselling is available through the University's Student Services, telephone 9433 0580 or contact the School's Head of Student Matters.

Post exposure prophylaxis (HIV PEP)

1. Post Exposure Prophylaxis (PEP) is the use of a four week course of antiretroviral drugs to try and prevent an individual who has been exposed to HIV from becoming infected. Currently HIV PEP consists of a combination of drugs depending on the level of risk associated with the exposure. It is indicated where there has been a high risk exposure-unprotected anal, vaginal, oral intercourse, sharing needles, or an occupational injury with significant percutaneous exposure to blood or body substances, through skin puncture or contact with broken skin or mucosa, when the source is known or inferred to be HIV positive.

2. In the vast majority of cases, exposure to HIV does not result in seroconversion. However, evidence exists to support the use of HIV PEP for high risk occupational exposures. (The HIV Prevention Trials Network (HPTN) 052, 2011).
3. Ensure your physician is advised of any pregnancy, breast feeding and underlying disease which may affect antiretroviral drug choice, as well as information about other medications being taken. HIV PEP is a complex area and you will need advice from a specialist in HIV management
4. Prior to starting PEP you should know the history of HIV infection including symptoms, signs and serology and side effects of HIV PEP which may include nausea, headaches, fatigue and gastroenteritis as well as more severe side effects.

Australian anti-retroviral guidelines

The US Department of Health and Human Services (DHHS) released guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents on 29 March 2012 which the Australasian Society of HIV Medicine (ASHM) has provided a commentary: [ARV Guidelines | HIV Treatment Guidelines - ASHM](#).

Guidelines for Hep B management

Guidelines for management of Hepatitis B are available from

http://www.gesa.org.au/files/editor_upload/File/Professional/Chronic%20Hep%20B%20Summary%20Algorithm.pdf

OVERSEAS ELECTIVES

1. Students undertaking electives in developing countries need to be aware that standards of infection control may be inadequate to prevent the spread of blood borne viral infections and they may be at high risk of exposure. Reuse of medical supplies such as needles and syringes is common. Sterilization of instruments may be inadequate. Blood transfusion services may be basic and much of blood unscreened so that there is risk of infectious disease from blood transfusions.
2. Infected blood can enter the body through a break in the skin or lining of the mouth, vagina, penis and anus. To reduce risk:
 - a. Double glove;
 - b. Wear personal protective equipment at all times including eye wear;
 - c. Abstain from sex in high risk HIV areas or always use double condoms for vaginal or anal sex, dental dams and water based lubricant;
 - d. Don't share earrings, razors, toothbrushes, injecting equipment or get any tattoos;
 - e. Update your hepatitis B vaccine; and
 - f. Cover any cuts or sores.
3. Due to the urgency of starting HIV PEP, students who undertake electives in developing countries with a high HIV risk, must take a starter pack of HIV PEP with them. Currently the pathway to obtaining HIV PEP for Notre Dame School of Medicine students is to organise an individual or group consultation with [Travel Health Fremantle](#). If indicated, a referral will be made for a 7 day starter PEP pack of Truvada which the student must pay for. Students must

also undertake to return to Australia to complete the four week course under the guidance of an infectious diseases physician.

4. PEP medication has a limited shelf life of 12 months. Any unused starter packs can be left at the host hospital to improve their stocks.

BLOOD TRANSFUSIONS

In low income countries with available data, only 53% of blood donations were screened in a quality assured manner in 2008 (<http://www.unaids.org/>). Students need to be aware that blood transfusion safety is of concern in countries where the prevalence of transfusion-transmissible infections such as HIV, Hep B, Hep C and syphilis among blood donors is high, blood shortages are common and the quality and coverage of blood screening is inadequate.

TREATING HIV IN AUSTRALIA

In Australia today, HIV treatments can only be prescribed by hospital-based specialists, sexual health services or community based primary care practitioners, called s100 prescribers. For guidance in these matters, Australia adapts the USA Department of Health and Human Services (DHHS) Guidelines for the Management of HIV in Adults and Adolescents through the publication of a commentary on the DHHS Guidelines. The Antiretroviral Guidelines Panel is currently reviewing the recent DHHS Guidelines. The DHHS Guidelines and Australian commentaries can be found on the [ASHM Website](#).

HIV specialists are available on call 24 hours a day via Hospital switchboards for advice on using anti-retrovirals.

Facility	Telephone number	Who to contact
Royal Perth Hospital Clinical Immunology Dept	+61 8 9224 2899 (Mon-Fri)	Clinical Immunology Registrar (Mon-Fri). Page Immunology Registrar on call (all other times)
Fiona Stanley Hospital Infectious Diseases Department	+61 8 6152 2222	Infectious Diseases Physician
Sir Charles Gairdner Hospital Microbiology Department	+61 8 9346 3333	Clinical immunology Registrar (Mon-Fri). Page Immunology registrar on call (all other times)

APPENDIX 1

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.

Non Exposure: Intact skin visibly contaminated with blood or any body substance.

Doubtful Exposure

- i. Intradermal (superficial) injury with a needle considered not to be contaminated with blood or body substance.
- ii. Superficial wound not associated with visible bleeding, caused by an instrument considered not to be contaminated with blood or body substance.
- iii. Prior wound or skin lesion contaminated with a body substance other than blood, e.g. urine.
- iv. Mucous membrane or conjunctival contact with a body fluid other than blood.

Possible Exposure

- v. Intradermal (superficial) injury with a needle contaminated with blood or body substance.
- vi. A wound not associated with visible bleeding, produced by an instrument contaminated with blood or body substance.
- vii. Prior wound or skin lesion contaminated with blood or body substance.
- viii. Mucous membrane or conjunctival contact with blood or body substance.

Definite Exposure (Moderate Risk)

- i. Skin penetrating injury with a needle contaminated with blood or body substance.
- ii. Injection of blood/body substance < 1ml.
- iii. Laceration or similar wound which caused bleeding, and is produced by an instrument that is visibly contaminated with blood or body substance.
- iv. In laboratory settings, any direct inoculation with HIV tissue or material likely to contain HIV, HBV or HCV not included above.

Massive Exposure (High Risk)

- i. Transfusion of blood.
- ii. Injection of large volume of blood/body substance (>1ml).
- iii. Parenteral exposure to laboratory specimens containing high titre of virus.

Source: Operational directive 0091 December 2007 "Management of Occupational Exposure to Blood and Body Fluids in the Health Care Setting" Department of Health Western Australia.

APPENDIX 2

RECOMMENDATIONS FOR INFECTION CONTROL

1. Routine hand hygiene

Hand hygiene must be performed before and after every episode of patient contact. This includes:

- before touching a patient;
- before a procedure;
- after a procedure or body substance exposure risk;
- after touching a patient; and
- after touching a patient's surroundings.

Hand hygiene must also be performed after the removal of gloves.

2. Choice of product for routine hand hygiene practices

For all routine hand hygiene practices in healthcare settings, use alcohol-based hand rubs that:

- contain between 60% and 80% v/v ethanol or equivalent; and
- meet the requirements of EN1500.

3. Choice of hand hygiene product when hands are visibly soiled

If hands are visibly soiled, hand hygiene should be performed using soap and water.

4. Hand hygiene for *Clostridium difficile* and non-enveloped viruses

Hand hygiene should be performed using soap and water when *Clostridium difficile* or non-enveloped viruses such as norovirus are known or suspected to be present and gloves have not been worn. After washing, hands should be dried thoroughly with single-use towels.

5. Wearing of aprons/gowns

Aprons or gowns should be appropriate to the task being undertaken. They should be worn for a single procedure or episode of patient care and removed in the area where the episode of care takes place.

6. Use of face and protective eyewear for procedures

A surgical mask and protective eyewear must be worn during procedures that generate splashes or sprays of blood, body substances, secretions or excretions into the face and eyes.

7. Wearing of gloves

Gloves must be worn as a single-use item for:

- each invasive procedure;
- contact with sterile sites and non-intact skin or mucous membranes; and

- any activity that has been assessed as carrying a risk of exposure to blood, body substances, secretions and excretions.

Gloves must be changed between patients and after every episode of individual patient care.

8. Sterile gloves

Sterile gloves must be used for aseptic procedures and contact with sterile sites.

9. Safe handling of sharps

- Sharps must not be passed directly from hand to hand and handling should be kept to a minimum.
- Needles must not be recapped, bent or broken after use.

10. Disposal of single-use sharps

The person who has used the single-use sharp must be responsible for its immediate safe disposal. Used disposable sharps must be discarded into an approved sharps container at the point-of-use. These must not be filled above the mark that indicates the bin is three-quarters full.

11. Routine cleaning of surfaces

- Clean frequently touched surfaces with detergent solution at least daily, and when visibly soiled and after every known contamination.
- Clean general surfaces and fittings when visibly soiled and immediately after spillage.

12. Cleaning of shared clinical equipment

Clean touched surfaces of shared clinical equipment between patient uses, with detergent solution.

13. Surface barriers

Use surface barriers to protect clinical surfaces (including equipment) that are:

- touched frequently with gloved hands during the delivery of patient care;
- likely to become contaminated with blood or body substances; or
- difficult to clean.

Exceptions to this should be justified by risk assessment.

14. Site decontamination after spills of blood or other potentially infectious materials

Spills of blood or other potentially infectious materials should be promptly cleaned as follows:

- **wear utility gloves and other PPE** appropriate to the task;
- **confine and contain** spill, clean visible matter with disposable absorbent material and discard the used cleaning materials in the appropriate waste container; and
- **clean** the spill area with a cloth or paper towels using detergent solution.

Use of chemical disinfectants such as sodium hypochlorite should be based on assessment of risk of transmission of infectious agents from that spill.

15. Implementation of contact precautions

In addition to standard precautions, implement contact precautions in the presence of known or suspected infectious agents that are spread by direct or indirect contact with the patient or the patient's environment.

16. Hand hygiene and personal protective equipment to prevent contact transmission

When working with patients who require contact precautions:

- perform hand hygiene;
- put on gloves and gown upon entry to the patient-care area;
- ensure that clothing and skin do not contact potentially contaminated environmental surfaces; and
- remove gown and gloves and perform hand hygiene before leaving the patient-care area.

17. Patient-care equipment for patients on contact precautions

- Use patient-dedicated equipment or single-use non-critical patient-care equipment.
- If common use of equipment for multiple patients is unavoidable, clean the equipment and allow it to dry before use on another patient.

18. Implementation of droplet precautions

In addition to standard precautions, implement droplet precautions for patients known or suspected to be infected with agents transmitted by respiratory droplets that are generated by a patient when coughing, sneezing or talking.

19. Personal protective equipment to prevent droplet transmission

When entering the patient-care environment, put on a surgical mask.

20. Placement of patients requiring droplet precautions

Place patients who require droplet precautions in a single-patient room.

21. Implementation of airborne precautions

In addition to standard precautions, implement airborne precautions for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route.

22. Personal protective equipment to prevent airborne transmission

Wear a correctly fitted P2 respirator when entering the patient-care area when an airborne transmissible infectious agent is known or suspected to be present.

23. Placement of patients requiring airborne precautions

- Patients on airborne precautions should be placed in a negative pressure room or in a room from which the air does not circulate to other areas.
- Exceptions to this should be justified by risk assessment.)

24. Implementation of core strategies in the control of MROs (MRSA, MRGN, VRE)

Implement transmission-based precautions for all patients colonised or infected with a multi-resistant organism, including:

- performing hand hygiene and putting on gloves and gowns before entering the patient-care area;
- using patient-dedicated or single-use non-critical patient-care equipment;
- using a single-patient room or, if unavailable, cohorting patients with the same strain of multiresistant organism in designated patient-care areas; and
- ensuring consistent cleaning and disinfection of surfaces in close proximity to the patient and those likely to be touched by the patient and healthcare workers.

Source: National Health and Medical Research Council Australian Guidelines *Clinical Educators Guide for the Prevention and Control of Infection in Healthcare* 2010

APPENDIX 3

NEEDLESTICK/SHARPS INJURY OR EXPOSURE TO BODY FLUID REPORTS



School of Medicine, Fremantle

DEALING WITH A 'NEEDLESTICK OR SHARPS' INJURY OR 'CONTAMINATION WITH BODY FLUIDS' INCIDENT

Please note that a person who has an open wound/s is at greater risk from infectious agents.

If a person sustains a 'needlestick or sharps' injury or 'contamination with body fluids' incident follow the following procedure:

STEP 1	Wash the injured area thoroughly with soap and water. If the eye/s are involved, rinse with running water or saline. Should blood spray into mouth, spit out blood then rinse mouth out several times with water.
STEP 2	Administer appropriate first aid for any bleeding or embedded object. Gain assistance from a first aid attendant as required.
STEP 3	Identify the source individual or the source of the sharp if possible and assess the risk status of the source individual (see attached form).
STEP 4	If a source individual is identified, they should be strongly encouraged to undergo blood testing.
STEP 5	Report the incident to your supervisor and complete the attached CONFIDENTIAL NEEDLESTICK/SHARPS INJURY OR EXPOSURE TO BODY FLUID REPORT FORM and a UNDA Incident / Injury form as soon as practicable (form available on Blackboard, hard copy with site admin)

Advice is also available from The Needlestick Hotline on 1800 804 823.

STEP 5

INJURY AT UNIVERSITY: Report incident to supervising academic staff.

INJURY AT GP PLACEMENT: Report incident to supervising GP. Although students may have their own GP it is strongly advisable to seek medical attention from one of the practice GPs. GP preceptors have been advised of this potential occurrence. The Discipline Leader of General Practice should also be notified at the earliest opportunity.

INJURY AT A HOSPITAL: Report incident to supervising staff, Infection Control Services at the hospital and to Clinical Students' Coordinator.

INJURY WHILST ON YEAR 4 ELECTIVE: Report incident immediately to supervising staff, Infection Control Services at the site and the Notre Dame Associate Dean (Clinical). For additional guidelines post exposure to infectious disease, refer to the Year 4 elective portal under Infection Control.

UNIVERSITY CONTACTS:

- Prof Jane Courtney, Associate Dean (Clinical), +61 8 9433 0962, jane.courtney@nd.edu.au
- Assoc Prof Douglas Cordell, Discipline Leader of General Practice, 9433 0198, mobile 0419 960 813, douglas.cordell@nd.edu.au
- Meredith Jaap, Clinical Students' Coordinator, 9433 0226, meredith.jaap@nd.edu.au

Wherever the injury/incident occurs the University's report forms (attached) must be completed as soon as practicable and submitted to the Associate Dean, Clinical.

POST-EXPOSURE COUNSELLING

All medical students are advised that post-exposure counselling is available through the School's Clinical Student Services at any time. Contact the Head of Student Matters, Susie Stewart at susie.stewart@nd.edu.au or on 0417 940 111.

Counselling services can also be accessed through the University's Student Services, +61 8 9433 0580.

If on an overseas elective, additional counselling services are available through the Consular Emergency Centre on +61 2 6261 3305 to be transferred to a Lifeline telephone counsellor.

CONFIDENTIAL
NEEDLESTICK/SHARPS INJURY OR EXPOSURE TO BODY FLUID REPORT FORM

Seek medical advice **IMMEDIATELY**.

Please complete this form and follow the instructions below for any needlestick/sharps injury or incident involving exposure to body fluid.

Report the incident to your supervisor **IMMEDIATELY**. Return this form to the Associate Dean Clinical, email: jane.courtney@nd.edu.au.

1. PERSONAL DETAILS

Surname:		First Name:	
Date of Birth:		Sex: M / F	
Are you (please tick): - <input type="checkbox"/> Student <input type="checkbox"/> Notre Dame employee <input type="checkbox"/> Visitor/Contractor			
Home Address:			
Email:			
Contact phone numbers	Work:	Home:	Mobile:
Position in School of Medicine:			
Name of Supervisor/Year Coordinator:			
Has your Supervisor/Year Coordinator been advised?	YES / NO	Date advised: / /	

2. INCIDENT DETAILS

Where it occurred			
When it occurred	Date:	Time:	
What first aid treatment was administered on-site?			
Description of how the incident occurred and any injury received: (include information on protective garments worn; length of exposure; whether it was a sharps injury or body fluid exposure.)			
Was the exposure - <input type="checkbox"/> Intact skin <input type="checkbox"/> Nose (<i>mucosa</i>) <input type="checkbox"/> Non-intact skin <input type="checkbox"/> Mouth (<i>mucosa</i>) <input type="checkbox"/> Eyes (<i>conjunctiva</i>) <input type="checkbox"/> Other, describe			

Contact details of a witness (if there was one)	
Name:	
Address:	
Phone Nos:	
Contact details of source patient (if relevant)	
Name:	
Address:	
Phone Nos:	
Is the source known to be positive HIV, Hepatitis B or C?: YES / NO / UNKNOWN NB: Encourage source patient to have blood tests. Source patient tested? YES / NO	

3. FOLLOW UP ACTION

Medical treatment (please tick):	<input type="checkbox"/> First aid <input type="checkbox"/> Medical (Doctor) <input type="checkbox"/> Nurse
First aid treatment was provided. By whom?	
Have you previously been vaccinated against Hepatitis B?	YES / NO
What is your antibody status?	
Do you have an opinion on whether any other engineering control, administrative or work practice could have prevented the injury?	YES / NO Describe:
Signature (injured person):	Date:

Medical expenses:

Notre Dame employees may make a claim through workers' compensation to cover medical expenses. Students can only apply for non-Medicare costs (not including any gap).

4. TREATING DOCTOR'S REPORT

Nature of injury: _____

- Problem resolved – No further follow up required
- Follow up appointment required - . Date_____
- Vaccination_____
- Prophylactic treatment commenced

Surgery Stamp

Doctors signature: _____ Date: _____

Please send completed form to: Associate Dean Clinical, School of Medicine, Fremantle
Email: jane.courtney@nd.edu.au

Print Form



Incident / Injury Report Form

Instructions:
 1. A person involved in an incident must report that incident whether or not they have suffered an injury as a result of that incident.
 2. A person reporting an incident must complete this form within 1 working day of the incident.
 3. Please provide the form to your Dean/Manager immediately after completion.
 4. The Dean/Manager must sign the form and forward it to the Risk and Compliance Office (Fremantle and Broome Campus - fabian.d'mello@nd.edu.au, Sydney Campus - clare.stanford@nd.edu.au and sydney.cs@nd.edu.au) immediately.

Section A : Personal Details of Person Involved in Incident

Staff
 Student
 Visitor
 Staff/Student Number

Title
 First Name
 Last Name

Gender
 Date of Birth
 Email

Phone (Home)
 Phone (Work)
 Mobile

Residential Address

Occupation
 School/Office

Campus
 Site

Section B : Incident Details

Date of Incident
 Time of Incident

Room Number
 Site

Location
 If other, pls specify

School/Office
 Campus

Incident Reported To
 Position Title

Date Reported
 Time Reported

Name of Witness
 Witness Phone No.

Explain what happened.
 What were you doing at the time?
 Include details of equipment & methods used.

How did the incident happen?
In the case of a near miss, how do you think this could have been prevented, or prevented from happening again?

Section C : Injury or Illness Details (only complete if injury or illness occurs)

Type of Injury (e.g. cut, sprain)

Part(s) of Body Injured/Affected

Describe the Injury or Illness

Date Symptoms First Noticed Time Symptoms First Noticed

Was Treatment given? No Yes

Describe the Treatment

Date of Treatment Time of Treatment

Name of Person Giving Treatment

Do you intend to lodge a claim for Workers' Compensation or Student Personal Accident? No Yes
(Please complete a claim form through your office/school) If yes,

Do you intend to seek further treatment outside of the University? No Yes
(For UNDA staff, please provide a Work Cover Medical Certificate from your doctor to your campus Staffing Office) If yes, who?

Did you or do you require time off from work? No Yes
(Please submit your leave through Employee Self-Service) Time Lost (Days/Hours)

Section D : Damage to Buildings/Vehicles/Equipment (if any)

Describe Damage

Signature of Person Involved Date

Section E : Investigation & Corrective Actions (to be completed by appropriate Dean/Manager)

What actions are required to prevent a similar incident? By whom? By when?

Name Signature Date

REFERENCES

1. The Medical Board of Australia: Draft Guidelines for Medical Practitioners and Medical Students infected with Blood- Borne Viruses March 30 2011
<http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2F4740&dbid=AP&chksu m=aw4yGFhsa9fCO7SpmZy8pQ%3D%3D>
2. National Health and Medical Research Council (NHMRC) Australian *Guidelines for the Prevention and Control of Infection in Healthcare 2010 Clinical Educators Guide*
http://www.nhmrc.gov.au/ files_nhmrc/publications/attachments/cd33_infection_control_healthc are.pdf
3. Australian Department of Health and Ageing *Communicable Diseases Information*
<http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-communic-1>
4. Communicable Diseases Network Australia (CDNA) Guidelines on the Management of Healthcare Workers (HCWs) with Blood Borne Viruses Endorsed by the Australian Health and Medical Advisory Council (AHMAC) 28 February 2012, published at:
[www.health.gov.au/internet/main/publishing.nsf/E28B5CC8872BE9C5CA2572EC000829EE/\\$File/Guidelines-BBV-feb12.pdf](http://www.health.gov.au/internet/main/publishing.nsf/E28B5CC8872BE9C5CA2572EC000829EE/$File/Guidelines-BBV-feb12.pdf)
5. Medical Board of Western Australia Policies *Medical Practitioners and Blood Borne Viruses 2003*
6. Department of Health Western Australia *Management of Occupational Exposure to Blood and Body Fluids in the Health Care Setting Operational Directive OD 0091/07 December 2007*
www.health.wa.gov.au
7. Committee of Deans of Australian Medical Schools (CDAMS) *Guidelines for Infectious Diseases Policies and Programs for Medical Students 2001*
8. SHEA Guideline for Management of Healthcare Workers Who Are Infected with hepatitis B Virus, hepatitis C Virus, and/or Human Immunodeficiency Virus .D. K Henderson et al *Infection Control and Hospital Epidemiology, Vol. 31, No. 3 (March 2010), pp. 203-232*

USEFUL RESOURCES

1. Australasian Society for HIV Medicine (ASHM)

The Australasian Society for HIV Medicine (ASHM) is the peak representative professional body of health professionals in Australia who work in the areas of HIV/AIDS, viral hepatitis and related areas. They have up to date guidelines and policy and offer a GP Toolkit for initiating PEP:

www.ashm.org.au

HIV Viral hepatitis and STIs A Guide for Primary Care- A comprehensive monograph for primary health care professionals working in the areas of HIV, viral hepatitis and/or STIs (2009)
www.ashm.org.au/publications/monographs/HIV_viral_hepatitis_and_STIs_a_guide_for_primary_care/hiv_viral_hepatitis_and_stis_whole.pdf

GP Toolkit and Guidelines for initiating Post Exposure Prophylaxis www.ashm.org.au/guidelines/

The ASHM provides information on the HIV prescriber program www.ashm.org.au/hiv-prescribers/

The ASHM website also provides counselling and support services information with contact details available from www.ashm.org.au or www.napwa.org.au

2. West Australian Department of Health

The West Australian Department of Health has a directive entitled “Management of Occupational Exposure to Blood and Body Fluids in the Health Care Setting (20 Dec 2007) www.health.wa.gov.au

Health policy directives on “Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases” is also found on this site.

A good resource on Guidelines for Managing Sexually Transmitted Infections including HIV can be found at <http://silverbook.health.wa.gov.au>. It contains a table on Risk of Transmission of HIV Exposure from 2007 National Guidelines

3. The Australian National Health and Medical Research Council (NHMRC)

The Australian National Health and Medical Research Council provide guides and tools on preventing infection at: <http://www.nhmrc.gov.au>. including the NHMRC Australian Guidelines for the Prevention and Control of infection in Healthcare in 2010. A Summary of Recommendations is in the Clinical Educators Guide for the Prevention and Control of infection in Healthcare

4. Center for Disease Control and Prevention (CDC) United StatesThe Center for Disease Control (CDC) www.cdc.gov is part of the US Department of Health and Human Services (DHHS) which released the latest version of the Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents on 29 March 2012: <http://www.aidsinfo.nih.gov/guidelines>.

The Clinical Guidelines Portal contains Guidelines for Occupational Exposure to HIV and Guidelines for Occupational Exposure to HBV, HCV and HIV. www.aidsinfo.nih.gov/contentfiles/HealthCareOccupExpoGL.pdf.

CDC Updated US Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Post Exposure Prophylaxis MMWR 2001;50 (No RR-11) pp 1-42.

The CDC site provides a wealth of advice including a Travellers’ health site and the Yellow Book. The Yellow Book 2012 is a wide-ranging resource written primarily for health professionals and contains up to date information on infectious disease and health information for travel to over 200 destinations. It is published every two years by the Centre of Disease Control and Prevention (CDC) : <http://wwwnc.cdc.gov/travel/>

6. United Nations Organisation

The United Nations Organisation operates a website specifically related to HIV/AIDS www.unaids.org/en/.

7. World Health Organisation (WHO)

This website offers a multitude of useful information for travellers and its Health Topics fact sheets are useful resources. The WHO Infectious Diseases site offers wide-ranging information on symptomology and treatment of infectious disease.

WHO publishes regularly updated advice on vaccines against disease of international relevance www.who.int/immunization/en.

Post- exposure prophylaxis to prevent HIV infection: Joint WHO/ ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection Geneva: World Health Organisation 2007

8. The Australian Department of Foreign Affairs and Trade (DFAT)

This site gives travel advice by country for infectious disease and is an essential resource for Australian travelers: www.dfat.gov.au.

9. The HIV Prevention Trials Network (HPTN 052 study)

Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, et al. Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *N Engl J Med* 2011; 365:493-505

The HIV Prevention Trials Network (HPTN) 052 randomized study of immediate or deferred antiretroviral therapy in 1763 patients in an HIV discordant relationship, with a CD4 cell count between 350 and 500 cells/ μ L, showed a significant reduction in HIV transmission as well as reduction in clinical events in those randomised to immediate treatment compared to those who had treatment deferred until the CD4 count reached 250 cells/ μ L or they developed AIDS.

10. Information on infectious diseases

Information about infectious diseases can be found on reputed websites such as Center for Disease Control and Prevention, US Department of Health and Human Services. <http://www.cdc.gov> or A-Z diseases from the WA website: http://www.public.health.wa.gov.au/1/10/2/az_diseases.pm