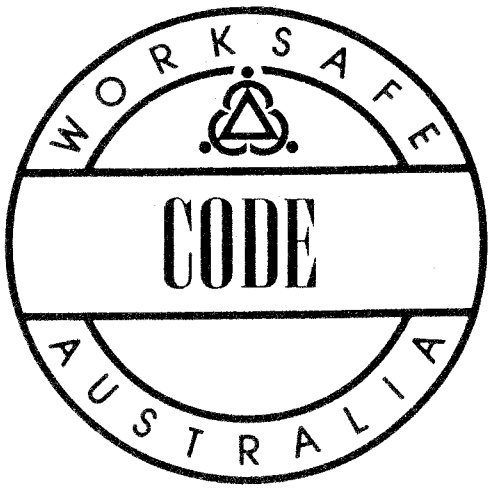

HUMAN IMMUNODEFICIENCY VIRUS AND HEPATITIS B AND THE WORKPLACE

National Consensus Statements
[NOHSC:6001(1993)]
[NOHSC:6003(1990)]

National Code of Practice
[NOHSC:2010(1993)]

NOVEMBER 1993

The National Occupational Health and Safety Commission has declared a *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace.*

National codes of practice declared by the National Commission under s.38(1) of the *National Occupational Health and Safety Commission Act 1985* (Cwlth) are documents prepared for the purpose of advising employers and workers of acceptable preventive action for averting occupational deaths, injuries and diseases in relation to workplace hazards.

The expectation of the Commonwealth Government and the National Commission is that national codes of practice will be suitable for adoption by Commonwealth, State and Territory governments. Such action will increase uniformity in the regulation of occupational health and safety throughout Australia and contribute to the enhanced efficiency of the Australian economy.

It should be noted that National Commission documents are instruments of an advisory character, except where a law, other than the National Occupational Health and Safety Commission Act, or an instrument made under such a law, makes them mandatory. The application of any National Commission document in any particular State or Territory is the prerogative of that State or Territory.

National Occupational Health and Safety Commission

HUMAN IMMUNODEFICIENCY VIRUS AND HEPATITIS B AND THE WORKPLACE

National Consensus Statement on Human Immunodeficiency Virus Infection/ Aquired Immune Deficiency Syndrome and the Workplace [NOHSC:6001(1993)]

National Consensus Statement on Hepatitis B and the Workplace [NOHSC:6003(1990)]

National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace [NOHSC:2010(1993)]

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FOREWORD

The National Occupational Health and Safety Commission is a tripartite body established by the Commonwealth Government to develop, facilitate and implement a national occupational health and safety strategy.

This strategy includes standards development, the development of hazard-specific and industry-based preventive strategies, research, training, information collection and dissemination and the development of common approaches to occupational health and safety legislation.

The National Commission comprises representatives of the peak employee and employer bodies — the Australian Council of Trade Unions and the Australian Chamber of Commerce and Industry — as well as the Commonwealth, State and Territory governments.

Consistent with the National Commission's philosophy of consultation, tripartite standing committees have been established to deal with issues relating to standards development, research and the mining industry. Expert groups and reference groups may be established to provide advice to the standing committees on those issues with which the National Commission is concerned.

PREFACE

This national code of practice has been developed to achieve a consistent approach to the management of occupational health and safety issues associated with HIV and hepatitis B, although it will also assist in the management of other blood-borne diseases in the workplace (including hepatitis C and hepatitis D).

This national code of practice was developed following a proposal of the Legal Working Party of the Intergovernmental Committee on AIDS, and funded by a Commonwealth AIDS Workforce Information, Standards and Exchange Grant from the Commonwealth Department of Health, Housing, Local Government and Community Services.

The National Commission convened the HIV/AIDS and Hepatitis B Expert Working Group in February 1992 to develop a *Draft National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus (HIV) and Hepatitis B in the Workplace*. This draft was released for a three month period of public comment at the end of September 1992.

Following the expiry of the public comment period, all the comments received were reviewed by a tripartite expert review group before referral to the Standards Development Standing Committee in April 1993. The Standards Development Standing Committee put forward a final document to the National Commission in July 1993 for declaration.

The National Commission, having considered the public comment on the draft national code of practice, now declares a final *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace* [NOHSC:2010(1993)].

To further assist employers and employees manage the occupational transmission of infectious diseases, such as HIV infection and hepatitis B, the National Commission has decided to include an updated version of the *National Consensus Statement on Human Immunodeficiency Virus Infection/Acquired Immune Deficiency Syndrome and the Workplace* [NOHSC:6001(1993)] (adopted by the National Commission in September 1993)] and a reprint of the existing *National Consensus Statement on Hepatitis B and the Workplace* [NOHSC:6003(1990)] with the *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace* [NOHSC:2010(1993)].

The purpose of including these two documents is to provide specific guidance on how to manage some of the personnel issues associated with HIV infection, AIDS and hepatitis B in the workplace. They cover such issues as policy principles, and policy development and implementation.

NATIONAL CONSENSUS STATEMENT ON HUMAN IMMUNODEFICIENCY VIRUS INFECTION/ ACQUIRED IMMUNE DEFICIENCY SYNDROME AND THE WORKPLACE [NOHSC:6001(1993)]

This consensus statement has been agreed to by the National Occupational Health and Safety Commission which comprises representatives of the Commonwealth Government and all State and Territory governments, the Australian Council of Trade Unions and the Australian Chamber of Commerce and Industry. It is based on the World Health Organization/International Labour Office document on AIDS and the workplace.

NATIONAL CONSENSUS STATEMENT ON HUMAN IMMUNODEFICIENCY VIRUS INFECTION/ACQUIRED IMMUNE DEFICIENCY SYNDROME AND THE WORKPLACE

GENERAL STATEMENT

Epidemiological studies throughout the world have demonstrated that the human immunodeficiency virus (HIV) is transmitted in only three ways:

(a) through sexual intercourse;

(b) through blood (principally through blood transfusions and the use of non-sterile injection equipment, and also through organ and tissue transplant); or

(c) from infected mother to infant (perinatal transmission).

There is no evidence to suggest that HIV transmission involves insects, food, water, sneezing, coughing, toilets, urine, swimming pools, sweat, tears, shared eating and drinking utensil or other items such as personal protective clothing or telephones. There is no evidence to suggest that HIV can be transmitted by casual, non-sexual, person-to-person contact in any setting.

The World Health Assembly resolution (WHA 41.24) entitled *Avoidance of Discrimination in Relation to HIV-infected People and People with AIDS* urges member states:

(a) 'to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS ... ;

(b) to protect the human rights and dignity of HIV-infected people and people with AIDS ... and to avoid discriminatory action against, and stigmatisation of, them in the provision of services, employment and travel; and

(c) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services.'

The stigma attached to HIV/AIDS is so great that the protection of the human rights and dignity of HIV infected people, including people with acquired immune deficiency syndrome (AIDS), is essential to the prevention and control of HIV infection and AIDS. People with HIV infection and AIDS come from all walks of life and all occupations, and go to all types of places to work. While it is true that HIV/AIDS have not yet impinged on the lives of many people at their place of work, this is likely to change as the epidemic progresses.

INTRODUCTION

This document is applicable to all workplaces regardless of whether the workers are employed in occupations in which there is no risk of HIV transmission.

In occupations or occupational situations, such as exist for health care and laboratory workers, in which there is a recognised risk of acquiring or transmitting HIV, people may need to refer to the *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficency Virus and Hepatitis B in the Workplace* [NOHSC:2010(1993)].

HIV infection and AIDS are likely to become issues for almost every enterprise as they find themselves dealing with issues raised by providing services to local people with HIV infection or AIDS, or dealing with the issues raised by staff members contracting the infection. Many may feel at present that these things do not concern them, however, with early policy development, companies can help prevent the spread of the disease and preserve the dignity of employees with HIV infection and AIDS, while ensuring a safe, productive working environment with an informed workforce.

This document suggests some basic strategies and provides advice on principles and core components for both education and policies regarding HIV/AIDS and the workplace. Both should be developed, implemented and monitored by management in consultation with employees. Where unions exist in the workplace, they should be included in these consultations.

POLICY PRINCIPLES

A workplace HIV/AIDS policy should communicate to all employees that the employer will:

(a) treat HIV infection and AIDS as they would any other chronic or life-threatening disease;

(b) give support to enable employees to continue working as long as it is reasonable and practicable, and that such support does not pose a risk to the health and safety of themselves or others;

(c) emphasise to all employees in the enterprise that there is no danger of transmission through normal workplace contact; and

(d) provide education for all employees about the disease, ways of transmission, the importance of maintaining confidentiality and prevention.

The policy enables the employer to set a standard of fair management, justice and compassion.

POLICY DEVELOPMENT

There are two different approaches to an HIV/AIDS policy:

(a) The '***life-threatening illness***' approach: a formal policy that HIV infection and AIDS will be treated no differently from any other major illness, such as cancer or heart disease. As long as employees perform their jobs satisfactorily (and do not, by their behaviour, put their own health or the health of others at risk), they will be treated in a fashion consistent with the treatment of other employees.

(b) The '***HIV/AIDS-specific***' approach: the company provides specific guidelines for handling HIV infection and AIDS-related issues and has a clear commitment to provide education on the facts about HIV infection and how it is spread. Employees with HIV infection or AIDS are assured that they will be allowed to work while they are able (and do not, by their behaviour, put their own health or the health of others at risk), that their confidentiality will be maintained and that co-workers have no right to refuse to work with them.

ELEMENTS OF A POLICY

Suggested components of a policy to adequately address workplace issues include:

(a) **Statement of intent:** the commitment of the enterprise to provide a healthy and safe working environment for all employees.

(b) **Management responsibilities:**

- (i) addressing personnel and management issues within the framework of existing procedures, guidance, statutes and regulations,
- (ii) providing training and guidance for supervisors and employees on HIV/AIDS-related issues,
- (iii) identifying work processes where there is potential occupational exposure,
- (iv) maintaining the confidentiality of medical information, and
- (v) having a post-occupational exposure management plan, covering such things as counselling, informed testing and treatment.

(c) **Employee responsibilities:** employees must carry out their duties in a responsible manner consistent with this instruction and other working procedures of the enterprise on health and safety matters.

(d) **Anti-discrimination:** the *Disability Discrimination Act 1992* (Cwlth) makes it unlawful to discriminate against a person with HIV/AIDS during all phases of employment (such as recruitment, promotion, training and retrenchment). The Act also obliges employers to provide a person with HIV/AIDS with services and facilities to enable them to do the job as long as the provision of such services or facilities does not impose unjustifiable hardship on the employer.

(e) **HIV/AIDS screening:** screening, both pre-employment and during employment, as part of an assessment of fitness to work is unnecessary and should not be required, whether direct (HIV antibody testing) or indirect (assessment of risk behaviours). There should be no general obligation on the employee to inform the employer of his/her HIV/AIDS status.

(f) **First aid:** in any situation requiring first aid in the workplace, infection control procedures need to be taken to reduce the risk of blood-borne infections, including hepatitis B. These standard precautions will be equally effective against HIV transmission. First aid providers should be recognised as a priority group for workplace education and training.

POLICY EDUCATION AND IMPLEMENTATION

When implementing a workplace policy, it needs to be reinforced with information and education programs. When developed, the policy should be:

(a) displayed and communicated to all concerned, taking into account the language and literacy levels of all people at the workplace;

(b) continually reviewed in the light of epidemiological and other scientific information;

(c) monitored for its successful implementation; and

(d) evaluated for its effectiveness.

The objectives of workplace HIV infection and AIDS education programs should be directed towards:

(a) providing accurate, up-to-date information on:

- **(i)** how HIV is transmitted,
- **(ii)** how it is not, and
- **(iii)** safe work practices and protective behaviour;

(b) informing all employees at the workplace of their rights and responsibilities under current workplace legislation and civil rights legislation;

(c) identifying and controlling 'at risk' work practices to prevent workplace transmission;

(d) creating a workplace climate that is supportive of employees making and maintaining healthy and safe behaviour choices;

(e) responding to the fears and anxieties of people in the workplace about HIV infection and AIDS, and providing reassurance when appropriate;

(f) informing employees with HIV infection or AIDS of their rights and responsibilities; and

(g) encouraging an understanding attitude towards people with HIV infection or AIDS, and countering any prevalent prejudice and stigmatisation.

NATIONAL CONSENSUS STATEMENT ON HEPATITIS B AND THE WORKPLACE [NOHSC:6003(1990)]

This consensus statement has been agreed to by the National Occupational Health and Safety Commission which comprises representatives of the Commonwealth Government and all State and Territory governments, the Australian Council of Trade Unions and the Australian Chamber of Commerce and Industry.

NATIONAL CONSENSUS STATEMENT ON HEPATITIS B AND THE WORKPLACE

The purpose of this document is to provide guidance to those people considering issues raised by a potential risk of hepatitis B infection in the workplace. It discusses the basic principles and necessary components of a workplace policy relating to hepatitis B.

A consideration of hepatitis B and the workplace may involve the review of existing policies or the development of new ones. Policies should be developed and implemented by management in consultation with employees. Where unions exist in the workplace, they should be included in the consultations.

Policies in the workplace about hepatitis B will enable employees, employers, unions and government agencies to contribute actively to local and national efforts for the prevention and control of hepatitis B infection.

GENERAL STATEMENT

Infection with the hepatitis B virus is a significant Australian public health problem. Prevention and control involves a wide range of health and social services.

Occupational transmission of the hepatitis B virus is not a major cause of hepatitis B infection. However, some people in particular occupations are at risk of hepatitis B infection because of the nature of their work. People who work in areas of the country where there are high rates of the disease also require special programs.

Workplace programs are an important and necessary part of any program to reduce the incidence of hepatitis B infection. People at risk of occupational transmission of the virus and all other employees will benefit from these workplace programs.

BACKGROUND INFORMATION

Infections of the liver by a number of viruses, including hepatitis types A, B and C, cause hepatitis. Hepatitis A is spread by sewage contamination of food and water. Hepatitis C has only recently been fully characterised and appears to be spread by infected blood and blood products.

Hepatitis B infections have given rise to concerns in particular occupations, and workplace prevention and control programs will be required in those occupations.

Many scientific studies world-wide have shown that there are only a limited number of ways that the hepatitis B virus is spread:

(a) through sexual intercourse with infected people;

(b) through close physical contact with infected blood, other body fluids and tissues, and biological products derived from these; and

(c) from infected mother to infant (perinatal transmission).

There is no evidence that the virus is spread by insects, food, water, sneezing, coughing, toilets, urine, swimming pools, sweat, tears, shared eating and drinking utensils or other items such as protective clothing or telephones. There is no evidence to show that hepatitis B is transmitted by casual person-to-person contact such as sitting next to an infected person.

Most people recover from the infection after the acute illness phase. A small number remain chronically infected and are carriers of the hepatitis B virus. People who are carriers are physically well and able to work. All chronic carriers of the hepatitis B virus have an increased risk of developing chronic liver disease and liver cancer many years later.

The blood and body fluids of people in the acute phase of infection, and that of carriers, contain the virus, but disease transmission to another person only occurs if this infectious material enters the body through the skin or, less commonly, comes into contact with mucous membranes such as the inside of the mouth or the surface of the eyes.

Sexual transmission and intravenous drug use account for the great majority of cases of short-term (acute) hepatitis B in Australia.

In order for disease transmission to take place, a person has to:

(a) come into physical contact with infected material, such as blood or other body fluids and tissues; and

(b) have the infected material introduced into the body.

In the workplace, disease transmission means, for all practical purposes, accidents where the skin is punctured or, less commonly, if infected material is splashed into the eyes, mouth or onto open wounds.

In the vast majority of occupations and occupational settings, a person's work does not involve a risk of acquiring or transmitting the hepatitis B virus.

Certain occupations have a risk of acquiring or transmitting hepatitis B and require specific preventive programs. Health care workers and laboratory workers are particularly at risk.

Groups of workers who are at less risk include police officers, prison officers, accident and emergency workers, some of the staff of psychiatric institutions and people who have to work in communities where there are increased rates of infection. These groups of workers are at risk because their occupation potentially exposes them to injuries that breach the skin and expose them to human blood.

People in all occupations, whatever their actual risk of infection at work, have concerns about the risk of hepatitis B infection. These concerns can best be addressed by discussion in the workplace with occupational health and safety practitioners, to provide information about hepatitis B infection and safe working procedures to prevent transmission of the virus. This prevents misconceptions about the nature of the disease and risk of infection becoming established. These misconceptions can lead to inappropriate workplace responses to perceived risks and the establishment of inappropriate work practices.

POLICY PRINCIPLES

The following policy principles form the basis of this consensus statement:

(a) Safe work practices to prevent the entry into the body of another person's blood, body fluids or tissues should be used at all times.

(b) People with hepatitis B illness should not be treated differently from any other employee with an infectious disease.

(c) People who are chronic carriers of the virus, but are otherwise healthy and who pose no risk of infection to other people, should not be treated differently from any other employee.

(d) People who are chronic carriers have a responsibility to their fellow workers to act in ways that do not expose them to the risk of infection.

(e) People who work in occupations where there may be exposure to potentially infectious material should be vaccinated.

(f) Appropriate work procedures which prevent the transmission of hepatitis B should be fully resourced to ensure such procedures are capable of being maintained at all times.

POLICY DEVELOPMENT AND IMPLEMENTATION

Policies and procedures consistent with these general principles should be developed at the enterprise level through consultation between employers, employees, unions and government agencies. These policies and procedures should be part of an overall strategy to prevent and control infectious diseases in the workplace. It is recommended that these policies be developed and implemented before hepatitis B-related questions arise.

Workplace policies to prevent and control hepatitis B infections should be:

(a) communicated to all concerned;

(b) continually reviewed in the light of epidemiological and other scientific information;

(c) monitored for successful implementation; and

(d) evaluated for effectiveness.

WORKPLACE PROCEDURES

The following workplace procedures are recommended for employers and employees in situations related to hepatitis B.

(a) The prevention of hepatitis B infection in the workplace is based on the universal application of work practices which prevent the introduction of other peoples' blood, body fluids and tissues into the body. These will include work procedures incorporating the handling and disposal of potentially infected waste, the use of appropriate equipment and the use of protective clothing, such as gloves and masks, where necessary.

(b) Hepatitis B screening should not be required as part of the assessment of fitness for work. Screening of this kind refers to direct methods (antibody testing) or indirect methods (assessment of risk behaviours).

(c) Confidentiality regarding all medical and personal information, including the results of blood tests, has to be maintained.

(d) People who are chronic carriers of the hepatitis B virus are entitled to all the rights and benefits of any other person. These include protection from discrimination, access to benefits and training, and the right to continuity of employment where work is available and is within their capacity and poses no risk of infection to other workers or the public.

(e) There is no general obligation to inform the employer regarding hepatitis B carrier status. In certain occupations, such as health care providers, the employee should discuss the issue with their treating doctor.

(f) There is an absolute obligation on people who know that they are hepatitis B carriers to act safely towards other employees and members of the public.

(g) A person who has had hepatitis B is able to return to work when certified medically fit to do so by their treating doctor.

(h) Where a person is a hepatitis B carrier and has a potential to transmit the virus at work, work practices should be reviewed. If necessary, the person should be redeployed to other duties in order to prevent further transmission.

(i) Where first aid is administered in the workplace, providers must be trained in safe procedures which minimise the risk of transmission of all infections, including hepatitis B.

(j) Standard procedures to manage exposures to potentially infectious materials should be developed in each workplace in consultation with employees. Where unions exist, they should be included in consultations. First aid providers have to be trained in the use of these standard procedures.

(k) Employees exposed at work to potentially infectious material, such as blood or other body fluids and tissues, should be involved in the development of safe work practices, trained in the use of those safe work practices and provided with facilities so that those safe work practices can be implemented.

(l) Vaccination should be offered by employers to those people working in occupations where there is a risk of repeated exposure to human blood or other body fluids and tissues. Vaccination to prevent occupational transmission is recommended for:

  (i) Health care workers, including trainees, laboratory workers, accident and emergency workers, people who work in centres for the treatment of drug addiction, people who work in facilities for the physically and mentally disabled and hospital workers (with the exception of clerical workers), including cleaners, volunteer and domiciliary health workers.

  (ii) Police and prison officers who come into physical contact (with potential for exchange of body fluids) with groups who have a high incidence of hepatitis B.

  (iii) People, such as those working in hostels, who come into physical contact (and potential contact with body fluids) with cultural groups among whom hepatitis B is endemic.

  (iv) People who work in institutions which house refugees and other people from countries or communities where hepatitis B is endemic.

  (v) People, such as clinical waste collectors, who work in situations where there is a risk of disease transmission due to accidents which puncture the skin and introduce infectious material into the body.

(m) For one-off exposure by employees to potentially infectious materials (blood or other body fluids and tissues), the employer should ensure that procedures are in place for medical assessment of the employee and for treatment, if required, with hyperimmune immunoglobulin given immediately after exposure.

(n) People who travel for work to countries where hepatitis B is endemic may have a higher risk of contracting hepatitis B. They should be educated about how the disease is spread, including other infectious diseases, using professional assistance as required. Health care workers should take precautions appropriate to their occupation. (Information about countries where hepatitis B is endemic can be obtained from your local Public Health Unit or your local doctor).

FIRST AID AND DISINFECTION

First Aid

Simple policies on the administration of first aid, based on the principles of infection control, should be developed and implemented to prevent the transmission of all blood-borne infections. The underlying strategy should be to consider all human blood or other body fluids and tissues as potentially infectious.

First aid boxes should include appropriate disinfectants, disposable plastic or latex gloves and one way-mouth pieces suitable for mouth-to-mouth resuscitation.

Hand washing after administration of first aid is essential.

Cover open cuts or sores with water-proof bandages or dressings.

Wash the hands and any other surfaces of the body splashed with blood or other body fluids as soon as possible. Use soap and water.

Carefully mop up spilt blood and then clean surfaces with disinfectants.

Safe disposal procedures should be developed and implemented.

Clean soiled equipment in cold water and detergent and then boil for 10 minutes or wash with disinfectants. Gloves should be worn when handling and cleaning equipment.

Disinfectants

The following disinfectants are suitable when used in conjunction with the procedures outlined above:

(a) bleach (household bleach, Milton solution, etc) in water, freshly prepared at a concentration of one per cent; or

(b) disinfectants containing iodine (Povidone-iodine, Betadine, etc).

FURTHER READING

'Prevention of Blood-borne Infection-HBV, non-A non-B Hepatitis and HIV', *Bulletin Number 6*, revised 1989. Available from:

Secretary
Sterilisation and Disinfection Society of Victoria
PO Box 73
PARKVILLE VIC 3052

'Update: Universal Precautions for the Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus and Other Blood-borne Pathogens in Health-care Settings', *Morbidity and Mortality Weekly Report*, vol. 37, no. 24, 24 June 1988.

'Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B to Health-care and Public-safety Workers', *Morbidity and Mortality Weekly Report*, vol. 38, supplement no. S-6, 23 June 1989.

NATIONAL CODE OF PRACTICE FOR HEALTH CARE WORKERS AND OTHER PEOPLE AT RISK OF THE TRANSMISSION OF HUMAN IMMUNODEFICIENCY VIRUS AND HEPATITIS B IN THE WORKPLACE [NOHSC:2010(1993)]

APPENDIXES

INTRODUCTION

This *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace* [NOHSC:2010 (1993)] will assist employers and employees to develop and implement practices to minimise the risk of workplace transmission of HIV and hepatitis B. It will also minimise the risk of transmission of other infectious blood-borne diseases such as hepatitis C.

Because many employees have unwarranted fears of the risk of transmission of HIV, and to a lesser extent hepatitis B, it is important that the ***limited*** ways that HIV and hepatitis B can be spread in the workplace are understood.

At this time, only three cases of occupational transmission of HIV have been reported in Australia[1]. In the United States, only 29 cases of occupational transmission of HIV have been confirmed among health care workers[2], even though over one hundred and fifty thousand people with AIDS have been cared for by health care workers in that country. Many more cases of occupational transmission of hepatitis B have been reported.

Transmission of HIV and hepatitis B is possible only through certain body fluids[3] — blood, cerebrospinal fluid, peritoneal fluid, amniotic fluid, pleural fluid, pericardial fluid, synovial fluid, breast milk, semen, vaginal secretions, unfixed organs and tissues, saliva in association with dentistry and any other body fluids containing visible blood. HIV and hepatitis B are not transmitted through sweat, sputum, faeces, vomitus, urine or nasal secretions.

Transmission of HIV and hepatitis B in the workplace has occurred in two major ways:

(a) when sharps contaminated with infected blood or body fluids penetrate the skin; or

(b) when infected blood or body fluids splash into the eye or other mucous membranes, onto broken skin or into a cut.

The risk of contracting HIV from a sharps injury involving ***infected*** blood is estimated to be less than 0.5 per cent. The risk of contracting hepatitis B from a sharps injury involving ***infected*** blood is estimated to be between seven per cent and 30 per cent[4].

Unwarranted fears about transmission are often related to a perception that HIV infection is only associated with homosexuality and illegal injecting drug use. These perceptions often lead to discrimination, and discrimination may contribute to unsafe work practices. The management of discrimination in the workplace is addressed in the revised *National Consensus Statement on Human Immunodeficiency Virus Infection/Acquired Immune Deficiency Syndrome and the Workplace* [NOHSC: 6001 (1993)] printed at the front of this publication. Employers and employees may obtain further advice about the management of discrimination in the workplace from Appendix 1 of this national code of practice, from the relevant Commonwealth, State and Territory organisations listed in Appendix 4 of this national code of practice, and from some of the publications listed in the chapter 'Further Reading'.

This national code of practice has been developed to achieve a consistent approach to the management of occupational health and safety issues associated with HIV and hepatitis B. It has been developed in consultation with the National Health and Medical Research Council sub-committee which recently completed a revision of the *Guidelines for the Control of Infectious Disease Hazards in Health Care Establishments*[5].

This national code of practice was developed following a proposal of the Legal Working Party of the Intergovernmental Committee on AIDS[6], and funded by a Commonwealth AIDS Workforce Information, Standards and Exchange Grant from the Commonwealth Department of Health, Housing, Local Government and Community Services.

Guidance material for the following 11 high risk areas is being developed to supplement this national code of practice:

(a) anaesthetic procedures;

(b) operating theatres;

(c) obstetric procedures;

(d) accident and emergency departments;

(e) emergency response workers;

(f) post mortems;

(g) cleaners;

(h) laboratories;

(i) dentistry;

(j) police; and

(k) prison officers.

This material will be available from Worksafe Australia during 1994.

1. TITLE

1.1 This national code of practice may be cited as the *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace* [NOHSC:2010(1993)].

2. PURPOSE

2.1 The purpose of this *National Code of Practice for Health Care Workers and Other People at Risk of the Transmission of Human Immunodeficiency Virus and Hepatitis B in the Workplace* [NOHSC:2010(1993)] is to assist employers and employees to meet requirements under existing Commonwealth or State and Territory occupational health and safety legislation as it relates to HIV and hepatitis B in the workplace by providing practical guidance on the identification, assessment and control of occupational health and safety risks associated with blood or body fluids.

2.2 In most workplaces, employees are not at risk of transmission of HIV and hepatitis B. However, in workplaces in which employees have contact with blood or body fluids there is a potential for transmission of HIV and hepatitis B. This national code of practice applies to those at highest risk — health care workers, police, prison officers and emergency response workers (firefighters and ambulance officers). This national code of practice will assist employers of these groups to identify when the risk of transmission exists in the workplace, and, if a risk is identified, to assess and control that risk.

2.3 This national code of practice should:

(a) address concerns in the workplace regarding HIV, AIDS and hepatitis B by providing guidelines for program development;

(b) assist with the formulation and implementation of workplace procedures and practices in accordance with developed programs;

(c) minimise the risk of transmission of HIV and hepatitis B in the workplace; and

(d) contribute to a better understanding of the workplace issues associated with HIV and hepatitis B through the provision of guidelines, resources, information and training by employers.

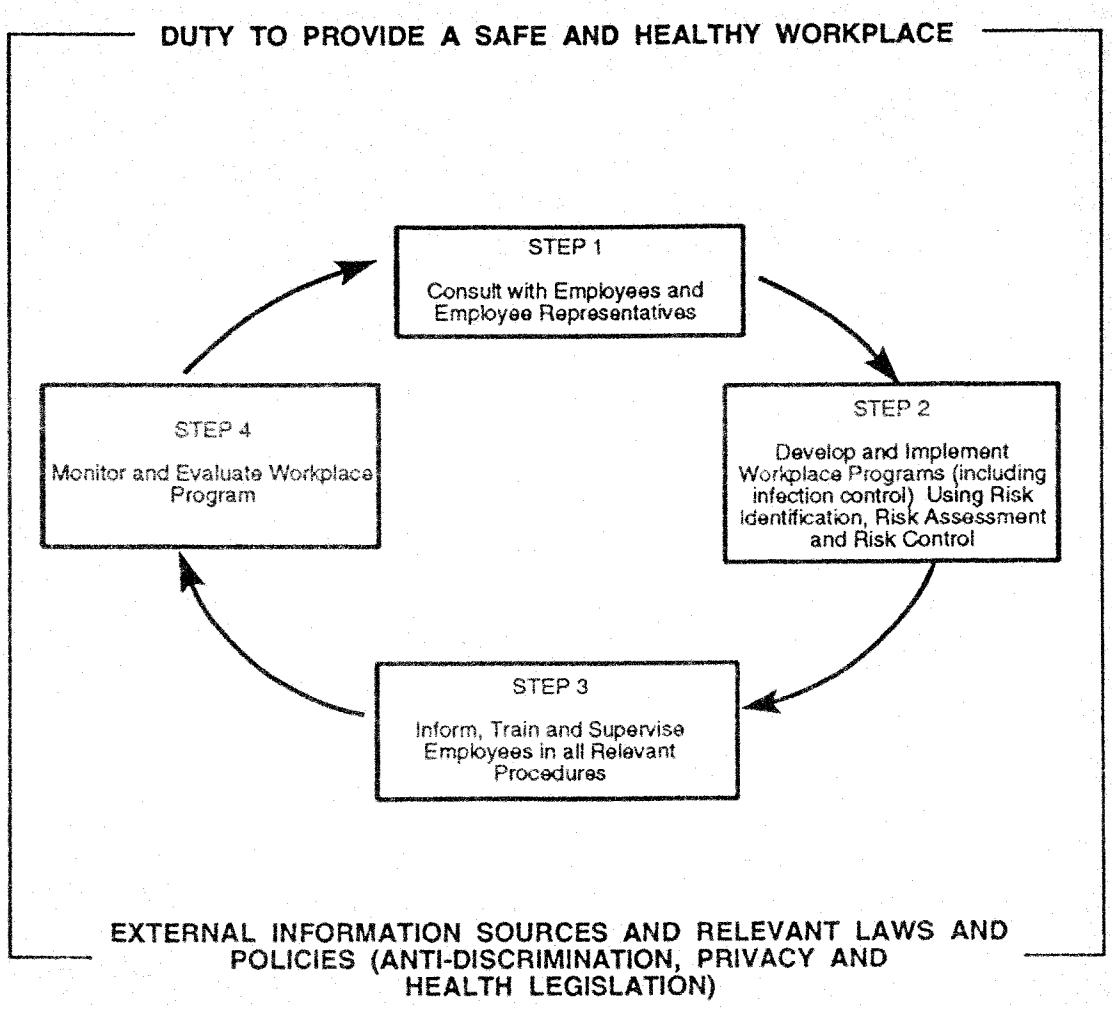
3. SCOPE AND APPLICATION

3.1 This national code of practice applies to health care workers, police, prison officers and emergency response workers (firefighters and ambulance officers) who have a risk of transmission of HIV and hepatitis B in the workplace.

4. OVERVIEW

4.1 This national code of practice provides advice on the general principles for developing a control program to prevent transmission of HIV and hepatitis B in the workplace which includes information, training, monitoring and evaluation. This is represented in Figure 1.

Figure 1 *Provision of a Safe and Healthy Workplace for Health Care Workers, Police, Prison Officers and Emergency Response Workers Who may be Exposed to Blood or Body Fluids in their Work*



5. DEFINITIONS

5.1 In this national code of practice, the following meanings of terms apply:

'Acquired Immune Deficiency Syndrome' (AIDS) is a condition in which the body's immune system loses its ability to fight off infection and thus becomes vulnerable to opportunistic infections, and certain cancers. This condition is caused by infection with HIV.

'Antibody' is a protein, produced by the body's immune system after infection or immunisation, whose function is to adhere to and neutralise foreign substances in the body. This usually provides protection against the infecting organism or agent. This is not the case with the HIV antibody.

'Anti-viral drug' is a substance which blocks or slows down the reproduction of viruses.

'Blood' means human blood, human blood components, and products made from human blood.

'Body fluids' means cerebrospinal fluid, peritoneal fluid, amniotic fluid, pleural fluid, pericardial fluid, synovial fluid, breast milk, semen, vaginal secretions, unfixed organs and tissues, saliva in association with dentistry and any other body fluids containing visible blood.

'Cleaning' is the removal of all visible foreign material from objects, most commonly using water, mechanical action and detergents. Cleaning must precede disinfection and sterilisation.

'Client' means a member of the public (that is, not an employee) who is seeking or receiving a service (including training) from an organisation.

'Contaminated' means the presence, or reasonably anticipated presence, of blood or other potentially infectious materials on an item or surface.

'Discrimination' means treating someone less favourably because they belong, or are presumed to belong, to a particular group of people.

'Disinfection' is a process that eliminates many or all infectious micro-organisms, except bacterial and fungal spores.

'Exposure' means contact with blood or body fluids which may lead to the transmission of HIV and hepatitis B. Transmission in the workplace has occurred in two major ways:

(a) when sharps contaminated with infected blood or body fluids penetrate the skin, or

(b) when infected blood or body fluids splash into the eye or other mucous membranes, onto broken skin or into a cut.

'Health care workers' are people who work in health care settings (including students, trainees, and voluntary workers) whose activities normally involve client care and/or contact with blood or body fluids.

'Hepatitis' is inflammation of the liver which can be caused by viruses, bacteria, chemicals, alcohol, and some medications.

'Hepatitis B' is a form of viral hepatitis which can result in chronic hepatitis, cirrhosis of the liver or cancer of the liver, in addition to acute hepatitis. There is a vaccination available for hepatitis B.

'Hepatitis B immunoglobulin' (HBIG) is a solution containing antibody from human blood made to provide immunisation against hepatitis B. Hepatitis B immunoglobulin is also used as a treatment following exposures to blood or body fluids. Immunoglobulin preparations are free from HIV and other human pathogens.

'Human Immunodeficiency Virus' (HIV) (includes HIV1 and HIV2) is the name of the virus that causes AIDS. This virus attacks a certain type of white blood cell that is a vital part of the body's immune system.

'HIV antibody' is the protein produced by the body's immune system against the HIV virus. It serves as a marker for the presence of the virus and is the basis of the most common test for HIV. Persons who become infected with HIV usually develop HIV antibodies within 6-12 weeks of infection.

'Immunisation' is the process of providing immunity artificially by administering an immunobiological product.

'Infection' is the invasion and multiplication of micro-organisms in body tissues. It may or may not lead to disease, either local or systemic.

'Mucous membrane' is the membrane lining body cavities and passages, usually moistened with mucus, includes the mouth, eye, nose, rectum, vagina and urethra.

'Opportunistic infections' are infections caused by a variety of agents that take advantage of the opportunity offered by an impaired immune system. These infections would seldom cause illness in people with normal immune function.

'Prophylaxis' is treatment given to prevent illness or infection.

'Seroconversion' is the new production of antibodies.

'Sharps' means needles, cannulas, scalpels or blades, ends of dental wires, edged instruments, broken glassware, bone fragments or any other item that might penetrate the skin or mucous membranes.

'Sharps injury' is an injury which occurs when a sharp penetrates the skin or mucous membranes. The most common form of sharps injury is a needlestick injury. Sharps injuries may lead to transmission of HIV or hepatitis B only if the sharp is contaminated with infected blood or body fluids.

'Source individual' means any individual living or dead whose blood or body fluids are the source of exposure to HIV or hepatitis B.

'Sterilisation' is a process which kills micro-organisms, including bacterial and fungal spores.

'Transmission' means the spread of infectious viruses, bacteria, etc. from an infected person to another person.

'Universal precautions' involves the routine use of safe work practices and protective barriers to minimise the spread of infectious diseases. It is a strategy which assumes that all blood and body fluids are potential sources of infection. This is consistent with the approach taken by the National Health and Medical Research Council[5] and the Australian National Council on AIDS[7].

'Unsafe sex' is any form of sex in which HIV (and other infectious diseases) passes from the blood, semen or vaginal fluids of one person directly into the blood stream of another person[8].

'Vaccine' is a biological substance administered into the body to induce immunity and thereby prevent infectious disease.

'Window period' is a term used to describe the period of time between infection with HIV and seroconversion. It is called the window period because the person may be negative when tested, but may be infectious. The window period after HIV infection is usually 6-12 weeks.

6. CONSULTATION

6.1 Employers should take all practicable steps to ensure that consultation takes place with employees and employee representatives, and where they are established, occupational health and safety committees or infection control committees, at all stages of the development, implementation and review of programs and procedures recommended in this national code of practice.

6.2 Consultation should occur when:

(a) the employer is identifying risks;

(b) determining the approach and methods to be used in risk assessment;

(c) decisions are being taken on the use of risk controls;

(d) new information becomes available about HIV, hepatitis B and safe work practices; and

(e) the effectiveness of implemented infection control measures and information and training programs are being evaluated.

7. TRANSMISSION OF HIV AND HEPATITIS B

7.1 This table sets out the ways in which HIV and hepatitis B can and cannot be transmitted. The shaded areas indicate ways in which transmission of HIV and hepatitis B may occur in the workplace.

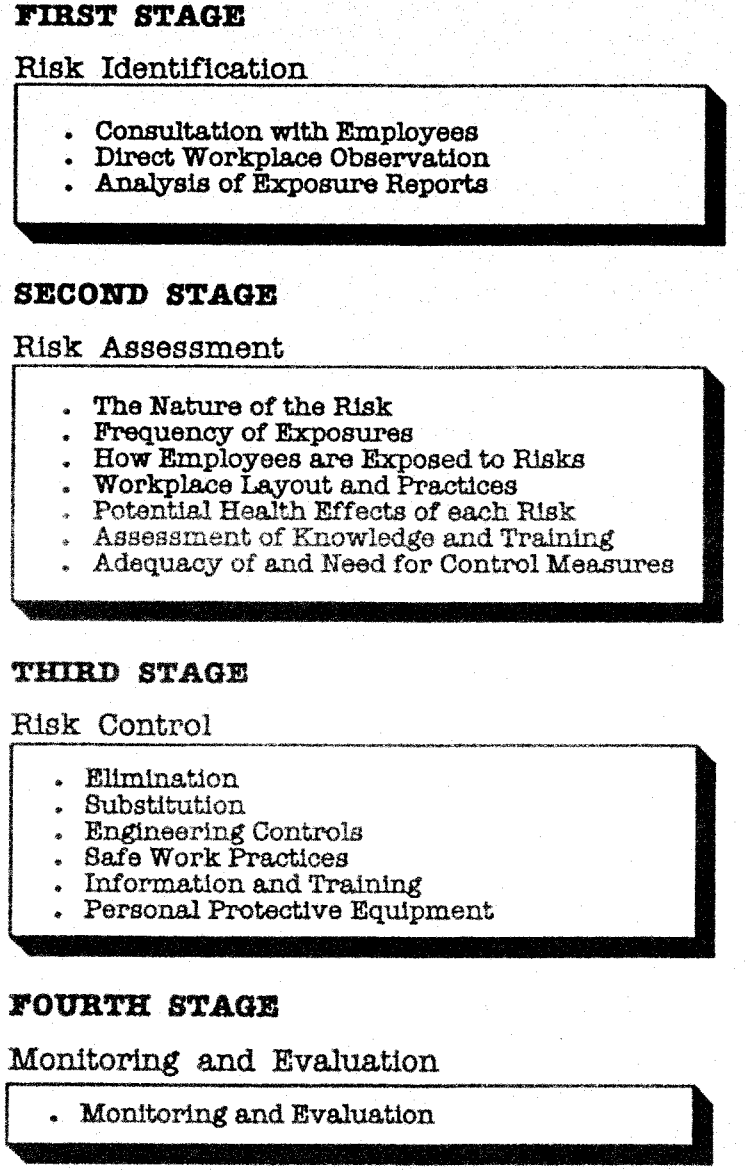
MODE OF TRANSMISSION	RISK OF TRANSMISSION HIV	HEPATITIS B
Unsafe sex with an infected partner	yes	yes
Sharing needles during injecting drug use with an infected person	yes	yes
When sharps contaminated with infected blood or body fluids penetrate the skin	**yes**	**yes**
When infected blood and body fluids splash into the eye or other mucous membranes, onto broken skin or into a cut	**yes**	**yes**
From infected mother to child at or around the time of birth	yes	yes
Through blood transfusions, organ transplants and artificial insemination[1]	minimal risk	minimal risk
From insects, animals, food or swimming pools	no	no
From casual social contact (hugging or shaking hands)	no	no

1. All blood donations and semen and organ donors are now tested for HIV and hepatitis B and C. There is minimal risk of contracting HIV or hepatitis B from donations of blood, semen or organs.

8. CONTROL PROGRAM FOR PREVENTION OF TRANSMISSION OF HIV AND HEPATITIS B

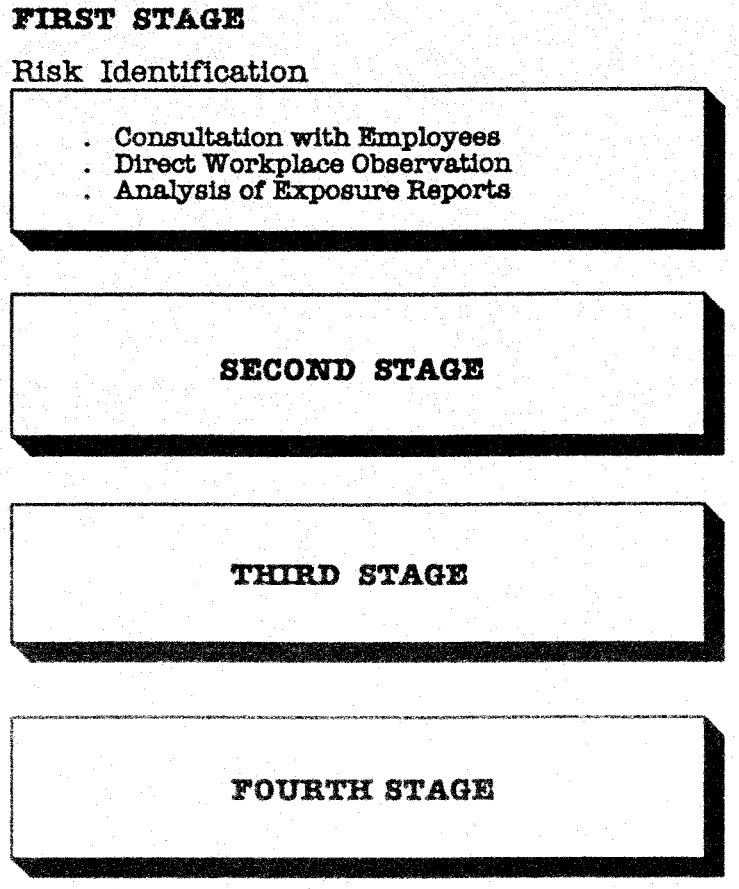
8.1 Employers should develop a four stage ***control program*** to prevent transmission of HIV and hepatitis B in the workplace. The program involves the development of procedures to prevent transmission of HIV and hepatitis B, and to monitor and evaluate these procedures.

Figure 2 Outline of the Four Stage Approach to the Control Program



9. RISK IDENTIFICATION

Figure 3 Risk Identification



9.1 The purpose of risk identification is to identify the activities and tasks in the workplace which put employees at risk of transmission of HIV and hepatitis B.

9.2 The process of risk identification involves identifying, and placing in order of priority, the activities or tasks which require action to reduce the risk of transmission of HIV and hepatitis B. If a likely risk to health and safety is identified, risk assessment should be carried out.

9.3 Risk identification should be carried out as follows:

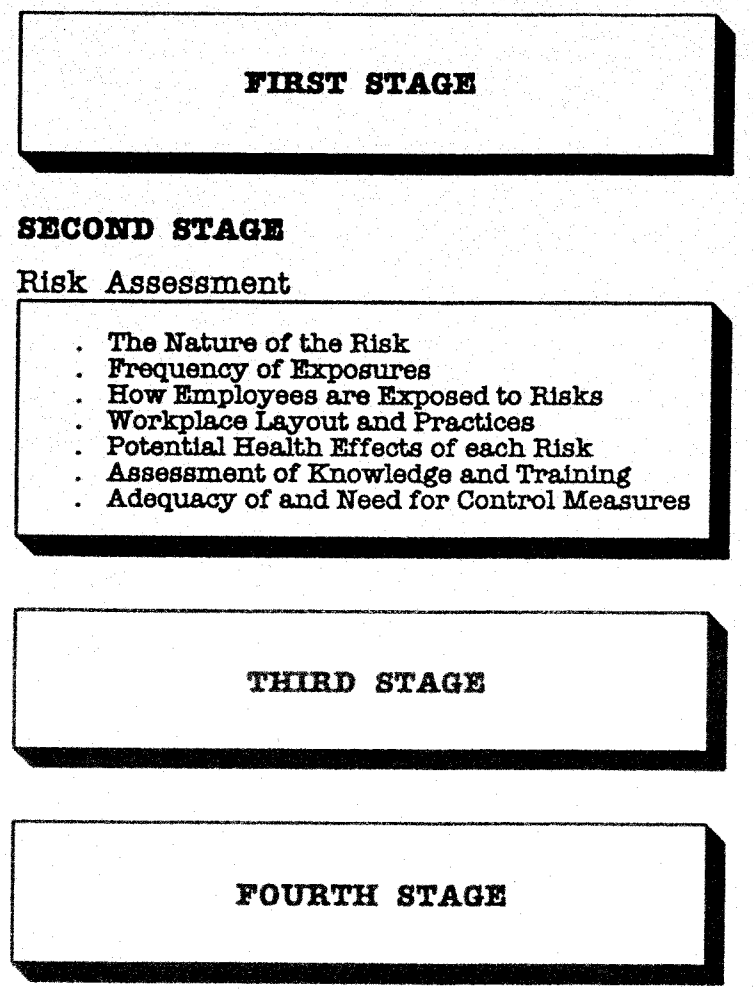
(a) Ask employees. This is one of the easiest and most effective ways to identify hazards in the workplace. Employees are usually well aware of what can go wrong and how this happens.

(b) Analyse available reports of exposures to blood or body fluids to identify trends and identify high risk activities and tasks, evaluate reporting and documentation procedures, and monitor effectiveness of follow-up and the effectiveness of treatment.

(c) Conduct a survey of the workplace layout, work practices and other sources of employee exposure to blood or body fluids. The resulting list should identify job classifications, knowledge, attitudes, and work practices which are most likely to put employees at risk of exposure to blood or body fluids. All activities and tasks or groups of related activities and tasks in which employees may be exposed to blood or body fluids should be listed and matched to job classifications.

10. RISK ASSESSMENT

Figure 4 Risk Assessment



10.1 If the process of risk identification indicates the presence of a risk factor for the transmission of HIV and hepatitis B, risk assessment should be carried out.

10.2 The purpose of assessment is to evaluate the health and safety risks to employees arising from exposure to blood or body fluids in the workplace, and to determine the measures necessary to minimise those risks.

10.3 Risk assessment should include consideration of:

(a) modes of transmission of HIV and hepatitis B which may occur in the workplace. Studies [1,3,4,5] have shown that this may occur in the workplace in two major ways:

- **(i)** when sharps contaminated with infected blood or body fluids penetrate the skin, or
- **(ii)** when infected blood or body fluids splash into the eye or other mucous membranes, onto broken skin or into a cut;

(b) frequency of exposures to blood or body fluids, the amount of blood or body fluid, the probable route of transmission, the type of body fluid encountered and analysis of multiple exposures;

(c) factors which contribute to exposures and their recurrence;

(d) risks of exposure to blood or body fluids associated with current workplace layout and work practices;

(e) the potential health effects resulting from infection with HIV or hepatitis B and access to services;

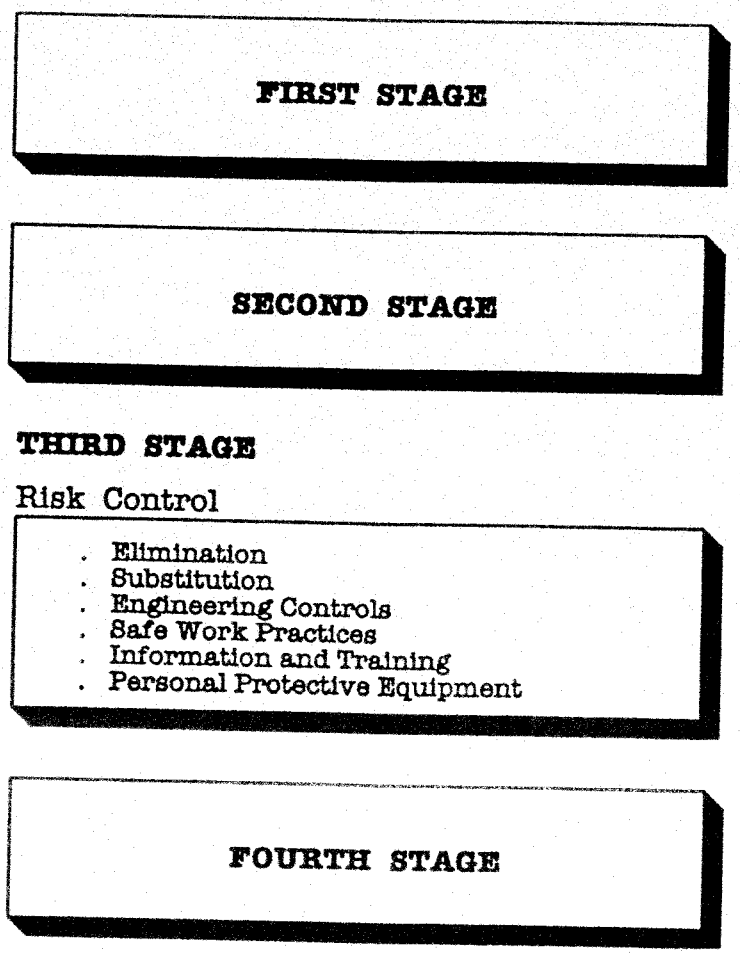
(f) assessment of the knowledge and training of employers, supervisors and employees regarding HIV and hepatitis B and safe work practices;

(g) assessment of the suitability of equipment for the task(s) for which it is being used, that is, whether or not the use of the equipment is likely to lead to exposures to blood and body fluids; and

(h) assessment of other current risk control measures and the need for new risk control measures.

11. RISK CONTROL

Figure 5 Risk Control



11.1 The purpose of risk control is to minimise employee exposures to blood or body fluids in the workplace.

11.2 Risk control should be achieved by applying the risk control hierarchy outlined below.

ELIMINATION

11.3 Work practices associated with exposures to blood or body fluids which have been assessed as not being necessary should be eliminated.

SUBSTITUTION

11.4 Where elimination is not practicable, the employer should substitute the work practices with suitable practices which present a lesser risk of exposure to blood or body fluids.

ENGINEERING CONTROLS

11.5 Engineering controls are designed to prevent occupational disease and injury by management of the work environment. Engineering controls may include the isolation of the process, material or worker, enclosure of the process, ventilation of the process or work environment, the use of mechanical equipment or automation, and modification of tools and equipment.

11.6 Employers should ensure that the workplace and equipment used in the workplace is designed to minimise exposures to blood or body fluids.

11.7 This should include consideration of:

(a) ergonomic factors, such as lighting, workplace maintenance and work station layout;

(b) new technology which may become available to improve employee safety by eliminating or substituting unsafe procedures, for example, resheathing needles, puncture-proof gloves, and lasers for use in surgery;

(c) the instruments and equipment used in the workplace; and

(d) the development of procedures to ensure that instruments and equipment are checked regularly, and repaired or replaced as appropriate, to ensure their effectiveness.

SAFE WORK PRACTICES

11.8 The fundamentals of minimising the risk of transmission of HIV and hepatitis B in the workplace are personal hygiene, universal precautions and an infection control program.

11.9 Employers should ensure safe work practices are in place to minimise exposures to blood or body fluids.

11.10 If accidents occur in the workplace, employers should establish a procedure for safe first aid. Information about first aid is set out in Chapter 13.

11.11 If exposures to blood or body fluids do occur in the workplace, employers should have a procedure in place to manage such exposures. This procedure is set out in Chapter 14.

11.12 Any identified unsafe work practices should be modified after the consideration of elimination, substitution and engineering controls.

Personal Hygiene

11.13 Hand washing and hand care are important measures in infection control.

11.14 Employers should ensure that hand washing facilities are provided at clearly identified sites in the workplace. Hand washing facilities should be equipped with adequate supplies of running water, soap and single-use paper towels or hot-air drying machines.

11.15 When it is not possible for employees to wash their hands in running water, alternative methods for hand cleaning should be made available.

11.16 Employees should wash and dry their hands:

(a) after contact with blood or body fluids; and

(b) immediately after removing gloves.

11.17 Employees should check for cuts or abrasions on exposed parts of the body. Cuts or abrasions should be covered with waterproof dressings.

11.18 Employees should maintain a high standard of personal hygiene, for example, hands should be washed at the beginning and end of each shift and before and after eating, drinking, smoking and going to the toilet.

Universal Precautions

11.19 Universal precautions is a strategy which requires employees to treat the blood or body fluids of all persons as potential sources of infection, independent of diagnosis or perceived risk. It involves the routine wearing of gloves, other protective clothing, handwashing and such infection control measures that are designed to place a barrier between potentially infectious blood or body fluids and employees.

11.20 The use of universal precautions will minimise the risk of transmission of HIV and hepatitis B from client to employee, from employee to client, and from employee to employee.

11.21 Universal precautions are intended to minimise transmission from:

(a) sharps contaminated with infected blood or body fluids penetrating the skin; and

(b) infected blood or body fluids splashing into the eye or other mucous membranes, onto broken skin or into a cut.

11.22 Universal precautions should be applied in all situations in which employees have contact with blood or body fluids.

Immunisation for Hepatitis B

11.23 Employers should offer to provide a course of hepatitis B immunisation to all employees who have regular contact with, and therefore may be exposed to, blood or body fluids.

11.24 A full course of hepatitis B vaccine should be given and consists of three doses, given at zero, one and six months. The full course must be given before protection will be adequate. The frequency of seroconversion increases from 35 per cent after one injection to over 90 per cent after the third injection. Employees should be screened for seroconversion one to three months after the third injection. Those who do not seroconvert should be offered a fourth dose of vaccine and they should be rescreened for seroconversion. Employers should refer to the National Health and Medical Research Council guidelines on immunisation for further information[9].

Cleaning, Disinfection and Sterilisation of Equipment

11.25 There are three levels for processing equipment. The choice of method depends on what the equipment is used for.

(a) If the equipment is to have contact only with intact skin, then it requires cleaning. However, if this equipment is contaminated with blood, then it should be cleaned and disinfected.

(b) If the equipment is to have contact with mucous membranes, then it requires cleaning and high level disinfection.

(c) If the equipment is to have contact with normally sterile tissue, then it should be cleaned and sterilised.

11.26 Cleaning should be done with detergent and water. Gloves should be worn during cleaning. Items should be washed and scrubbed to remove all visible contaminant. This should be done by mechanical means, such as a dishwasher, if possible. Care should be taken during cleaning to avoid splashing. Eye protection should be worn if splashing is likely to occur.

11.27 Cleaning must always precede disinfection or sterilisation.

11.28 The incorrect use of some disinfectants can be hazardous. Instructions set out on labels and Material Safety Data Sheets should be followed. An Australian Standard relating to the *Cleaning, Disinfecting and Sterilising of Medical and Surgical Instruments and Equipment, and Maintenance of Associated Environments in Health Care Facilities* is currently being developed and should be available late 1993. A revision of the *Therapeutic Goods Act 1989* (Cwlth) is soon to be introduced that will ensure that all instrument disinfectants are registered, and hence assessed, by the Therapeutic Goods Administration and any claim for virucidal or tuberculocidal activity will be prohibited unless approved by the Therapeutic Goods Administration. This Order will supersede State and Territory legislation in this area.

11.29 Sterilising equipment should be used according to instructions.

Blood Spills

11.30 Blood spills should be assessed and attended to immediately.

11.31 When managing blood spills:

(a) Gloves should be worn.

(b) Absorbent material, such as paper towels, cloth or sawdust, should be used to absorb the bulk of the blood or body fluids. This should be disposed of in approved leak-proof waste bags after use.

(c) The area should then be cleaned and disinfected.

(d) Large spills, such as may occur after a road accident, may be safely hosed down with water by employees wearing protective clothing.

Laundry

11.32 A procedure should be developed to cover:

(a) distribution of clean linen;

(b) bagging used linen for collection;

(c) storage and transport of used linen;

(d) checking for sharps in used linen; and

(e) cleaning of used linen.

11.33 The following work practices for handling used linen should be followed:

(a) All used linen should be:

(i) treated as potentially infectious; and

(ii) be placed in a standard linen bag unless there is a risk of contamination from outside the bag by moist body fluids. If this occurs, the linen bag should be placed into a clear leak-proof plastic bag.

(b) Linen bags should only be three-quarters filled and should be secured prior to transport.

(c) Leather or other puncture resistant gloves should be worn when handling dirty linen because sharps may be found in the linen.

(d) Sharps containers should be made available for disposal of sharps found when sorting used linen.

(e) All linen should be washed with detergent.

Waste Management

11.34 A procedure should be developed to cover:

(a) the preliminary disposal of waste in the area where waste is generated;

(b) collection and transport of waste from the area where waste is generated;

(c) storage of waste;

(d) transport of waste; and

(e) final disposal of waste in accordance with the requirements of the relevant local, State and Territory or Commonwealth authorities.

Handling of Sharps

11.35 Employers should develop procedures for the safe handling and disposal of sharps.

11.36 A procedure should be developed to cover:

(a) Placement of clearly marked sharps containers for the disposal of sharps as close as practical to the areas where the sharps are being used or found.

(b) Regular replacement of full sharps containers. Sharps containers should be sealed before they are removed.

(c) The disposal of disposable sharps.

11.37 Reusable sharps containers should comply with Australian Standard AS 4031 *Non-reusable Containers for the Collection of Sharp Items Used in Health Care Areas*[10]. Standards Australia is now preparing a standard relating to reusable sharps containers *Reusable Containers for the Collection of Sharp Items Used in Human and Animal Applications.*

11.38 The following should be observed in the handling of sharps:

(a) When sharps are used, the person ***using*** the sharp should be responsible for its proper disposal. When sharps are found, the person ***finding*** the sharp should be responsible for its proper disposal.

(b) Used needles should not be recapped by hand, removed from syringes by hand, or purposely bent or otherwise manipulated by hand unless using a special device designed for that purpose.

(c) Used needles and other disposable sharp instruments should be ***immediately*** discarded into an approved sharps container.

(d) Sharps containers should be positioned safely.

INFORMATION AND TRAINING

11.39 Workplace information and training programs should:

(a) form part of the orientation program for new employees;

(b) be regularly repeated to employees on an ongoing basis;

(c) relate to the day-to-day activities of the workplace and be targeted to specific work activities;

(d) be sufficient to deal with the range of issues involved;

(e) provide updates when there are changes in information about HIV and hepatitis B;

(f) provide updates when changes in work procedures and practices are introduced;

(g) provide updates when new equipment is introduced;

(h) provide training for the safe provision of first aid;

(i) train employees to correctly use personal protective equipment;

(j) inform employees of the correct procedure following an exposure to blood or body fluids;

(k) utilise a variety of educational and training techniques, such as peer educators and group sessions, which involve the active participation of employees;

(l) be provided in a manner appropriate to the workplace;

(m) inform employees about their legal obligations regarding occupational health and safety; and

(n) direct employees to other reliable sources of information.

Purpose of Information and Training

11.40 Information and training programs for ***managers and supervisors*** should enable them to:

(a) ensure that employees at risk are informed about the transmission of HIV and hepatitis B;

(b) identify and anticipate situations where employees may be exposed to HIV and hepatitis B;

(c) uphold universal precautions and other workplace policies and practices;

(d) be aware of their legal obligations regarding occupational health and safety;

(e) report any incidents where potential exposures to HIV and hepatitis B have occurred; and

(f) know where to refer employees for counselling and support when they have concerns about exposure.

11.41 Information and training programs for ***employees*** should enable them to:

(a) understand modes of transmission of HIV and hepatitis B;

(b) identify and anticipate situations where they may be exposed to HIV and hepatitis B;

(c) follow universal precautions and other workplace practices;

(d) use and handle equipment and personal protective equipment;

(e) be aware of their legal obligations regarding occupational health and safety; and

(f) report promptly and accurately to the identified person in the workplace any exposures to blood or body fluids.

PERSONAL PROTECTIVE EQUIPMENT

11.42 Employers should provide items to protect employees from exposures to blood or body fluids.

11.43 Employers should ensure that there are adequate supplies of items for personal protection and that employees have access to these items.

11.44 The following should be provided, ***as appropriate***:

(a) a variety of non-porous waterproof dressings for employees with chapped or broken skin;

(b) a variety of gloves in a range of sizes:

(i) sterile and non-sterile,

(ii) heavy latex or vinyl gloves, and

(iii) Waterproof leather and other puncture resistant gloves; and
(*See* Australian Standard *AS 4011 Examination Gloves for General Medical and Dental Use*[11]).

(c) masks for mouth-to-mask resuscitation.
(Standards Australia are revising AS 2488 entitled *Resuscitators Intended for Use with Humans* and preparing draft *Ancillary Devices for Expired Air Resuscitation*).

11.45 Gloves should be worn whenever employees are likely to come into contact with blood or body fluids or when handling anything contaminated with blood or body fluids.

11.46 In addition, the following items should also be available to employees who may be splashed or sprayed by blood in their work:

(a) plastic aprons;

(b) waterproof gowns;

(c) eye protection;

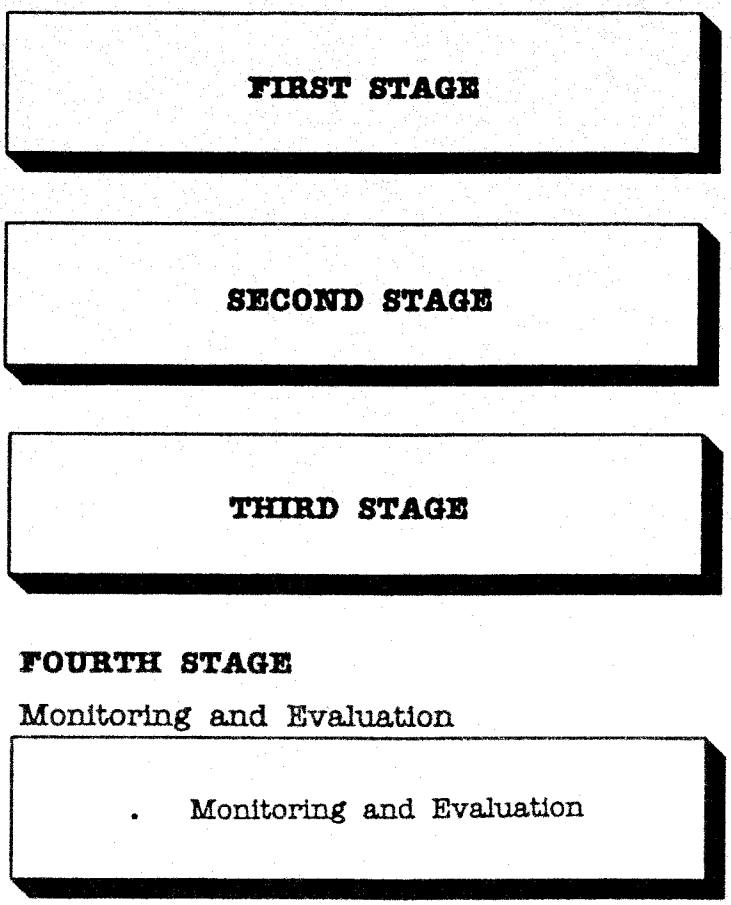
(d) fluid resistant masks;

(e) overalls; and

(f) overboots.

12. MONITORING AND EVALUATION

Figure 6 Monitoring and Evaluation



12.1 Employers should regularly monitor and evaluate work practices and ensure that action is taken to modify work practices when indicated. The following should be considered:

(a) effectiveness of workplace policies and procedures;

(b) level of compliance with universal precautions;

(c) effectiveness of information and training programs;

(d) causes of exposures to blood or body fluid;

(e) evaluation of incident debriefing; and

(f) effectiveness of post-exposure follow-up.

12.2 There should be an identified person, or group of people, in the workplace to carry out monitoring and evaluation. The identity of this person, or group of people, should be made known to all employees.

13. THE SAFE PROVISION OF FIRST AID IN THE WORKPLACE

13.1 All workplaces have the potential for accidents which require first aid treatment. Major activities in the delivery of first aid are the management of bleeding and expired air resuscitation. Both may involve exposure to blood or body fluids. (Standards Australia is preparing standards entitled *Resuscitators Intended for Use with Humans* and *Ancillary Devices for Expired Air Resuscitation.*)

13.2 A workplace first aid procedure should be based on universal precautions.

13.3 Most States and Territories have existing codes of practice and/or regulations relating to the practice of first aid. Employers should approach the relevant occupational health and safety authority for further information (***see*** Appendix 4 of this national code of practice).

14. MANAGEMENT OF EMPLOYEE EXPOSURES TO BLOOD OR BODY FLUIDS

See Appendix 2 of this national code of practice, ANCA Bulletin No. 16 *Management of Exposure to Blood/Body Fluids Contaminated with Blood, Including Needlestick/Sharps Injuries, with a Potential for HIV or Other Bloodborne Infections*[12], for further information about the assessment and treatment of employees accidentally exposed to blood or body fluids.

14.1 Employers should develop procedures for managing employee exposures to blood or body fluids. These procedures should be consistent with procedures for other workplace accidents and should utilise existing mechanisms for compensation, rehabilitation, retraining and long term follow-up of employees injured at work.

14.2 The employer should designate someone in the workplace who has received appropriate training to:

(a) conduct initial assessment and refer exposed employees; and

(b) be responsible for documentation and follow-up of all exposures.

See Appendix 4 of this national code of practice for contact details for Health Department HIV/AIDS Units which could provide information about appropriate training for workplace contacts.

14.3 The identity of this person should be made known to all employees.

IMMEDIATE ACTION

14.4 If an employee has an exposure to blood or body fluids, the following action should be taken:

(a) wash away the blood or body fluid with soap and water;

(b) if the eyes are contaminated, rinse eyes while open with tap water or saline; and

(c) if blood gets into the mouth, spit it out and then repeatedly rinse with water.

WHAT TO DO NEXT

14.5 After carrying out the appropriate first aid measures outlined above:

(a) The incident should be reported to the designated person in the workplace.

(b) The employee at risk should be referred immediately to a doctor who will assess the risk of transmission and discuss options for testing and treatment (***see*** Part C of Appendix 2 of this national code of practice for details about medical assessment). The employee should also have access to appropriate professional counselling.

RECORD KEEPING

14.6 A system for recording occupational exposures to blood or body fluids should be maintained.

14.7 Such a recording system should be designed in consultation with employees and/or their representatives. The system should:

(a) allow for the development and sharing of accumulating information between employers and employee representatives; and

(b) ensure confidentiality.

14.8 All exposures should be documented and reported to the relevant occupational health and safety authority. It is recommended that Australian Standard/Worksafe Australia *Workplace Injury and Disease Recording Standard*[13] be adapted to record exposures to blood or body fluids.

CONFIDENTIALITY

14.9 The confidentiality of all records of employees who have been exposed to blood or body fluids should be maintained.

14.10 Information that is released will be available to employers and employees in a form that is agreed to in prior consultation.

14.11 Procedures to manage breaches of confidentiality in the workplace should be established.

APPENDIX 1

DISCRIMINATION

A1.1 This appendix provides information about anti-discrimination legislation in relation to HIV, hepatitis B and other infectious blood-borne diseases in the workplace.

A1.2 Employers and employees may obtain further advice about the management of discrimination in the workplace from the relevant Commonwealth and State and Territory organisations listed in Appendix 4 of this national code of practice.

A1.3 Employers should take all reasonable steps to prevent discrimination and to prevent victimisation as a result of discrimination complaints. This should include:

(a) The development of policies and procedures to eliminate discrimination in the workplace. These policies and procedures should be made known to all employees.

(b) The development of information and training programs which address the issues of discrimination in the workplace, including employee attitudes.

(c) The establishment of an effective, confidential internal grievance handling mechanism to deal with complaints of discrimination.

A1.4 Most States and Territories in Australia [except Tasmania and the Northern Territory (legislation not yet proclaimed, June 1993)] have anti-discrimination or equal opportunity laws which make it illegal to discriminate in various areas of public life including employment (for example, recruitment, advancement and termination of employment), access to accommodation, and the provision of goods and services.

A1.5 The recently declared *Disability Discrimination Act 1992* (Cwlth) covers past, present, imputed and future impairments, including HIV and hepatitis B status. It applies to virtually every employer and service provider in each State and Territory.

A1.6 Discrimination can be direct or indirect. Direct discrimination involves treatment that is obviously unfair, less favourable or unequal. An example of direct discrimination is terminating the employment of someone because they have HIV or requiring patients who have HIV to wear identifying wrist bands. Indirect discrimination can occur if there are rules or requirements which apply to everyone, but which have the effect of disadvantaging one group. An example of indirect discrimination would be requiring all job applicants to be capable of donating blood. In this case, applicants who are HIV positive or have hepatitis B will be excluded because they will be unable to meet this requirement. This requirement will amount to indirect discrimination unless it is reasonable in all circumstances.

A1.7 Anti-discrimination laws state the 'grounds' on which it is unlawful to discriminate. Not all unfair treatment is covered by these laws. In relation to ***HIV, AIDS and hepatitis B***, anti-discrimination laws make it illegal to discriminate because of:

(a) **Physical impairment:** HIV infection, AIDS and hepatitis B are generally classified as physical impairments which are covered by anti-discrimination laws. Physical impairment is defined very broadly in the *Disability Discrimination Act 1992* (Cwlth). It makes it illegal to discriminate not only against a person who has HIV, AIDS or hepatitis B, but it is unlawful to discriminate against them if you think they have any of these conditions, they had any of these conditions in the past, or they are likely to acquire any of these conditions in the future.

(b) **A person's sexual preference:** For example, discrimination against someone because of their homosexuality, or assumed homosexuality, and therefore the assumption that they may have HIV infection or AIDS.

(c) **A person's race:** For example, if it is assumed that people from certain countries are likely to have HIV infection or AIDS.

APPENDIX 2

ANCA BULLETIN NO.16: MANAGEMENT OF EXPOSURE TO BLOOD/BODY FLUIDS CONTAMINATED WITH BLOOD, INCLUDING NEEDLESTICK/SHARPS INJURIES, WITH A POTENTIAL FOR HIV OR OTHER BLOODBORNE INFECTIONS[12]

This Bulletin describes the recommended course of action to be taken by all persons who are exposed to blood or body-fluids contaminated with blood.

Treatment for exposure to an HIV positive source should commence as soon as possible after the exposure.

Part A applies to the affected person.

Part B applies to the affected person's supervisor, manager and/or occupational health and safety officer.

Part C applies to medical practitioners and/or nurses providing care to the affected person.

DEFINITIONS

Affected person: the person exposed to blood or body fluid contaminated with blood.

Source individual: the person whose blood or body fluid was inoculated or splashed onto the affected person. The source individual may sometimes not be identifiable (for example, when an affected person has been injured by a needle/instrument and it is not known on whom it was used).

EXPOSURE

Exposure is contact with blood (or body fluids contaminated with blood). Exposure should be categorised in the following manner:

Doubtful Parenteral Exposure

(a) Intradermal ('superficial') injury with needle considered not to be contaminated with blood or body fluid.

(b) A superficial wound not associated with visible bleeding produced by an instrument considered not to be contaminated with blood or body fluid.

(c) Prior wound or skin lesion contaminated with body fluid other than blood and with no trace of blood.

(d) Mucous membrane surface contact with body fluid other than blood.

Non-Parenteral Exposure

(a) Intact skin visibly contaminated with blood or body fluid.

The following exposures should be taken seriously and appropriate care and follow up provided.

Massive Exposure

(a) Transfusion of blood.

(b) Injection of large volume of blood/body fluids (> 1 ml).

(c) Parenteral exposure to laboratory specimens containing high titer of virus.

Definite Parenteral Exposure

(a) Intramuscular penetrating injury with a needle contaminated with blood or body fluid.

(b) Injection of blood or body fluid not included under 'Massive Exposure'.

(c) Laceration or similar wound which causes bleeding and is produced by an instrument that is visibly contaminated with blood or body fluid.

(d) Any direct inoculation with HIV/HBV not included above—this refers to accidents in research settings.

Possible Parenteral Exposure

(a) Intradermal ('superficial') injury with a needle contaminated with blood or body fluid.

(b) A wound not associated with visible bleeding produced by an instrument contaminated with blood or body fluid.

(c) Prior (not fresh) wound or skin lesion contaminated with blood or body fluid.

(d) Mucous membrane surface contact with blood.

If everyone involved follows the guidelines below, the risk of serious illness can be reduced.

PART A—INFORMATION FOR THE AFFECTED PERSON

At once:

(a) if skin is penetrated, wash the area well with soap and/or water (alcohol-based hand rinses/foams [60-90% alcohol by weight] should be used when water is not available);

(b) if blood gets on the skin, irrespective of whether there are cuts or abrasions, wash well with soap and/or water;

(c) if the eyes are contaminated, rinse the area gently but thoroughly with water or normal saline, while the eyes are open; or

(d) if blood gets in the mouth, spit it out and then rinse the mouth with water several times.

Then report immediately to your supervisor or occupational health officer. Complete an accident report form and include:

(a) date and time of exposure;

(b) how the incident occurred; and

(c) name of the source individual (if known).

Incidents which did not occur at work should be reported to your doctor or the Accident and Emergency (Casualty) Department at the nearest hospital.

If a needle/syringe was involved, place it in a rigid-walled container such as a lunch box. Take it with you to your doctor. Do not attempt to cover the needle because you run the risk of further injury.

In the event of an exposure to an individual who has been previously tested and confirmed as HIV positive or Hepatitis positive, the exposure should immediately be evaluated by a physician with experience in the management of these infections, at a teaching hospital or STD clinic.

PART B—INFORMATION TO SUPERVISORS, MANAGERS AND OCCUPATIONAL HEALTH AND SAFETY OFFICERS

If an employee has suffered a possible parenteral, definite parenteral or massive exposure (***see*** the definitions above), it is important that you make sure that immediate steps are taken to reduce the risk to the employee of contracting a serious illness:

(a) Ensure that the exposed area has been washed thoroughly.

(b) Arrange for blood to be taken from the employee (***see*** Part C).

(c) Find out whether a known source individual is involved in the incident and if so:

(i) contact a medical officer to organise for blood to be taken from the source individual after obtaining consent to be tested for:

- HIV antibody,
- Hepatitis B surface antigen (HBsAg), and
- Hepatitis C antibody (Anti-HCV).

Blood samples should be collected as soon as possible after the incident and processed urgently. ***Remember:*** informed consent is required. The following steps must be taken:

(a) When the **source individual is known to be positive for either HIV antibody, HBsAg or anti-HCV** ensure that a physician with experience in the management of these infections (for example, from a major teaching hospital or STD clinic) has been contacted.

(b) Ask the employee to complete an incident report form.

(c) Check to see that it is correctly filled out.

(d) Make sure that the form includes:

(i) the date and time of the incident,

(ii) how the incident happened, and

(iii) whether the affected person had been stabbed by a syringe or other sharp or had been splashed.

(e) Process urgently.

(f) Arrange for the employee to visit the Occupational Health Department, the Accident and Emergency (Casualty) Department or their own doctor for the treatment outlined in this document as quickly as possible.

(g) Reassure the employee that only a small proportion of accidental exposures to blood result in infection.

'The risk of infection with HIV following one needlestick exposure to blood from a patient known to be infected with HIV is approximately 0.3%. [*Annals of Internal Medicine* 1992, vol. 116, pp. 871-72.] This rate of transmission is considerably lower than that for HBV' (hepatitis B).

(a) If necessary, further information, support and counselling can be arranged with Occupational Health Nurses, Infection Control Nurses, Infectious Diseases Physicians or HIV Liaison Officers at teaching hospitals or STD clinics.

(b) All health care establishments should develop their own infection control guidelines for communicable diseases including HIV infection. This should include clear instructions on the appropriate course of action in the event of an incident involving an HIV positive individual, that is:

  (i) the physician to be contacted,

  (ii) the laboratory which will process emergency specimens, and

  (iii) the pharmacy which stocks prophylactic medication (for example, Zidovudine—ZDV).

Please Note: It is most important that confidentiality of employee/source individual records be maintained.

Ideally, persons nominated to provide support to affected persons should have an appropriate knowledge base of factors concerning transmission of HIV/HBV, and have counselling expertise. Where this is not possible (for example, rural/remote areas) then a person with appropriate knowledge of disease transmission should be used.

PART C—PROTOCOL FOR THE MEDICAL PRACTITIONER TREATING THE EXPOSURE

The source individual may be infected with HIV, hepatitis B (HBV) or hepatitis C (HCV). Informed consent should be obtained from the source individual for the following investigations:

(a) HIV antibody;

(b) Hepatitis B surface antigen (HBsAg); and/or

(c) Hepatitis C antibody (Anti-HCV).

The affected person should be counselled regarding the possibility of transmission of bloodborne disease. The results of the source individual tests will determine the relevant testing of the affected person, that is, there is no basis for performing tests on the affected person if the source individual is negative for hepatitis B, C and HIV.

If the source individual is positive for any of these infections or the source is unknown, proceed as outlined below.

N.B. Informed consent should be obtained from the affected person prior to tests being undertaken.

MANAGEMENT OF THE AFFECTED PERSON

If the source individual is HIV positive:

(a) The exposure should be IMMEDIATELY evaluated by a physician with experience in the management of HIV infection—at an STD clinic or teaching hospital.

(b) Baseline testing for HIV antibody should be undertaken.

(c) Post-exposure prophylaxis with Zidovudine (ZDV), also known as Azidothymidine (AZT) (or other drugs which may become available for this purpose), may be offered to the affected person when the risk of transmission is considered to be significant.

(i) Zidovudine should not be recommended to pregnant women as it is still regarded as an experimental drug for prophylaxis of HIV infection.

(ii) Prophylaxis should be commenced only after counselling the affected person, informing them of the absence of data regarding the efficacy, toxicity and safety of Zidovudine for this purpose.

(iii) Prophylactic Zidovudine should be at no cost to the affected person.

(iv) Treatment should begin as soon as possible after the exposure (preferably within two hours).

(v) Suggested dose of Zidovudine—200 mg orally five times per day or 250 mg q.i.d. for six weeks.

(vi) Doctors should stress to the affected person the importance of strict compliance with the treatment regimen, describe the potential side-effects and the appropriate course of action if these are experienced.

(vii) State and Territory Health Authorities should widely publicise details on obtaining access to Zidovudine in remote and rural areas.

(d) The affected person should be advised to report any febrile illness that occurs within three months after exposure. Such an illness—particularly one characterised by fever, rash or lymphadenopathy—may indicate primary infection with HIV.

(e) The affected person who is initially seronegative should be retested for HIV antibody at:

(i) six weeks, and

(ii) three, six and twelve months after exposure;

(f) The affected person should be offered counselling, and informed about the risk of transmission, especially during the first 6-12 weeks by which time most infected persons are expected to have developed HIV antibody. Specialised care is required at the early stages after exposure and early testing for p24 Antigen and antibody may be useful. During the period of surveillance:

(i) **do not donate** plasma or blood, body tissue, milk or sperm until approved by the evaluating physician,

(ii) **protect sexual partners** from contact with blood, semen or vaginal fluids by using condoms, and

(iii) **avoid pregnancy** until HIV status is known.

If the source individual is seronegative but at high risk to HIV infection:

(a) This refers to rare situations where it is suspected that the source individual is in the 'window' period of HIV infection. In these situations the source individual should be followed for up to three months to ascertain whether they develop HIV antibodies.

(b) The affected person should have baseline testing for HIV antibody and may be tested for HIV antibody at three, six and twelve months in the event that the source is identified as HIV positive.

(c) If necessary, further information, support and counselling should be arranged.

If the source individual is seronegative and has no identified risk of HIV infection:

(a) The affected person requires no further follow-up for HIV. Refer to ***OTHER POTENTIAL BLOODBORNE PATHOGENS*** in this Bulletin.

If the source is unknown:

(a) Appropriate follow-up should be determined on an individual basis depending on:

(i) type of exposure; (refer to definitions),

(ii) likelihood of source being HIV positive, and

(iii) community prevalence of HIV.

OTHER POTENTIAL BLOODBORNE PATHOGENS

If the source individual is positive for hepatitis B surface antigen (HBsAg) or where the source is unknown:

The affected person should be investigated to determine the nature of protection that should be provided. The approach to investigation is modified according to whether or not the affected person has received a course of hepatitis B vaccine.

(a) If the affected person **has been vaccinated:**

(i) take blood for estimation of hepatitis B surface antibody to confirm that vaccine immunity is being maintained. Antibody titres may fall below protective levels some years after vaccination. (non-protective levels < 10 IU/ml)

(b) If the affected person **has not previously been vaccinated for hepatitis B:**

(i) take blood for estimation of hepatitis B core antibody (Anti HBc), hepatitis B surface antibody (Anti-HBs) or other test such as HBs Ag that is available in your local laboratory to determine previous infection.

These tests will indicate whether the affected person has previously been infected with hepatitis B. If the affected person has previously been infected, then no further action is required.

(a) Where the affected person has not been infected with hepatitis B and is negative for hepatitis B surface antibody or has levels which are non-protective (< 10 IU/ml), hepatitis B immunoglobulin (HBIG) should be given within 48 hours of injury when:

(i) the source individual is hepatitis B surface antigen positive.

(ii) the source individual is unknown;

(iii) the results of tests on the source individual and/or affected person are unavailable within 48 hours;

Persons eligible for hepatitis B vaccination should commence a vaccination course at the same time. Three vaccinations at zero, one, and six months are required.

(a) When the affected person is immune (hepatitis B surface antibody positive), consider booster vaccination if previous course was completed > 5 years ago.

If the source individual is positive for hepatitis C antibody (Anti-HCV):

(a) Test the affected person for Anti-HCV at zero and nine months. Follow up should be undertaken by a specialist with knowledge of hepatitis C infection.

If the source is unknown:

(a) Appropriate follow-up should also determine the risk of tetanus. Depending on the circumstance of the exposure, the following may need to be considered.

- **(i)** tetanus immunoglobulin;
- **(ii)** a course of ADT; or
- **(iii)** ADT booster.

REFERENCES

1. *Exposure of Health Care Workers to HIV*, San Fransisco General Hospital, 1991.
2. *Management of Health Care Workers or Others Exposed to Blood from a Person Infected or Suspected to be Infected with the Human Immunodeficiency Virus*, Australian National Council on AIDS Bulletin No. 2, January 1990.
3. *Guidelines for the Control of Infectious Disease Hazards in Health Care Establishments*, National Health and Medical Research Council, 1988.
4. *Instructions to All Persons Involved in Accidental Exposure to Blood or Body Fluids*, Flinders Medical Centre, December 1990.
5. *Protocol for Needlestick Injuries and Mucous Membrane Exposure to Blood*, Westmead and Parramatta Hospitals and Community Health Services, August 1990.
6. *Protocol for Management of Staff Biohazard Injuries*, Royal Darwin Hospital, 1990.
7. *Protection Against Viral Hepatitis: Recommendations of the Immunization Practices Advisory Committee (ACIP)*, MMWR 1990:39 (No. RR-2pp 5-11). Centres for Disease Control.
8. 'Risk for Occupational Transmission of Human Immunodeficiency Virus type 1 (HIV-1) Associated with Clinical Exposures—A Prospective Evaluation, *Annals of Internal Medicine*, 1990; vol. 113, pp. 740-46.

ANCA gratefully acknowledges the assistance given by staff from Flinders Medical Centre in producing these guidelines.

Enquiries regarding this Bulletin to Secretariat, Australian National Council on AIDS, GPO Box 9848, CANBERRA ACT 2601. Telephone (06) 289 7767.

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APPENDIX 3

HIV AND HEPATITIS B INFECTED EMPLOYEES

A3.1 This appendix provides an outline of the current policy of the Intergovernmental Committee on AIDS, as endorsed by the Australian Health Ministers Conference in April 1992, on HIV infected health care workers. These principles would apply to any other infectious blood-borne disease. The Health Ministers agreed that State and Territory governments should develop their own polices regarding infected health care workers. (***See*** Appendix 4 of this national code of practice for contact details for Health Department HIV/AIDS Units.)

A3.2 The following general principles were endorsed by the Intergovernmental Committee on AIDS:

(a) Adherence to proper infection control procedures is the most important step in reducing the risk of HIV transmission from health care workers to patients.

(b) A nationally consistent approach to HIV positive health care workers is desirable.

(c) Mandatory testing is not an appropriate response to the issue of infected health care workers.

(d) Mandatory reporting of a health care worker's status to their employer, registration board or like authority is not supported but should be consistent with the reporting requirements for illnesses and impairments likely to affect professional practice.

(e) Development of State and Territory policy guidelines for infected health care workers should take into account the relevant preferred options outlined in the IGCA Legal Discussion Papers on *Legislative Approaches to Public Health Control* and *Employment Law* and *HIV/AIDS and Civil Liability for Transmission of HIV/AIDS*.[14]

APPENDIX 4

SOURCES OF INFORMATION

OCCUPATIONAL HEALTH AND SAFETY

National	
National Occupational Health and Safety Commission	(02) 565 9555
Comcare Australia	(06) 275 0669
New South Wales	
Prevention Programs Branch WorkCover Authority	(02) 289 9511
Victoria	
Victorian Occupational Health and Safety Authority	(03) 628 8188
Queensland	
Department of Employment, Vocational Education, Training and Industrial Relations	(008) 17 7717
South Australia	
South Australian Occupational Health and Safety Commission	(08) 226 3120
Western Australia	
Department of Occupational Health, Safety and Welfare	(09) 327 8777
Tasmania	
Tasmania — Development and Resources	(002) 33 8333
Northern Territory	
Work Health Authority	(089) 89 5042
Australian Capital Territory	
Occupational Health and Safety Unit Industrial Relations Branch Chief Ministers Department	(06) 205 0338
Australian Capital Territory Occupational Health and Safety Office	(06) 205 0200

INFECTION CONTROL

EACH MAJOR TEACHING HOSPITAL WILL HAVE AN INFECTION CONTROL PRACTITIONER WHO CAN BE CONTACTED FOR INFORMATION AND ADVICE.

HEALTH DEPARTMENT HIV/AIDS UNITS (LISTED BELOW) CAN ALSO PROVIDE INFORMATION ABOUT INFECTION CONTROL

HEALTH DEPARTMENT HIV/AIDS UNITS — INFECTION CONTROL ADVICE, INFORMATION ABOUT TRAINING, COUNSELLING AND OTHER SERVICES

National

AIDS/Communicable Diseases Unit
Commonwealth Department of Health, Housing, Local Government and Community Services — (06) 298 8389

New South Wales

AIDS Bureau
New South Wales Department of Health — (02) 391 9234

Victoria

AIDS and STD Unit
Health Department — (03) 616 7333

Queensland

HIV/AIDS and Sexual Health Section
Queensland Department of Health — (07) 234 1296

South Australia

HIV/AIDS Programs Unit
South Australian Health Commission
(Education and Training) — (08) 226 6604

Western Australia

Disease Control Branch
Department of Health — (09) 222 2107

Tasmania

AIDS Unit
Health Department — (002) 30 2872

Northern Territory

Communicable Diseases Centre — (089) 22 8007

Australian Capital Territory

AIDS and STD Reference Centre — (06) 244 2184

TESTING

ALSO SEE LISTINGS OF SEXUAL HEALTH CLINICS IN THE LOCAL PHONE BOOK

New South Wales

Albion Street (AIDS) Centre	(02) 332 4000
Sydney Sexual Health Centre	(02) 223 7066

Victoria

Melbourne Sexual Health Centre	(03) 347 0244

Queensland

AIDS Medical Unit	(07) 224 5526

South Australia

Clinic 275	(08) 226 6025

Western Australia

Sexually Transmissible Disease Control Murray Street Clinics	(09) 220 1122

Tasmania

STD Clinic, Royal Hobart Hospital	(002) 388 308

Northern Territory

Nightcliff Community Health Centre (counselling, information and screening)	(089) 85 3044

Australian Capital Territory

AIDS Clinic	(06) 284 2200

DISCRIMINATION

National

Human Rights and Equal Opportunity Commission	(02) 229 7600
Privacy Hotline	(008) 023 985

New South Wales

Anti-Discrimination Board of New South Wales	(02) 318 5400

Victoria

Commissioner for Equal Opportunity	(03) 602 3222

Queensland

Regional Office, Human Rights and Equal Opportunity Commission	(07) 844 6099

South Australia

The Commissioner for Equal Opportunity	(08) 226 5660

Western Australia

The Commissioner for Equal Opportunity	(09) 222 8999

Tasmania

Regional Office, Human Rights and Equal Opportunity Commission	(002) 23 8511

Northern Territory

Regional Office, Human Rights and Equal Opportunity Commission	(089) 81 9111

AIDS COUNCILS—DISCRIMINATION, INFORMATION, HIV/AIDS SERVICES

National

Australian Federation of AIDS Organisations	(06) 247 3411

New South Wales

New South Wales AIDS Council and Australian Federation of AIDS Organisations Legal Project	(02) 206 2000

Victoria

Victorian AIDS Council	(03) 417 1759

Queensland

Queensland AIDS Council	(07) 844 1990

South Australia

South Australian AIDS Council	(08) 362 1611 (008) 888 559

Western Australia

Western Australian AIDS Council	(09) 227 8355

Tasmania

Tasmanian AIDS Council	(002) 31 1930

Northern Territory

Northern Territory AIDS Council	(089) 41 1711

Australian Capital Territory

AIDS Action Council of the Australian Capital Territory	(06) 257 2855

HIV/AIDS TELEPHONE INFORMATION

New South Wales

AIDS Information Hotline	(02) 332 4000

Victoria

AIDS Line	(03) 419 3166 (008) 133 392

Queensland

AIDS Information Line	(07) 224 5526

South Australia

Family Planning Sexual Health Hotline	(08) 364 0444 (008) 18 8171

Western Australia

AIDS Information Line	(09) 220 1122

Tasmania

AIDS Counselling	(008) 00 5900

Northern Territory

AIDS Recorded Information Line	(089) 41 0024

Australian Capital Territory

AIDS Line	(06) 244 2184

REFERENCED DOCUMENTS

1. National Centre in HIV Epidemiology and Clinical Research, communication with Worksafe Australia, 18 March 1993.

2. United States Centre for Disease Control (CDC) HIV/AIDS Prevention, *Facts About HIV/AIDS and Health-Care Workers*, Atlanta.

3. United States Centre for Disease Control, 'Guidelines for the Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health Care and Public-Safety Workers', *Morbidity and Mortality Weekly Review*, vol. 38, No. S-6, June 23, Atlanta, 1989.

4. Hu, D. J., Kane, M. A. and Heymann, D. L., 'Transmission of HIV, Hepatitis B Virus, and Other Bloodborne Pathogens in Heath Care Settings: a Review of Risk Factors and Guidelines for Prevention', *Bulletin of the World Health Organization*, vol. 69(5), pp. 623-30, Geneva, 1991.

5. National Health and Medical Research Council, *Guidelines for the Control of Infectious Disease Hazards in Health Care Establishments*, Canberra, (due for release in late 1993).

6. Intergovernmental Committee on AIDS:

   Discussion Paper—Civil Liability for Transmission of HIV/AIDS, Australian Government Publishing Service, Canberra, 1992.

   Discussion Paper—Employment Law and HIV/AIDS, Australian Government Publishing Service, Canberra, 1991.

   Discussion Paper—Legislative Approaches to Public Health Control of HIV-Infection, Australian Government Publishing Service, Canberra, 1991.

7. Australian National Council on AIDS, *Bulletin No. 7 Infection Control Guidelines—AIDS and Related Conditions*, Canberra, 1990.

8. Australian Federation of AIDS Organisations, *Safe Sex Guidelines 1991*.

9. National Health and Medical Research Council, *Immunisation Procedures*, 4th Edition, Australian Government Publishing Service, Canberra, 1991.

10. Standards Australia, Australian Standard AS 4031 *Non-Reusable Containers for the Collection of Sharp Items Used in Health Care Areas*, Australian Standards, Melbourne.

11. Standards Australia, Australian Standard AS 4011 *Examination Gloves for General Medical and Dental Use*, Standards Australia, Melbourne.

12. Australian National Council on AIDS, *Bulletin No.16 Management of Exposure to Blood/Body Fluids Contaminated with Blood, Including Needlestick/Sharps Injuries, with a Potential for HIV or Other Bloodborne Infections*, Canberra, 1993.

13. Standards Australia, in conjunction with Worksafe Australia, National Standard, AS 1885.1 - 1990 *Workplace Injury and Disease Recording Standard* [NOHSC:1002(1990)], Standards Australia, 1990.

14. *Intergovernmental Committee on AIDS (IGCA) Endorsed General Principles Regarding HIV Positive Health Care Workers*, Intergovernmental Committee on AIDS, Canberra, 1992.

FURTHER READING

Anti-Discrimination Board of NSW, *HIV & AIDS Removing Discrimination from the Workplace—A Comprehensive Kit for Managers, Trainers and Employees,* Anti-Discrimination Board of NSW, Sydney, 1991.

AIDS Bureau, New South Wales Department of Health:

NSW Infection Control Policy for HIV, AIDS and Associated Conditions, New South Wales Department of Health, Sydney, 1992.

AIDS and HIV Infection Statement No. 1 Protocol for Autopsies of HIV Infected Bodies, Sydney, 1989.

AIDS Task Force *HIV Infection and Autopsies: Report of the Working Party,* Canberra, 1988.

AIDS Taskforce Working Party, *HIV Infection and Autopsies,* Report of an AIDS Taskforce Working Party, 27 January, 1988.

Australian Council of Trade Unions, *Healthy Working and AIDS — An ACTU Industry Unions Education Program about HIV and AIDS for all Health Industry Workers*, Australian Council of Trade Unions, Melbourne, 1991.

Australian Federal Police, *Infection Control Guidelines for Communicable Diseases*, Australian Federal Police, Canberra, 1990.

Australian National Council on AIDS:

Bulletin No. 1 *AIDS Facts about Acquired Immune Deficiency Syndrome*, Canberra, 1990.

Bulletin No. 2 *Management of Health Care Workers and Others Exposed to Blood from a Person Infected or Suspected to be Infected With Human Immunodeficiency Virus*, Canberra, 1990.

Bulletin No. 3 *Laboratory Guidelines that take Account of HIV and Other Blood Borne Agents*, Canberra, 1990.

Bulletin No. 4 *HIV and Blood Transfusion and Administration of Blood Products,* Canberra, 1990.

Bulletin No. 5 *HIV Infection and Bone Grafting*, Canberra, 1990.

Bulletin No. 6 *Hydrotherapy Pools and their Use by HIV/AIDS Patients*, Canberra, 1990.

Bulletin No. 8 *being updated.*

Bulletin No. 9 *Infection Control Recommendations for Skin Piercing Procedures Such as Acupuncture, Hair Electrolysis, Ear Piercing, and Tattooing*, Canberra, 1991.

Bulletin No. 10 *Disinfection in Hairdressing Salons/Barbers Shops to Prevent the Transmission of HIV and Other Blood Borne Agents*, Canberra, 1991.

Bulletin No. 11 *Condoms*, Canberra, 1991.

Bulletin No. 12 *Pain Management in People with HIV/AIDS*, Canberra, 1991.

Bulletin No. 13 *Pain Management in Injecting Drug Users with HIV/AIDS*, Canberra, 1991.

Bulletin No. 14 *Contact Tracing in HIV Infection*, Canberra, 1992.

Bulletin No. 15 *Infection Control Precautions in First Aid and Resuscitation*, Canberra, 1992.

Australasian College of Occupational Medicine, *Ethical Guidelines for Occupational Physicians*, Australasian College of Occupational Medicine, Melbourne, 1987.

Brown, K. C. and Turner, J. G., *AIDS: Policies and Programs for the Workplace*, Van Nostrand Reinhold, New York, 1989.

Commonwealth AIDS Research Grant Committee, *Attitudes, Knowledge and Behaviour of General Practitioners in Relation to HIV Infection.*

Federal Government, Australia, *National HIV/AIDS Strategy*, Australian Government Publishing Service, Canberra, 1989.

Health Department of Western Australia, *Exposure of Health Care Workers to HIV*, Health Department of Western Australia, Perth, 1991.

Health Services Advisory Committee, *Safety in Health Services Laboratories—Safe Working and the Prevention of Infection in the Mortuary and Post-Mortem Room*, The Health and Safety Executive Library and Information Services, London, 1991.

Hunt, L., Waddell, C., Robathan, G., 'AIDS Attitudes and Education' *Australian Journal of Advanced Nursing*, vol. 7, No. 3, March, 1990.

Intergovernmental Committee on AIDS, *Discussion Paper—HIV/AIDS and Anti-discrimination Legislation*, Australian Government Publishing Service, Canberra, 1991.

United States Centre for Disease Control, 'Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers', *Morbidity and Mortality Weekly Review*, vol. 38, No. S-6, June 23, Centre for Disease Control, Atlanta, 1989.

National Health and Medical Research Council:

Guidelines for the Prevention of Transmission of Viral Infection in Dentistry, to be published later in 1992.

National Occupational Health and Safety Commission:

National Consensus Statement on AIDS and the Workplace [NOHSC:6001(1988)], Australian Government Publishing Service, Canberra, 1988.

Hazard Alert—Glutaraldehyde: Use in the Health and Associated Industries [NOHSC:9001(1991)], Worksafe Australia, Sydney, 1991.

New South Wales Department of Corrective Services, *Communicable Diseases in Prison—Procedures/Management Polices*, New South Wales Department of Corrective Services, Sydney, 1992.

New South Wales Department of Health:

NSW Infection Control Policy for HIV, AIDS and Associated Conditions, New South Wales Department of Health, Sydney, 1992.

'Foundations and Principles of HIV/AIDS Education', *AIDS and HIV Infection Statement No. 3*, New South Wales Department of Health, Sydney, 1989.

Occupational Health, Safety and Welfare Commission of Western Australia, *Hepatitis B and HIV/AIDS in the Workplace,* Perth, 1991.

Rutala, W., 'APIC Guidelines for Selection for the Use of Disinfectants', *American Journal of Infection Control*, vol. 18, No. 2, April 1990.

South Australia Department of Correctional Services, *Communicable Diseases Policy and Procedure Manual,* South Australia Department of Correctional Services, Adelaide, 1992.

South Australian Health Commission, *Guidelines for Infection Control in Health Care Establishments*, No. 1, Dated 24 April, South Australian Health Commission, Adelaide, 1992.

Standards Association of Australia:

Standard No. 91102, *Guide to Cleaning Disinfection and Sterilising of Medical and Surgical Instruments and Equipment, and Premises in Health Care Facilities*, due for release mid 1993.

The New South Wales Health Care Cleaning Services Managers' Association, *Code of Disinfection Practice*, The NSW Health Care Cleaning Services Managers' Association, Sydney, 1991.

Tillett, G., *AIDS and the Workplace*, CCH Australia Limited, Sydney, 1989.

Tomnay, Jane, *HIV/AIDS Education Project — Project Report and Evaluation Comments*, Victoria Police, Melbourne, 1992.

Victorian Office of Corrections, *Sample Personnel Policy—Management of Communicable Diseases at the Workplace*, Victorian Office of Corrections, Melbourne, 1991.

Western Australia Department of Corrective Services:

HIV Positive/AIDS Policy, Western Australia Department of Corrective Services, Perth, 1990.

AIDS Your Information Kit, Western Australia Department of Corrective Services, Perth, 1989.

Western Australia Police Department, *Infection Prevention Procedures* (pamphlet), Western Australia Police Department, Perth, 1991.

World Health Organization:

'WHO/ILO Consultation Issues Statement on AIDS in the Workplace', Press Release WHO/24 5 July 1988, *Bulletin of the International Union Against Tuberculosis and Lung Disease*, vol. 63, No. 3, Geneva, September, 1988.

'Biosafety Guidelines for Diagnostic and Research Laboratories Working with HIV', *WHO AIDS Series 9*, World Health Organization, Geneva, 1991.

'Guidelines for Nursing Management of People Infected with Human Immunodeficiency Virus (HIV)', *WHO AIDS Series 3*, World Health Organization, Geneva, 1988.

'Guidelines on AIDS and First Aid in the Workplace', *WHO AIDS Series 7*, World Health Organization, Geneva, 1990.

'Guidelines on Sterilization and Disinfection Methods Effective against Human Immunodeficiency Virus (HIV)', *WHO AIDS Series 2*, 2nd Edition, World Health Organization, Geneva, 1989.

Report of a WHO Consultation on the Prevention of Human Immunodeficiency Virus and Hepatitis B Virus Transmission in the Health Care Setting, World Health Organization, Geneva, 1991.