School of Medicine

First year medicine
Health advisory booklet for students
2007
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Introduction

This booklet is important for all students who will have contact with patients. Included with this book is your personal immunisation record that should be copied and kept up to date.

There are two general concerns about infectious diseases in health care establishments:
1. that you do not inadvertently acquire infections from patients
2. that you do not transmit infections to your patients.

The attached infection control policies indicate the proper procedures to be followed to minimise inadvertent infection. You have a responsibility for your own health and to the health of others by following the guidelines. We specifically draw your attention to the risks of blood borne viruses (Hepatitis B & C and HIV) and keeping yourself fully informed about infection risks if you travel overseas on electives/or holidays.

When working in a hospital, you will be at increased risk of exposure to some infectious agents against which you should be vaccinated. You may also transmit infectious agents during the incubation period of the diseases that can be very serious in specific patient groups (e.g. chicken pox and rubella in immunosuppressed or non-immune pregnant patients). Refer to the Immunisation and Blood Borne Viruses Policy and Flowchart in this booklet to ensure you comply with the requirements of the School of Medicine.

Before enrolment, a student should seek medical advice to determine the student’s immunity to common infections (including measles, mumps, rubella, hepatitis B, diphtheria, tetanus and poliomyelitis). Students are required to obtain appropriate immunisation where effective programs are available, prior to the commencement of hospital-based clinical training in Year1, Semester 2.

Should you have any queries on these policy matters please speak directly to Associate Professor Michael Yelland (07 3382 1358).
THE AUSTRALIAN STANDARD VACCINATION SCHEDULE


Students need to check which of the vaccines in the Australian Standard Vaccination Schedule they have already received:

Diphtheria and Tetanus: The recommended schedule comprises immunisation at 2, 4 and 6 months of age, with boosters at 4 and 15 years. Thereafter, boosting is no longer routinely recommended unless a high risk injury occurs, until the age of 50 when a further booster is given.

Poliomyelitis: The recommended schedule comprises immunisation with inactivated polio vaccine (IPV) at 2, 4 & 6 months of age with a booster at 4 years. A single reinforcing dose, every 10 years, is indicated ONLY for travel to endemic areas.

Measles, Mumps & Rubella: The recommended schedule for measles, mumps and rubella comprises immunisation with MMR at 12 months, and at 4 years. MMR is also recommended for adults born since 1966 who have not received two doses of vaccine in the past.

Hepatitis B: This was only added into the routine childhood schedule in 2000 and therefore few adults will have received immunisation.

Varicella Zoster Virus (chickenpox): Students with a reliable past history of chickenpox can be considered immune. If there is no history of chickenpox, serological status should be determined and, if seronegative, vaccination given (2 doses 1-2 months apart).

Pertussis: A single booster dose (given as dTpa) is recommended prior to paediatric or obstetric terms.

Influenza: Yearly vaccination is recommended for all students with patient contact.

Tuberculosis: BCG is not generally recommended but Mantoux status should be determined.

In addition to the vaccines listed above, students may require other vaccinations e.g. Hepatitis A. Please use the guidelines on page 6 to determine which vaccines you will require.

How to obtain information on your immunisation status

Your parents or general practitioner may have the relevant information on file. Alternatively, local government immunisation clinics may have it, but you would need to know where you were vaccinated in order to get the information.
STUDENT'S ACTION LIST

- Read, understand and adopt the recommended practices concerning infection control (see following pages).
- Sign and date the students’ agreement to comply with the Immunisation and Blood-Borne Viruses Policy form (Form A). This is a requirement prior to commencement of clinical studies.
- Review your immunisation status and bring records of previous immunisations or blood tests as outlined in the “immunisation and blood borne viruses flow chart” (page 8) to your healthcare appointment. You can make an appointment with the University’s Health Service (phone 07 55528794) - located on the Gold Coast campus.
- You will need to provide the health care provider with a copy of the “Healthcare Providers’ form -confirmation of student’s compliance with “Immunisation and Blood-Borne Viruses Policy” (Form B).
- Mantoux testing will be incorporated into the first semester of the first year program and BCG vaccination can be arranged subsequently if appropriate.
- If you are exposed to infections against which you are unlikely to be immune or plan to work amongst patients who might be particularly susceptible to infection, you can seek advice from the Clinical Skills Coordinator about a referral to an Infectious Disease Consultant.

Work related accident (e.g. needle stick injury)

Should you have, in the course of your studies, a work-related accident with risk of infection (e.g. needle stick injury) it is necessary to report it immediately, either to Occupational Health Services at the Hospital you are in, or, after hours, to the Emergency Department. A procedure for follow-up of blood or body fluid exposure is included in this manual as a general guide.
IMMUNISATION AND BLOOD-BORNE VIRUSES POLICY

Aim
To minimise the risk of medical students contracting or spreading an infectious or blood-borne disease.

Standard
The Policy has been devised in accordance with the Guidelines established by the former Committee of Deans of Australian Medical Schools (now Medical Deans Australia and New Zealand).

Immunisation
Immunisation of medical students should be in accordance with the standard recommendations of the National Health and Medical Research Council as documented in the Australian Immunisation Handbook 8th edition 2003 which can be accessed at http://www.immunise.health.gov.au. In addition to these standard recommendations, students should be immunised (if not already immune) against infectious diseases that they are likely to be exposed to during clinical training and later in medical practice, including hepatitis B and varicella. A flow chart to guide students on any tests or vaccines they may require is included below.

Process
Students are expected to attend a health care provider with expertise in infectious diseases prior to and/or during the first semester of Year 1 of medical school for assessment, counselling and immunisation as necessary. Appointments can be made with health care providers at the Griffith University Health Service (Gold Coast - Ph 07 55528794). At this appointment, previous infection with or immunity to a number of infections will be assessed. It is recommended you complete the flowchart prior to your appointment and bring it and any records of blood tests or immunisations with you when you attend.

Confidentiality
All students will be assessed by the immunisation service with absolute confidentiality. The Dean will be notified of a student’s compliance with this Policy but will not be advised of individual results.

Compliance
Students are required to sign a statement indicating that they have read and agree to comply with the Policy at the time of enrolment (Form A). The statement and must be signed and submitted in the first week of term. Students will also need to provide documentation of compliance with this Policy, signed by their health care provider prior to commencement of hospital-based clinical training in Semester 2 of Year 1 (Form B). Both forms are included at the end of this booklet. Students who do not feel that they can comply with the Policy are required to discuss their objections with a nominated representative of the Dean.

Electives
Students are required to seek pre-travel advice before undertaking overseas medical electives where special precautions may be necessary.

Discrimination
No student will be discriminated against or prevented from qualifying for the award of the degrees of Bachelor of Medicine and Bachelor of Surgery as a result of not complying with this Policy. However, the University will not place either students or patients at risk because of non-compliance with this request.
**Infection control**
Students are expected to understand and practice appropriate infection control measures during all clinical experiences. Infection control information and policies are attached.

**Occupational health and safety**
All medical students should have access to medical advice, either in the teaching hospitals to which they are assigned or through an occupational health and safety service. Guidelines for the management of exposure to blood or body fluids are attached.

**Blood-borne viruses**
Students have a responsibility to be aware of their status in relation to blood-borne viruses including HIV, hepatitis B and hepatitis C prior to commencing the medical course. Students who engage in at risk behaviour or suspect that they may have been infected with a blood borne virus at any time during the course have an ethical duty to seek testing and counselling.

Students who are infected with HIV, hepatitis B or hepatitis C are not required to disclose their status to the Medical School. However, infected students must not undertake exposure-prone procedures. (Details of what is considered to be an exposure prone procedure are attached below). The Faculty recognises the right of infected students to confidentiality and will neither coerce nor contrive to determine a student’s status. However, infected students are strongly encouraged to inform the Dean of their status and to seek counselling in relation to personal health measures and training and vocational issues.

**Exposure prone procedures (EPPs)**
Procedures where there is potential for contact between the skin of the health care worker and sharp objects (including surgical instruments and splinters or pieces of bone) in body cavities or in poorly visualised or confined body sites (including the mouth).

Provided they are not conducted in poorly visualised or confined body sites, the following procedures are not considered to be exposure prone:
- phlebotomy,
- administering injections,
- placing intravenous (IV) or central venous (CVC) lines,
- performing needle biopsies or aspirations, lumbar punctures, venous cutdowns or angiographic procedures,
- excision of epidermal or dermal lesions,
- suturing of superficial skin lacerations,
- any other procedure where the use of sharps is superficial, well visualised and very unlikely that a health care worker skin injury would result in exposure of a patient to the health care worker’s blood or body substances.

Oral, vaginal or rectal examinations, endoscopy, placing nasogastric tubes or urinary catheters or other procedures that do not involve sharps are also excluded from the definition of EPPs.
IMMUNISATION AND BLOOD-BORNE VIRUSES FLOWCHART

1. **HIV**
   Do you have results from a recent HIV antibody test?

   **Yes:** If you are HIV antibody positive it is suggested you seek confidential medical and career advice from an infectious diseases specialist. You must not undertake exposure prone procedures.

   **No:** You need to know your HIV status but you do not need to inform the School of the result.

2. **Hepatitis B**
   i) Do you have results from a recent Hepatitis B surface antigen test?

   **Yes:** Go to Q ii)

   **No:** You need to know your HepBsAg status.

   ii). Was your Hep B sAg test positive?

   **Yes:** It is highly recommended that you seek confidential medical and career advice from an infectious diseases specialist. You must not undertake any exposure prone procedures.

   **No:** If you have documented surface antibody to Hepatitis B you don’t need to do anything further. If not, you will need 3 shots of Hepatitis B vaccine followed by a blood test 3 months after the final injection to confirm you have developed immunity to Hepatitis B. For students at risk of hepatitis A (see below) there is an option of combined hepatitis A and B vaccine (Twinrix).

3. **Hepatitis C**
   Do you have results from a recent Hepatitis C antibody test?

   **Yes:** If you are Hepatitis C antibody positive, it is strongly suggested you seek confidential medical and career advice from an infectious diseases specialist (as above). You must not undertake any exposure prone procedures.

   **No:** You need to know your Hepatitis C antibody status although you do not need to inform the School of the result.

4. **Chickenpox (varicella zoster virus - VZV)**
   Have you previously had chicken pox?

   **Yes:** You are considered to be immune to chickenpox.

   **No:** You need to have a blood test to see if you are immune to chickenpox (presence of IgG to VZV) and if you are not immune you should be vaccinated.

5. **Diphtheria/Tetanus**
   Have you received at least 5 diphtheria/tetanus toxoid shots, at least one of which was administered above the age of 10 years?

   **Yes:** You do not require any boosters unless you sustain a high risk injury.

   **No:** You will need diphtheria/tetanus toxoid shots.
6. **Pertussis**  
Have you had a pertussis booster in the last 5 years?

**Yes:** You do not require a further pertussis booster  
**No:** You will require a Pertussis Booster provided a primary course of immunisation was given in childhood. This is available with a combination vaccine for diphtheria and tetanus as an adult formulation (DTPa). This single immunisation will provide cover for conditions listed in Item 5.

7. **Measles, Mumps, Rubella**  
Have you documented evidence of vaccination with at least 2 doses of measles mumps rubella (MMR) vaccine?

**Yes:** You are considered immune to MMR.  
**No:** You will need to complete your 2 vaccinations against MMR (a history of previous infection with one or more of measles mumps or rubella is not considered reliable evidence of immunity nor is it a contraindication for vaccination against the other components of the vaccine. It is not necessary to check serology prior to vaccinating against MMR).

8. **Influenza**  
Will you be having contact with patients this year?

**Yes:** It is recommended but not essential that you receive an annual influenza vaccine.  
**No:** You are not required to have an influenza vaccine this year.

9. **Hepatitis A**  
Are you planning to work in areas where Hepatitis A, meningococcus, malaria or HIV are prevalent?

**Yes:** You may wish to discuss the pros and cons of vaccinations, antimalarials and/or post exposure prophylaxis against HIV with an infectious diseases specialist.  
**No:** In Queensland teaching hospitals, vaccination against Hepatitis A is not normally required but it is recommended if working in remote communities. When students go overseas, they are strongly advised to discuss their likely exposures and prophylactic medications with an Infectious Diseases Consultant.

10. **Tuberculosis (TB)**  
i) Do you have a scar from a previous BCG vaccine (against TB) or have you lived in a country in which TB is endemic?

**Yes:** You should have a 2-step Mantoux test.  
**No:** You should have a 1-step Mantoux test.

ii) If you have had your Mantoux test already, was it positive?

**Yes:** You will be referred for further advice at the time of your Mantoux test.  
**No:** It is not essential that you have a BCG vaccination but, if you are exposed to TB, you should have a repeat Mantoux test. **BCG vaccination is only offered to students at high risk of exposure.**

**NB** Mantoux testing will be incorporated into the first semester of the first year program and BCG vaccination can be arranged subsequently if appropriate.
STANDARD AND ADDITIONAL PRECAUTIONS

Standard precautions
(formerly Universal Precautions) are work practices required for the basic level of infection control and are recommended for the treatment and care of all patients. Standard Precautions are designed to reduce the risk of transmission of micro-organisms from both recognised and unrecognised sources of infection to a susceptible host. Standard Precautions include:

- hand washing,
- use of personal protective equipment (PPE),
- aseptic practices,
- appropriate reprocessing of instruments and equipment following use,
- safe handling and disposal of potentially infectious material and
- environmental controls.

Additional precautions
These are recommended for specified patients known or suspected to be infected or colonised with epidemiologically important or highly transmissible pathogens that can cause infection. Additional Precautions are implemented when Standard Precautions may be insufficient to prevent transmission of infection. Additional Precautions when required are always in addition to Standard Precautions.

The precautions implemented are based on disease transmission and are specific to the situation.

- Airborne transmission (tuberculosis, measles, chicken pox)
- Droplet transmission (mumps, rubella, influenza, pertussis)
- Contact transmission (MRSA, Clostridium difficile)
- Any combination of these routes.
- immunocompromised patients,
- patients with altered mental state and/or poor hygiene,
- patients with large areas of infected skin or large open purulent wounds.

Additional precautions may include one or any combination of the following:

- allocation of a single room with ensuite facilities,
- cohorting (room sharing by persons with the same infectious agent),
- special ventilation requirements (a negative pressure room),
- a ‘STOP’ sign on the door directing all persons to consult staff prior to entering,
- antiseptic hand cleansers for routine hand washing,
- extended sterilisation time of used instruments/equipment when reprocessing (currently only required for Creutzfeldt-Jakob Disease – low risk patients),
- additional use of protective barriers (eg. gowns, gloves, masks, dressings),
- immune staff to care for infectious patients (for example only staff who have had chicken pox or VZV vaccination should care for a patient with chicken pox),
- additional room cleaning,
- special scheduling of the patient on a procedure list,
- dedicated patient equipment.
Hand washing

Hand washing is the most important and most basic technique to prevent the spread of infection. Plain soap should be used for hand washing unless otherwise indicated. The rationale for using either a routine or surgical hand wash is based on the knowledge that hands carry two different types of flora: resident and transient.

Resident flora

These organisms live and multiply on the skin (mainly on superficial layers, but 10-20% inhabit deep layers) and can be repeatedly cultured, even after routine hand washing. Although these organisms are generally harmless, they are of special concern if staff are performing invasive procedures. In these circumstances they need to be reduced and inhibited using an antimicrobial preparation, to prevent cross-infection.

Transient flora

These organisms are present in the hospital microenvironment and contaminate the hands of hospital staff during normal work activities. They can be readily passed on to another person during contact and will survive on the hands for up to 24 hours, if not removed by hand washing. (Occasionally, despite routine hand washing, a transient organism may take up "temporary residence" for a period of several weeks.) Contamination with transient flora may occur in the absence of visible soiling. Routine hand washing is performed to remove transient microbial flora derived from touching one's skin, another person's skin, or some object in the environment. Antimicrobial skin cleansers are not required.

Hands should be washed before significant contact with any patient. Significant contact activities include: examination of a patient, or similar prolonged contact, inspection of a wound or intravascular cannula site, emptying a catheter or drainage reservoir, undertaking a venipuncture or a dressing, changing an I.V. flask or manipulating any similar "closed" sterile system, delivery of IM or IV injections.

Hands should be washed after activities likely to cause significant contamination. Activities known to cause significant contamination: handling objects or materials soiled with body secretions or excretions, direct contact with body secretions or excretions, direct contact with mucous membranes, wounds, tracheostomy, personal hygiene after toileting. Gloves should be used as an adjunct to hand washing when contamination of hands with blood or body fluids is anticipated. Gloves should be changed and hands washed between patients.

Procedure

(Minimum 15 second wash) Ensure all skin surfaces are accessible. Ensure nails are clean, short and unvarnished. Wet hands thoroughly. Hands should then be lathered with soap or skin cleanser (antiseptic preparations are not required) and vigorously rubbed together for at least 15 seconds, paying attention to all areas on both hands. Commonly missed areas are fingertips, interdigital areas, thumbs and wrists. Rinse under a moderate stream of water. Thoroughly dry hands with paper towel. To minimize "chapping" of hands, pat dry rather than rubbing them (personal barrier cream application will also help prevent "chapping"). If elbow operated taps are unavailable, whilst still holding towel, use this to turn off the tap.

Personal protective equipment (PPE)

... provides a barrier between the source and the operator. Its use does not negate the need for safe work practices or hand washing. In many situations the risk of exposure to blood and body fluids can be determined in advance, so the appropriate PPE should be worn prior to performing the procedure or task. PPE may include: gloves, gowns and aprons, eye and/or facial protection (glasses, goggles, face shields), masks, adequate footwear.
Gloves
... must be worn whenever there is a risk of direct contact with blood, body fluids, mucous membranes, non-intact skin or contaminated equipment or surfaces. Types of gloves worn should be appropriate to the task: sterile gloves for procedures involving normally sterile areas of the body, non sterile examination gloves to be used for all other contacts, general-purpose utility gloves to be used for cleaning and during manual decontamination of used instruments and equipment. Allergy or sensitivity may develop to glove powder or contact with latex proteins. Powder free latex gloves or alternatives to latex are available and should be used by those who develop sensitivity. Seek advice from the Occupational Health and Safety Unit.

Gowns
... are worn to protect the wearer’s clothing and skin from contamination with blood and body substances. Fluid resistant gowns/plastic aprons are indicated in situations where contamination with large amounts of blood or body fluid is anticipated. A plastic apron can be worn beneath a sterile gown to give added protection if strike through is a possibility during surgical procedures. Gowns/aprons are also worn by personnel during the care of patients infected or colonised with epidemiologically important micro-organisms to reduce the opportunity for transmission of pathogens from patients or items in their environment to other susceptible patients

Protective eyewear
... (goggles, glasses or face shields) must be worn during procedures likely to cause splattering, splashing or spraying of blood or body fluids. Eyewear should be: shielded at the side and close fitting, cleaned after use in detergent and water if contaminated.

Masks
... are worn to protect the mucous membranes of the mouth and nose during procedures likely to cause splattering, splashing or spraying of blood or body fluids. High efficiency masks with filtration to 1 micron must be used for care of patients known or suspected to be infected with pathogens spread by the airborne route. To provide protection against airborne pathogens masks provide a snug fit and be changed when they become moist or visibly soiled during use.

Specimens
... should be collected with gloved hands, placed in a correctly labelled leak proof container, enclosed in a sealed bag for transport with the request form in the outer sleeve pocket of the plastic bag to prevent contamination.
ASEPSIS, REPROCESSING AND ENVIRONMENTAL CONTROL

Asepsis

Aseptic practices refer to precautions designed to prevent undue contamination of a person, object or area by micro-organisms. Aseptic practices are indicated if performing any invasive procedure, for example surgical procedures, dressing open wounds or insertion of indwelling cannulae. Measures employed to achieve asepsis include:

- performance of appropriate hand washing,
- preoperative skin and body cavity preparation,
- processing,
- supply and storage of sterile equipment,
- antiseptic and disinfectant use,
- management of indwelling devices,
- environmental controls such as air filtration.

Reprocessing equipment

Cleaning is the essential first step for any form of reprocessing. If an item cannot be thoroughly cleaned, it cannot be reprocessed. Thorough cleaning should commence as soon as practicable after use. Inadequate cleaning may result in ineffective disinfection or failure to sterilize instruments or equipment. Hospital crockery and cutlery require no special precautions. The combination of hot water and detergents used in hospital dishwashers is sufficient to render the items safe for reuse.

Environmental controls

A neutral detergent is the cleaning solution of choice for environmental surfaces. Extra cleaning may be necessary in the presence of some micro-organisms. Blood and body substance spills must be dealt with by wiping the area immediately with a paper towel and then cleaning the area with detergent and water if the spill is small. Large spills should be contained and in addition to cleaning with detergent and water, chlorine-generating disinfectants may be used. Linen: Soiled linen is discarded into linen bags which when 2/3 – ¾ full must be securely tied off for transport. Any linen bags likely to leak blood or body fluid must be contained by a clear plastic bag and secured prior to transport. Alternatively waterproof linen bags should be used. All used linen is considered contaminated therefore minimal handling is recommended.

Waste disposal

Standard Precautions must be employed when handling all waste. Waste is segregated at the point of generation into general, medical, cytotoxic, radioactive and hazardous streams. There is a legal obligation to classify waste appropriately.

Sharps

The person generating the sharp is responsible for its safe disposal. Sharps should never be passed by hand between health care workers. Disposal should occur immediately following its use and at the point of use into designated puncture resistant containers that conform to Australian Standard AS4031. Discard sharps containers when 2/3 full, seal appropriately and place in the medical waste stream. Never recap used needles unless an approved recapping device is used.

Nosocomial infection

Nosocomial infections are infections acquired directly or indirectly in a medical setting. The probability of a micro-organism causing infection in a host is dependent upon the dose
(number of micro-organisms), a receptive host site of contact with the organism, time of contact (sufficient for multiplication or not) and the virulence of the organism.

The source(s) of the infecting agents may be patients, staff or visitors and may include:

- persons with acute diseases,
- persons in the incubating or window period of a disease or
- persons who are colonised or chronic carriers of the infecting agent
- the person's own endogenous flora,
- inanimate objects including equipment and medications.

**Susceptible host**

Resistance to infection varies depending upon underlying medical conditions and other factors that may compromise a person's immune status. Trauma, surgical procedures, anaesthesia, invasive indwelling devices, and therapeutic and diagnostic procedures render a person more susceptible to infection. Immunocompromised patients are at increased risk of infection from both their own flora (endogenous) as well as other sources (exogenous). Susceptibility to infection depends on the severity and duration of immunosuppression. They may be particularly susceptible to environmental contaminants such as Legionnaires disease or Aspergillus. Where invasive medical procedures are involved, consideration should be given to placing patients at the start of the operating schedule. If considerable immunosuppression or neutropenia is present the Additional Precaution of single room accommodation is desirable.

**Routes of transmission**

- Direct contact transmission involves direct physical transfer of micro-organisms from an infected or colonised person to a susceptible host. Indirect contact transmission involves the contact of a susceptible host with a contaminated inanimate object, such as contaminated instruments or equipment.
- Droplets are generated during coughing, sneezing, talking, and during certain procedures such as suctioning and bronchoscopy. Transmission occurs when droplets containing micro-organisms come in contact with the conjunctiva, nasal mucosa or mouth of a susceptible person. Droplet distribution involves close association, usually 1 metre or less.
- Airborne transmission occurs by dissemination in the air of either droplet nuclei or dust particles containing the infectious agent. Micro-organisms carried in this manner can be widely dispersed via air currents and can remain airborne for long periods before being inhaled by the susceptible host.
- Vehicle transmission applies to micro-organisms transmitted by contaminated food, water, drugs, blood or body fluids.
- Vector-borne transmission occurs when mosquitoes, flies, rats or other vermin transmit micro-organisms

**Procedure for follow-up of blood/body fluid exposure**

Wash the affected area with soap and water. If cuts and abrasions are involved they should be included in the washing. For eye splashes rinse gently but thoroughly with water or normal saline, while the eyes are open. If blood gets in the mouth, spit it out and rinse the mouth with water several times. Record the accident details (for FMC this will be on BBFE Accident Report Form) including your name, contact number, ward, and the source name and MR number if available.
The affected person

… should have blood taken either in the Emergency Department or in the Occupational Health Unit. Blood is tested for Hepatitis B antibody if not previously tested, and serum is held for 7 years.

The source individual

… should have blood taken for HIV Antibody, Hepatitis B surface antigen, Hepatitis C antibody (NB: informed consent is required to undertake these tests usually obtained by the doctor responsible for the patient). If blood is already available in serology (from previous tests) then more blood may not have to be taken. If source does not consent to have tests taken, the affected person is to be followed up as if the source was unknown.

If the source is known or suspected to be HIV positive, the on-call Infectious Diseases Physician must be contacted urgently for advice.

Source HIV positive

Post-exposure prophylaxis with antiretroviral therapy may be offered (at no cost) when the risk of transmission is considered to be significant. Commence as soon as possible after the exposure (preferably within two hours). Counselling will be provided on the risk of transmission, the importance of strict compliance with the treatment regimen and the potential side effects and appropriate course of action if these are experienced.

Follow-up: Report any febrile illness that occurs within three months after exposure. Repeat testing for HIV antibody will be performed 3 and 6 months after exposure. During the first 3 months you should not donate plasma or blood, body tissue, milk or sperm. Sexual partners should be protected from contact with blood, semen or vaginal fluids by using condoms. Pregnancy should be avoided until HIV status is known and you must avoid performing exposure prone procedures.

Source HBV positive (HBsAg positive)

If you have previously had Hepatitis B infection or you have been vaccinated against Hepatitis B and have confirmation of seroconversion no further action is required. If there is no record of seroconversion to confirm that vaccine immunity has been achieved or if you have not been previously vaccinated for hepatitis B, blood is taken for hepatitis B surface antibody. If negative, hepatitis B immunoglobulin (HBlg) will be offered and a Hepatitis B vaccination course should commence at the same time. Three vaccinations at 0, 1 and 6 months are required.

Source Anti-HCV positive

At present, apart from thorough washing (as for HIV and HBV) at the time of injury there is no known treatment that can alter the likelihood of transmission. If HCV infection does occur, early treatment with interferon may be offered. Repeat testing for HCV antibody will be done 3 months after exposure.

Source unknown

Reasonable efforts should be made to identify source persons or syringes. If the source remains unknown, appropriate follow-up should be determined on an individual basis depending on type of exposure and likelihood of source being positive for a blood pathogen.

Source negative

… for HIV, HBV, HCV: No further action is required.

Special care **NOT** required

- Non-parenteral exposure: Intact skin visibly contaminated with blood or body fluid.
• Doubtful parenteral exposure: Intradermal (superficial) injury with a needle considered not to be contaminated with blood or body fluid, eg. giving IV medication; drawing up medication. A superficial wound not associated with visible bleeding produced by an instrument not contaminated with blood or body fluid. Prior wound or skin lesion contaminated with a body fluid other than blood and with no trace of blood eg. urine.

Follow-up and appropriate care ARE required
• Possible parenteral exposure: Intradermal injury with a needle contaminated with blood or body fluid. A wound not associated with visible bleeding produced by an instrument contaminated with blood or body fluid. Old wound or skin lesion contaminated with blood or body fluid. Mucous membrane or conjunctival contact with blood.
• Definite parenteral exposure: Laceration or similar wound which causes bleeding, and is produced by an instrument that is visibly contaminated with blood or body fluid. Any direct inoculation with human immunodeficiency virus (HIV) tissue or material likely to contain HIV, Hepatitis B virus (HBV) or Hepatitis C virus (HCV) not included above - this refers to accidents in laboratory settings.
• Massive exposure: Transfusion of blood. Injection of large volume of blood/body fluids (>1ml). Parenteral exposure to laboratory specimens containing high titre of virus.

Electives in developing countries
Students undertaking Electives in developing countries are strongly encouraged to seek advice well in advance of travel, on illnesses and personal health and safety issues which may be encountered in those countries. Students planning Electives in countries with high rates of HIV positivity (e.g. most of Africa, India and South East Asia) are strongly advised to consult with an infectious diseases physician several months prior to undertaking the Elective. Students may require specific preventative treatment medications for malaria and traveller’s diarrhoea and may be advised to carry emergency HIV drugs to take immediately should a high risk blood/body fluid exposure take place. Vaccination status needs to be reviewed for students undertaking electives in developing countries and additional vaccines such as Typhoid, Hepatitis A, Meningococcal and Yellow Fever vaccinations may be required. Further information can be obtained from the ‘Web pages’ from the Centre for Disease Control, Atlanta, Georgia (www.cdc.gov/travel/) or the Infectious Diseases Unit.

Frequently asked questions
Q: Will the School of Medicine cover the costs of my blood tests and consultation(s) with a doctor?
A: No (although for most students Medicare will cover the cost). The University Health Service Clinic has agreed to bulk bill for consultation. Private health insurance policies may vary in their cover and so students ineligible for Medicare will need to clarify their cover with their own health insurance provider. The cost for pathology may be billed.

Q: Can I get reimbursed for vaccines purchased from private pharmacies or get private scripts?
A: No.

Q: Should I carry anti-HIV drugs to take in the event of possible exposure during Electives in parts of Africa and Asia?
A: These may be required if you are doing an Elective in some areas. You should seek advice from the Infectious Diseases Service who may arrange for you to carry an ‘emergency’ supply of anti-HIV drugs.
Form A
School of Medicine

Compliance with Immunisation and Blood-Borne Viruses Policy

Student form

Statement of Compliance

I have read and agree to comply with the Immunisation and Blood-Borne Viruses Policy.

Student Name: ____________________________________________________
Student Id:________________________________________________________
Signature: ________________________________________________________
Date: ____________________________________________________________

NOTE: This form must be completed before students will be permitted to commence clinical studies / patient contact. Students who do not feel that they can comply with the Policy are required to discuss their objections with a nominated representative of the Dean.

Please return completed form to
Placement Officer, GH1, 3.15
Griffith University
School of Medicine
PMB 50, GCMC
QLD 9726
Form B  
School of Medicine

Compliance with immunisation and blood-borne viruses policy  
Health Care Provider Form

Student Name:______________________________________________________________
Student Id:_________________________________________________________________
Signature:_____________________________________   Date: ______________________

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Date/s</th>
<th>Batch Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV results from a recent HIV antibody test</td>
<td></td>
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<tr>
<td>Hepatitis C results from a recent Hepatitis C antibody test</td>
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<tr>
<td>Hepatitis B results from a recent Hepatitis B surface antigen test (HepBsAg)</td>
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<tr>
<td>If HepBsAg was negative, student has received 3 shots of Hepatitis B vaccine</td>
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<tr>
<td>and a blood test &gt;3 months after the final injection, confirming presence of</td>
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<tr>
<td>Hepatitis B surface antibody.</td>
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<tr>
<td>Tetanus at least 3 diptheria/tetanus toxoid shots, at least one of which was</td>
<td></td>
<td></td>
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<tr>
<td>administered aged &gt;10 years</td>
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<tr>
<td>Measles/Rubella at least 2 doses of MMR vaccine</td>
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<tr>
<td>Chickenpox (VZV) EITHER a past history of clinical chicken pox, presence of</td>
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<tr>
<td>IgG to VZV, OR 2 shots of Varilrix</td>
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<tr>
<td>Pertussis Boosters within last 5 years provided primary course completed</td>
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</tbody>
</table>

I confirm that the following student has provided me with evidence satisfying the above requirements

Service:...........................................................................................................
Doctors Name (Print): ..........................................................................................
Contact Details: ............................................................................................... 

Please return form to:
Placement Officer, GH1, 3.15
Griffith University
School of Medicine
PMB50, GCMC
QLD, 9726