Guidelines for the Management of Exposure to Blood and Body Fluids Prophylaxis
Guidelines for the Management of Exposures to Blood and Body Fluids

Acknowledgements

These guidelines have been updated from those developed in January 2004.

Members of the working group who participated in updating these guidelines are:

- Dr. Saqib Shahab, Deputy Chief Medical Health Officer, Saskatchewan Ministry of Health
- Dr. Stuart Skinner, Infectious Diseases, Royal University Hospital
- Dr. Johnmark Opondo, Deputy Medical Health Officer, Saskatoon Health Region
- Dr. Maurice Hennink, Deputy Medical Health Officer, Regina Qu’Appelle Health Region
- Dr. Brenda Cholin, Medical Health Officer, Prairie North Health Region
- Dr. Mark Vooght, Medical Health Officer, Five Hills Health Region
- Dr. Stephen Helliar, Family Physician, Saskatoon Community Clinic - Westside
- Dr. Linda Sulz, Pharmacy Manager, Strategic Initiatives, c/o Regina General Hospital, Regina Qu’Appelle Health Region
- Sherry Herbison, Occupational Health Nurse, Regina General Hospital, Regina Qu’Appelle Health Region
- Deana Nahachewsky, Regional Communicable Disease Coordinator, First Nations and Inuit Health Branch
- Jerry Bell, Manager, Emergency Pasqua Site, Regina Qu’Appelle Health Region
- Lisa Lockie, HIV/BBP/IDU Consultant, Saskatchewan Ministry of Health
- Lisa Haubrich, Communicable Disease Consultant, Saskatchewan Ministry of Health
- Christine McDougall, Public Health Agency of Canada HIV Field Surveillance Officer, Saskatchewan Ministry of Health
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<td>HIV Management</td>
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<td></td>
<td>Hepatitis B Management</td>
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  How long before an exposed person can be reasonably sure that they have not been infected?
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Introduction

December, 2014

Purpose of Guidelines/Goals
To ensure individuals exposed to blood and body fluids receive appropriate management, follow-up and information to prevent further transmission of infectious diseases including human immunodeficiency virus (HIV), hepatitis B, hepatitis C and, in the event of sexual assault, sexually transmitted infections (STIs).

General Considerations Regarding Recommendations for Prophylaxis
In evaluating the need for HIV post-exposure prophylaxis (PEP), the following factors should be considered:
- duration of time passed since the potential exposure;
- likelihood of HIV infection in the source;
- risk of transmission given the source material and type of exposure;
- effectiveness of therapy at modifying that risk;
- toxicity of the therapy;
- burden of adherence to antiretroviral therapy.

Introduction
This document is intended to guide health care providers caring for persons who have been exposed to blood and body fluids in the workplace or community setting. This guideline deals primarily with exposure to HIV, however information on hepatitis B virus (HBV), hepatitis C virus (HCV) and STIs are included so comprehensive care can be provided. This guideline details the process for the initial assessment and management for PEP for HIV in occupational and non-occupational settings in Saskatchewan, including instances of sexual assault. Information on how to access the HIV PEP kit and obtaining the remainder of prophylaxis is included.

This guideline does not address:
- prevention of perinatal transmission from a pregnant woman with HIV;
- pre-exposure prophylaxis (PrEP) as an approach to prevent HIV transmission for those who have ongoing high-risk exposures. Persons interested in PrEP should be referred to an infectious diseases specialist.
Introduction

For hepatitis B or C refer to Appendices 8 and 9 – Management of Potential Exposures to Hepatitis B and C. Additional information can be found in the Saskatchewan Immunization Manual\(^1\) and the Canadian Immunization Guide, current edition.\(^2\) The Saskatchewan Communicable Disease Control Manual\(^3\) and the Canadian Guidelines on Sexually Transmitted Infections\(^4\) also provide information on HBV and HCV as well as STIs.

**Prevention**
Prevention is an essential component for the overall control and management of exposure to blood borne pathogens.

In the health care setting, prevention is largely achieved through the establishment of administrative controls, the training and insistence on safer workplace practices, the use of personal protective equipment, and utilization of the best instrument design available. For additional information refer to your regional infection control manual or to Public Health Agency of Canada’s Prevention and Control of Occupational Infections in Health Care (2002).\(^5\)

In community settings, prevention is achieved through the use of standards for infection prevention and control by private industry and use of harm reduction measures including such things as needle exchange programs and safer sex practices. Resources include the latest Infection Prevention and Control Practices for Personal Services or the Saskatchewan Personal Service Facility Best Management Practices.

Specific measures for HIV, HBV and HCV are included in Appendix 7 – Prevention of Bloodborne Pathogens.

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\(^1\) [http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx](http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx)


\(^3\) [http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx](http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx)


Most exposures involve a one-way transmission of body fluid from the source to the exposed person; this guideline is prepared based on this premise. However, situations occasionally arise where both people involved in an incident could have been exposed to each other’s fluids (for example, biting incidents, sexual exposures or physical alterations) in which case it is prudent to assess both individuals from the perspective of both being the exposed and the source.

The risk from occupational and community exposures is assessed in the same manner and the same recommendations for management can be applied. The actual risk from exposures outside the healthcare setting for needle-stick injuries is usually significantly less than in the health care setting (Centers for Disease Control and Prevention, 2010); however, some other non-occupational exposures may be of similar or higher risk as some occupational exposures.

To date it appears no one has become infected with human immunodeficiency virus (HIV) from an abandoned needle in Canada, the United States or Europe. The primary route of HIV transmission in Saskatchewan is from sharing needles and other equipment related to illicit drug use, and from unprotected high-risk sexual activity.

<table>
<thead>
<tr>
<th>INFECTED BLOOD</th>
<th>HIV</th>
<th>HBV</th>
<th>HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of transmission after percutaneous exposure</td>
<td>0.3% (3 in 1000)</td>
<td>6-30% (6-30 in 100)</td>
<td>3-10% (3-10 in 100)</td>
</tr>
<tr>
<td>Risk of transmission after mucocutaneous exposure</td>
<td>0.1% (1 in 1000)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(U.S. Centers for Disease Control and Prevention, 2003)

The Exposure Incident Report Form (Appendix 3) must be completed. It includes all required information in considering the risk of transmission of HIV, HBV or HCV.
Risk of HIV Transmission
Conducting an objective and thorough risk assessment is the key to making a recommendation for HIV post-exposure prophylaxis (PEP). The risk of transmission is calculated based on the:

- exposure fluid;
- type of exposure;
- likelihood the source is infected.

An exposure can be defined as a percutaneous injury (e.g., needlestick or cut with a sharp object) or contact of mucous membrane or non-intact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, saliva, tissue, or other body fluids that are potentially infectious. Exposure incidents might place the exposed person at risk for HIV, HBV, or HCV infection, and therefore should be evaluated immediately by a qualified health-care professional (U.S. Centers for Disease Control and Prevention, 2001).

Risk by Fluid Type
Determine if a percutaneous, mucosal, or non-intact skin exposure to a potentially infectious body fluid poses a risk for HIV, HBV, or HCV transmission (Table 2.2).

Table 2.2 Fluids and tissues capable of transmitting blood borne pathogens

<table>
<thead>
<tr>
<th>FLUID</th>
<th>HIV</th>
<th>HBV</th>
<th>HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab specimens containing concentrated HIV, HBV or HCV</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood, serum, plasma or other biological fluids visibly contaminated with blood</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pleural, amniotic, pericardial, peritoneal, synovial and cerebrospinal fluids</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Semen, vaginal secretions</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Saliva</td>
<td>No, unless contaminated with blood</td>
<td>Yes</td>
<td>No, unless contaminated with blood</td>
</tr>
<tr>
<td>Breast milk</td>
<td>Yes</td>
<td>Biologically plausible, particularly if nipples are cracked or bleeding or if mother is HBeAg positive</td>
<td>Biologically plausible, particularly if nipples are cracked or bleeding</td>
</tr>
<tr>
<td>Organ and tissue transplants</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Screened donated blood &amp; manufactured blood products</td>
<td>Minimal risk in Canada</td>
<td>Minimal risk in Canada</td>
<td>Minimal risk in Canada</td>
</tr>
</tbody>
</table>

Although HBV and HIV have been found in secretions such as tears, vomitus, feces and urine, epidemiological studies have not implicated these substances in the transmission of HBV and HIV infections. The risk of transmission increases if these secretions have been contaminated with blood.

### Risk by Type of Exposure
The type of exposure (Table 2.3) and risk estimates based on exposures with an HIV infected source (Table 2.4) should be considered prior to recommending HIV PEP (New York State Department of Health AIDS Institute, 2010).

#### Table 2.3 Consideration of HIV PEP according to Type of Exposure

<table>
<thead>
<tr>
<th>Types of Exposures When HIV PEP Should Be Recommended (higher-risk exposures)</th>
<th>Types of Exposures That Do Not Warrant HIV PEP (no risk)</th>
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</thead>
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<tr>
<td>• Receptive and insertive vaginal or anal intercourse&lt;sup&gt;b&lt;/sup&gt;</td>
<td>• Kissing&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Needle sharing&lt;sup&gt;b&lt;/sup&gt;</td>
<td>• Oral-to-oral contact without mucosal damage (mouth-to-mouth resuscitation)</td>
</tr>
<tr>
<td>• Injuries with exposure to blood or other potentially infected fluids (including needlesticks with a hollow-bore needle, human bites, accidents) from a source known to be HIV-infected or has known risk factors</td>
<td>• Human bites not involving blood</td>
</tr>
<tr>
<td></td>
<td>• Exposure to solid-bore needles or sharps not in recent contact with blood&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>• Mutual masturbation without skin breakdown or blood exposure</td>
</tr>
<tr>
<td></td>
<td>• Found needle in community, no visible blood</td>
</tr>
<tr>
<td><strong>Lower-Risk Exposures That Require Case-by-Case Evaluation for HIV PEP</strong></td>
<td><strong>Factors that increase risk:</strong></td>
</tr>
<tr>
<td>(lower-risk exposures: assess for factors that increase risk before recommending initiation of HIV PEP)</td>
<td>• Source person is known to be HIV-infected with high viral load</td>
</tr>
<tr>
<td></td>
<td>• An oral mucosa that is not intact (e.g., oral lesions, gingivitis, wounds)</td>
</tr>
<tr>
<td></td>
<td>• Blood exposure – it is important to note that blood exposure can be minimal and therefore not recognized by the exposed person. If the exposed person reports frank blood exposure, PEP would be indicated</td>
</tr>
<tr>
<td></td>
<td>• Presence of genital ulcer disease or other STIs</td>
</tr>
</tbody>
</table>

<sup>a</sup> Table 2.4 provides risk calculations for specific risk behaviours.

<sup>b</sup> With a source know to be HIV-infected or HIV status is unknown.

<sup>c</sup> There is no risk associated with close-mouthed kissing. There is a remote risk associated with open-mouthed kissing if there are sores or bleeding gums and blood is exchanged.

<sup>d</sup> Examples of solid-bore needles include tattoo needles and lancets used by diabetics to measure blood sugar levels.

Source: Adapted from New York State Department of Health AIDS Institute, 2013.
The risk of HIV prophylactic medications usually exceeds the risk of an individual becoming infected from an abandoned needle.

These guidelines do not recommend prophylaxis for needlesticks from an abandoned needle outside the health care setting when there is no history of the origin of the needle or the time of its abandonment.

BC Center of Excellence in HIV/AIDS, 2010

Table 2.4 Estimated Per-Act Probability of Acquiring HIV from a Known HIV-Infected Source by Exposure Act

<table>
<thead>
<tr>
<th>Type of Exposure</th>
<th>Estimated Risk</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parenteral</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needle-sharing during injection drug use</td>
<td>0.63% (63 in 10000)</td>
<td></td>
</tr>
<tr>
<td>Percutaneous (needlestick)</td>
<td>0.23% (23 in 10 000)</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptive anal intercourse</td>
<td>1.4% (7 in 5000)</td>
<td>Patel, et al (2014)</td>
</tr>
<tr>
<td>Receptive penile-vaginal intercourse</td>
<td>0.08% (8 in 10000)</td>
<td>Patel, et al (2014)</td>
</tr>
<tr>
<td>Insertive anal intercourse</td>
<td>0.11% (11 in 10000)</td>
<td>Patel, et al (2014)</td>
</tr>
<tr>
<td>Insertive penile-vaginal intercourse</td>
<td>0.04% (4 in 10000)</td>
<td>Patel, et al (2014)</td>
</tr>
<tr>
<td>Receptive oral intercourse</td>
<td>Low&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Varghese, et al. (2002)</td>
</tr>
<tr>
<td>Insertive oral intercourse</td>
<td>Low&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Page-Shafer, et al. (2002)</td>
</tr>
<tr>
<td><strong>Other&lt;sup&gt;b&lt;/sup&gt;</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biting</td>
<td>Negligible</td>
<td>Pretty, et al. (1999)</td>
</tr>
<tr>
<td>Spitting</td>
<td>Negligible</td>
<td></td>
</tr>
<tr>
<td>Throwing body fluids (including semen or saliva)</td>
<td>Negligible</td>
<td></td>
</tr>
<tr>
<td>Sharing sex toys</td>
<td>Negligible</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> HIV transmission through oral sex has been documented, but rare. Accurate estimates of risk are not available. It is prudent to recommend HIV PEP for receptive oral sex with ejaculation, although discussion about the low risk should occur. Refer to Table 5.1 for further consideration.

<sup>b</sup> HIV transmission through these exposure routes is technically possible but extremely unlikely and cases are not well documented. Increased risk occurs when the activity involved exposure to blood

Factors known to further increase transmission of HIV infection should be included in the risk assessment. These include:
- trauma at the site of the exposure (for example, sexual assault);
- presence of genital ulcer disease and/or other sexually transmitted infections (STIs) in the exposed person;
- high plasma viral load in the HIV-infected partner or source (i.e., in seroconversion illness or late stage AIDS disease) (New York State Department of Health AIDS Institute, 2013);
- exposure to the blood/infectious body fluids from a source with advanced HIV disease;
- exposure to a source with concomitant hepatitis C.

Other factors that may enhance transmission include (Cardo et al., 1997; New York State Department of Health AIDS Institute, 2013):
- cervical ectopy;
- lack of circumcision;
- deep injury;
- visible blood on the device in enough volume to transmit virus; however, risk through exposure to dried blood on discarded needles is extremely low;
- direct injection into a vein or artery;
- terminal illness in the source patient.

Risk Assessment of Source
The New York State Department of Health AIDS Institute (2010) and The Ontario Network of Sexual Assault/Domestic Violence Treatment Centres have identified that sources with the following risks may be at increased risk of HIV infection:
- hepatitis C positive;
- sexually transmitted disease, particularly ulcerative diseases;
- men who have sex with men;
- from a country with an HIV prevalence rate greater than 5%;
- sex with known or suspected HIV positive people;
- history of multiple sexual partners;
- history of sharing needles;
- history of trading sex for money or drugs;
- prior convictions for sexual assault;
- has been in prison.
The details in the previous tables only represent an average risk and risk may be higher in the presence of other risk factors:

- high viral load in the source (i.e., in seroconversion illness or late stage AIDS disease);
- visible blood on the devise and/or devise was previously in a source’s artery or vein;
- depth of wound;
- volume of blood;
- gauge of needle in needlestick injuries.

The source, if available, should be tested and or interviewed to provide the most appropriate care to the exposed. The source must provide informed consent regarding use and disclosure of information prior to conducting the interview or obtaining specimens for testing. Refer to Appendix 15 – Collection Use and Disclosure of Information and Appendix 16 – Consent for Source Patient Testing Following a Blood/Body Fluid Exposure.

**Table 2.5 Recommendations for Source Based on HIV Status**

<table>
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<tr>
<th>Unknown HIV Status</th>
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</thead>
<tbody>
<tr>
<td>• Obtain risk history and HIV test.</td>
</tr>
<tr>
<td>• Consider evaluation and testing for other STIs, including hepatitis B and hepatitis C.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Known Positive HIV Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obtain history of antiretroviral medications, recent viral load, CD4 cell count, and date of results.</td>
</tr>
<tr>
<td>• Consider drawing HIV viral load, CD4 cell count and resistance testing.</td>
</tr>
<tr>
<td>• Consider evaluation and testing for other STIs, including hepatitis B and hepatitis C.</td>
</tr>
</tbody>
</table>

**Table 2.6 Considerations for Exposed Based on Source Status**

<table>
<thead>
<tr>
<th>Known HIV Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HIV PEP should be offered to exposed person based on the assessment of the risk carried by the exposure. See Tables 2.3 and 2.4.</td>
</tr>
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<table>
<thead>
<tr>
<th>Known HIV Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consideration should be given to when the source’s negative test was and history of risk factors since their last HIV test; history of a prior negative test may not indicate no risk for the exposed.</td>
</tr>
<tr>
<td>• Consider HIV Point of Care (POC) test if source available.</td>
</tr>
</tbody>
</table>

Guidelines for the Management of Exposure to Blood and Body Fluids
Unknown & Available for Interview and/or Testing

- Further investigation, including source testing for various blood borne pathogens. HIV PEP may be initiated before receipt of test results if exposure (based on source and type of exposure) is considered high-risk.
- HIV POC test should be considered where available for testing the source. See below for more information.
- If HIV POC test comes back negative this is very reassuring, however consider the source’s risk factors during the window period.

Unknown & Unavailable for Interview and/or Testing

- Emphasis should be placed on the type of exposure, as well as ascertainment of possible risk factors in source.

Refused Testing

- Carefully consider the reasons for refusal. If there is no reason to suspect the source is in a high-risk group and the refusal is based on factors other than fear of disclosure, consider a low-risk source. It is not appropriate to consider all persons who refuse testing as positive.

When results for the source are available, the health care provider who requested the testing should immediately notify the provider responsible for care of the exposed person. The exposed person is entitled to know if the full course of prophylaxis is required or not, but details regarding the source should NOT be provided to the exposed person.

**Window Period Considerations**

In HIV testing, the window period refers to the time between a person becoming infected and when laboratory tests can detect HIV infection. The window period varies based on the test that is completed; progress in HIV testing technologies continues to result in tests with shorter window periods (BC Centre for Disease Control, 2010).

In addition to test results, the risks that the individual has engaged in during the window period should be considered. There is an extremely low probability that an individual would test negative during the 3 month window period AND be involved in an exposure at the same time. Regardless, the possibility of a false negative test result during the window period should be considered in persons with ongoing risk factors. See Risk Assessment of Source and Appendix 14 – Source Patient Risk Assessment.

A summary of window periods based on the HIV test used provides context to the reliability of the test results:
- antibody/antigen (4th generation test) has window period of approximately 2 weeks;
- antibody test (3rd generation) has a window period of approximately 3-4 weeks;
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- point of care test has a window period of approximately 1 month (personal communication, Dr. Greg Horsman, October 2012);
- greater than 99% of individuals will have seroconverted by 3 months as detected by the Western blot.

Because window periods vary with the test, a negative test result at 3 months is deemed to be negative and no further testing is required.

Considerations Based on Saskatchewan Data
Prevalence of HIV information for Saskatchewan is not included in these guidelines. The World Health Organization (2007) has identified the following as challenges and cautions using prevalence data to make recommendations for HIV PEP due to:
- lack of reliable prevalence data;
- pockets of high prevalence within low-prevalence settings;
- differences in prevalence between exposed individuals and source subgroups;
- change of prevalence among various demographic groups over time;
- the possibility that HIV PEP may be denied to someone exposed to a known source of HIV infection.

Additional Considerations Prior to Initiating HIV PEP
One must weigh the risks of becoming infected with HIV (which are frequently extremely low) against the risk of taking antiretroviral therapy (which can be significant). Human immunodeficiency virus PEP should not be initiated if the risk/benefit ratio is unfavourable. Refer to Section 3 – Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis (HIV PEP) for details about HIV PEP medications to assist conducting the risk/benefit ratio.

Once the risk assessment is completed, refer to the appropriate section of this guideline that addresses the exposure setting (Section 4 – Occupational and Section 5 – Non-occupational (Community), Section 5a – Sexual Exposures and 5b – Lifestyle). Section 3 outlines information on medications for HIV PEP which is the same for all settings.

HIV Tests
Standard HIV tests routinely have a turn-around time from 2-3 days up to 2 weeks.

When managing an exposure, timely results of source tests can inform the decision for necessary management of the exposed.
An HIV POC test can provide more timely results and should be considered where available for the source and/or the exposed. “Patients must be informed that parallel [standard HIV] testing will be performed to confirm the results of all reactive (positive) and indeterminate point of care rapid tests” (Saskatchewan Ministry of Health, 2012, p. 9). Refer to the Guidelines for the Use of Point of Care (POC) Test Kits in Saskatchewan.⁶

Source:
Human immunodeficiency virus POC test should be considered on the source when they are available and their HIV status is unknown. If an HIV POC test is done and the result is:

- reactive (preliminary positive): prophylaxis is recommended based on the exposure until confirmatory test results are available;
- invalid or indeterminate: if the source has risk factors and the exposure is high-risk, prophylaxis should be strongly considered until confirmatory testing is completed;
- non-reactive: in most cases this result indicates a true negative. However, if the source has engaged in risk behaviour in the 1 month prior to the POC test and the exposure is high-risk, the window period should be considered in determining the appropriate treatment of the exposed.

Exposed:
Human immunodeficiency virus testing of exposed persons is recommended to avoid unnecessary HIV PEP in individuals already infected with HIV and to expedite referral for treatment. Circumstances for which an HIV POC test should be considered for the exposed person include:

- **Single or episodic exposure with a background of unprotected chronic exposure**
  - an individual who has regular, ongoing consensual unprotected sex with an HIV positive partner and presents with another type of exposure such as sharing of needles for injecting drugs or has been sexually assaulted.

- **Chronic exposure without taking precautions or inconsistent use of precautions**
  - intravenous drug users repeatedly sharing needles/works with individuals whose HIV status is known or unknown.
  - sexual assault by an intimate partner with whom a person is also having ongoing unprotected consensual sex.
  - domestic abuse.

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If the test result of the exposed person is reactive, HIV PEP is not required, but the individual should be referred for appropriate follow-up by an infectious disease Specialist.

Considering all the info gathered from the risk assessment of the fluid, of the exposure and of the source, as well as the results of the HIV POC test of the source and/or exposed, determine if HIV prophylaxis is indicated or not. Refer to the appropriate section of this guideline that addresses the exposure setting (Section 4 – Occupational and Section 5 – Non-Occupational (Community) including 5a – Sexual Exposures and 5b – Lifestyle) for further guidance. Section 3 outlines information on medications for HIV PEP which is the same for all settings.

**Risk of Hepatitis B Transmission**

For percutaneous and mucosal exposure to blood, several factors should be considered when making a decision to provide prophylaxis with hepatitis B vaccine and/or immune globulin (HBIG), including the predicted serostatus of the source, the exposed hepatitis B immunization status and vaccine response. Refer to Appendix 8 – Management of Potential Exposures to Hepatitis B.

Community needlestick injury exposures (when the source is unknown) are low-risk and should be managed with hepatitis B vaccine only as per (b) Management of Individuals with Percutaneous or Mucosal Exposure to an Uninfected or Low-Risk Source in Appendix 8.

Table 2.1 demonstrates that HBV is transmitted more efficiently than HIV. When the source is known, the following risk factors should be assessed:

- multiple sexual partners;
- type of sexual contact (anal intercourse carries a higher risk than vaginal intercourse which is higher risk than oral-anal); oral-genital and/or oral-oral contact do not appear to influence the risk of becoming infected with HBV;
- the presence of other sexually transmitted infections;
- if the source is from an endemic country;\(^7\)
- high HBV DNA levels or HBe antigen positivity in the source.

Exposed individuals, including sexual assault victims should be managed with hepatitis B vaccine and/or HBIG as outlined in Appendix 8 – (a) Management of Individuals with Percutaneous or Mucosal Exposure to an Infected or High-Risk Source.

Risk of Hepatitis C Transmission
While HCV is transmitted more efficiently than HIV by the parenteral route, transmission through sexual contact is much less efficient than either HBV or HIV. Persons with multiple partners and those with STIs are at increased risk of acquisition.

HIV co-infection seems to increase the rate of HCV transmission, while individuals without detectable HCV RNA appear to be at extremely low or near zero risk of transmitting HCV.

Currently, there is no effective post-exposure prophylaxis against HCV. Refer to Appendix 9 – Management of Potential Exposures to Hepatitis C.
Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis (HIV PEP)

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The human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP) starter kits are provided by the Saskatchewan Ministry of Health. Human immunodeficiency virus PEP starter kits are located in a variety of health care facilities throughout Saskatchewan (see Appendix 2 – Saskatchewan Post-Exposure Prophylaxis (PEP) Kit Sites).

If HIV PEP is indicated, it is recommended the antiretroviral therapy (ART) medications be initiated as soon as possible.

Initiation of all medications in the HIV PEP ‘starter kit’* should not be delayed:

- HIV PEP should start as soon as possible, preferably within 2 hours of the exposure and is unlikely to be of benefit if more than 72 hours post-exposure.
- Adherence to HIV PEP medications is critical for prevention of infection.

*Refer to Appendix 5 – Antiretrovirals in HIV PEP Kits

NOTE: Genotypic resistance testing of the source patient’s virus at the time of the exposure to confirm the most appropriate HIV PEP regimen is impractical as it may take two or more weeks to obtain the results.

An infectious diseases (ID) Specialist will authorize the remainder of the 28 days course of HIV PEP. A prescription for the balance of the therapy should be given by the attending physician/ID Specialist/RN(NP) to the exposed person if required. This section provides the details for obtaining the balance of HIV PEP medications.

Provision of HIV PEP Kit

The physician or RN(NP) will make the determination if an HIV PEP Kit is recommended. When the ER physician or RN(NP) requires a second opinion on the results of the Risk Assessment, the Medical Health Officer (MHO) or ID Specialist can be consulted to assist in decision-making. When the situation is questionable and access to an ID Specialist is delayed, it is better to start HIV PEP and ensure quick assessment by an ID Specialist to determine the need to continue therapy.

Before dispensing the HIV PEP Kit, the current list of medications the exposed person is on must be reviewed to determine if there are any contraindications. It is ideal to view the prescription history in the Saskatchewan Drug Plan’s electronic Pharmaceutical Information Program (PIP). Refer to Appendix 5 – Antiretrovirals in HIV PEP Kits for medications and drug interactions.

Guidelines for the Management of Exposure to Blood and Body Fluids

Government of Saskatchewan
Ministry of Health
**Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis (HIV PEP)**

**Determine Necessity of Ongoing HIV PEP**
The ER physician or RN(NP) doing the initial assessment is required to have a timely phone consultation (within 24 hours) with an ID Specialist so authorization for ongoing HIV PEP can occur (see note below). If the initial or ongoing risk assessment indicates that HIV PEP should be continued, the full treatment period is 28 days.

The HIV PEP Kit includes 3 days of medication. The remaining course for HIV PEP medications can be obtained with a prescription. Access to HIV PEP medications from a community pharmacy, if the pharmacy does not have the medication in stock, may take approximately 2 days.

**Decision for Ongoing HIV PEP**
The final determination for ongoing HIV PEP is made in consultation with an ID Specialist at the time of the exposure.

The ID Specialist will provide recommendations on the appropriate HIV PEP medications.

**Accessing HIV PEP Medications to Complete 28 Day Course**
If ongoing HIV PEP is recommended by the ID Specialist, the attending physician or RN(NP) will write a prescription for the client.

**Timely Access to Ongoing HIV PEP Medications**
It may take up to 2 days for the community pharmacies to obtain the medications for HIV PEP and it is imperative no doses are missed in the interim, therefore:

- Review the medications the exposed person is currently taking to determine if there are any contraindications or potential for severe drug interactions. Refer to Appendix 5 – Antiretrovirals in HIV PEP Kits for medications and drug interactions.
- Fax the prescription to the client’s pharmacy of choice as soon as written and indicate it is for “PEP” and the name of the ID Specialist who authorized it.

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8 PEP Kits located in sites north of Prince Albert contain 5 days of medications.
9 The Saskatchewan Pharmacy Information Program (PIP) is a recommended reference for this information.
The ongoing HIV PEP medications will be provided to the client free of charge:

- **Saskatchewan Drug Plan**
  The Saskatchewan Drug Plan authorizes Exception Drug Status (EDS)\(^{10}\) for the client when the physician or pharmacist requests it. The pharmacist needs to know the EDS criteria requested is ‘HIV PEP’ and the name of the ID Specialist authorizing ongoing HIV PEP so they can inform the Drug Plan.

- **Non-Insured Health Benefits (NIHB)**
  Health Canada NIHB provides coverage for registered First Nations and recognized Inuit individuals in Canada with a limited range of medically necessary health-related goods and services not provided through private or provincial/territorial health insurance plans. A link to the drug benefit list is found at: [http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/med-list/index-eng.php](http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/med-list/index-eng.php). Most medications are an open benefit and do not require prior approval. If prior approval is required, the pharmacist will call the Drug Exception Centre at 1-800-580-0950 to initiate the exception process. The prescriber will be faxed a form to complete so a decision can be made.

- **Workers’ Compensation Board (WCB)**
  In the instance of occupational exposures where WCB provides coverage, the usual WCB process should be followed.\(^{11}\) If the claim is not yet set up through WCB, options for payment include:
  a. The employer may pay for the prescription and submit the bill to WCB for coverage once the claim is set up.
  b. The employee can pay for the prescription and submit the bill to WCB for coverage once the claim is set up.
  c. The employee can request the prescription be filled for one week at a time to reduce upfront costs and to allow time for WCB to set the claim up.

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\(^{10}\) For immediate EDS approval during Monday to Friday office hours call (306) 787-8744. When after hours approval is sought, call 1-800-667-2549. Requests received in this manner may take longer to process.

Should WCB deny coverage, but the ID Specialist determines the exposure requires HIV PEP, the medications would be covered by the Ministry of Health. To facilitate coverage:

a. The Saskatchewan Drug Plan will approve the EDS for the HIV PEP medications.
b. The pharmacy will submit a manual pharmacy claim to the Drug Plan for the medications if there is a patient co-pay portion.
c. The Drug Plan will pay the pharmacy for the full cost of the prescription.

Potential Adverse Effects of One Month of Antiretroviral Therapy

The following provides a rough estimate of frequency of adverse effects to assist discussion between the physician and the exposed person in deciding about use of HIV PEP.

- **Minor Reactions** – nausea, fatigue, etc. (70% of patients).
- **Serious Reactions** – are rare. Due to the frequency of minor reactions, individuals may be unable to work for the month of therapy (30 – 60% of patients); however, this risk is probably lower with the newer regimens.
- **Long Term Effects** – are poorly defined: $\approx 1:5,000$.
- **Risk of Death** – is unknown, but estimated to be 1:15,000 to 1:150,000 (BC Centre for Excellence in HIV/AIDS, 2009).

Special Considerations

Considerations should be given to individuals with **renal insufficiency** and those on other medications. Significant drug interactions and dosing adjustments are highlighted in Appendix 5 – Antiretrovirals in HIV PEP Kits.

Pregnant/Breastfeeding Clients

The antiretroviral medications contained in the provincial HIV PEP kit are 1st line choices for treating pregnant HIV patients and as such may be used if HIV prophylaxis required. Do not deny HIV PEP solely on the basis of pregnancy. As with all HIV exposures where HIV PEP is initiated, expert consultation with an ID Specialist should be sought as soon as possible.

HIV PEP is indicated at any time during pregnancy when a significant exposure to HIV has occurred. Before administering to a pregnant woman, the clinician should discuss the potential benefits and risks to her and the fetus.
It should be noted there has been no evidence of human teratogenicity for Combivir® or Kaletra® (i.e., well-tolerated, short-term safety demonstrated in Phase I/II studies; both rated FDA pregnancy category C [Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission, 2011]).

**Avoid breastfeeding** while on HIV PEP and for 3 months after the exposure or until HIV transmission has been ruled out. The risk of breastfeeding is related to the risk of transmission of the virus through the breastmilk, not because of risks from the medications.

**Children**

The antiretroviral medications contained in the provincial HIV PEP kit are also 1st line choices for treating HIV positive children, though oral solution formulations should be obtained as soon as possible to ensure optimal doses of each agent and avoid the need to split tablets. (See **Appendix 5 – Antiretrovirals in HIV PEP Kits** for recommendations to accommodate pediatric dosing using a HIV PEP Kit).
An occupational exposure is an exposure to human immunodeficiency virus (HIV) contaminated blood or body fluids, or concentrated virus in an occupational setting including health care, corrections and policing, sanitation workers and other workplaces. This involves any non-intact skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious material that may result from the performance of employees’ duties.

For these guidelines, the following occupational groups have been identified:
- Regional Health Authority employees.
- Employees of other organizations – this may include civic, provincial or federal employees (sanitation workers, corrections workers, Royal Canadian Mounted Police, Health Canada employees working in facilities, or private industry).
- Self-Employed.

**Assumption:** An occupational exposure is where the source is the patient/client and the exposed is the care provider/worker.

The **Exposure Incident Report Form (Appendix 3)** should be completed by the attending physician/RN(NP) and submitted to the Regional Public Health Office. Public Health will redirect the Incident Report Form to the appropriate health department or jurisdiction responsible for follow-up for the client (for example, Employee Health Services for Health Region Staff or to First Nations and Inuit Health Branch/Northern Inter-Tribal Health Authority for First Nations clients living on reserve).

**Step 1 – History of the Incident**
Take a history of the incident – Complete **Exposure Incident Report Form (Appendix 3)** and refer to **Appendix 15 – Collection Use and Disclosure of Information**. Determine the time elapsed since the exposure. Human immunodeficiency virus post-exposure prophylaxis (PEP) is most beneficial if started within 2 hours. If the exposure occurred greater than 72 hours from presentation, HIV PEP is not recommended.
Step 2 – Risk Assessment – Refer to Section 2 – Risk Assessment.
  a. Exposure Fluid.
  b. Type of Exposure.

Step 3 – Classify the level of risk for HIV – Refer to Section 2 – Risk Assessment.
  High-risk.
  Low-risk.

Step 4 – Management of Exposure
  a. Wound/exposure site management.
  b. Tetanus vaccination or tetanus immune globulin should be provided based on the assessment of the injury and immunization history.
  c. Baseline laboratory evaluation of exposed person. See Appendix 10 – Monitoring Recommendations Following Exposures.
     - HIV testing;
     - serologic testing for hepatitis B and hepatitis C.
  d. Testing of source if available.

HIV Management – Refer to Section 3 – Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis.

Hepatitis B Management
I. Review Hepatitis B Immunization History and Immune Status.
   Health Region Employees
   Upon notification of exposure of an employee, the occupational/employee health nurse should determine if documentation for hepatitis B immune status is available. In the absence of the data, the employee should be asked to confirm hepatitis B immune status. Ideally, hepatitis B immune globulin (HB Ig) should be provided within 48 hours therefore if immune status cannot be obtained within this timeframe, refer to II – Arrange for Administration of appropriate Hepatitis Immunological Agents.
Non-Health Region Employees
The employee should provide consent before any attempts are made to contact their employing agency to obtain hepatitis B immunization records. Alternatively, during office hours Monday to Friday, the local public health office\textsuperscript{12} may be contacted to review immunization history.

**NOTE:** If the immunizations were provided by the employer, Public Health’s records may not be current.

II. Arrange for Administration of Appropriate Hepatitis Immunological Agents.
Hepatitis B vaccine and/or HBIg should be provided as per the algorithm in Appendix 8 – Management of Potential Exposures to Hepatitis B.

If indicated, HBIg should be provided within 48 hours after an exposure. The efficacy of HBIg decreases significantly after 48 hours but may be given up to 7 days after exposure. This allows time to review the necessity for the immune globulin and to access it from Canadian Blood Services (if it is not already available in the facility/region).

Individuals requiring immunization may be referred to Occupational/Employee Health or Public Health (if time allows) or be given the first dose of hepatitis B immunization in the ER and referred to Occupational/Employee Health or Public Health for completion of immunization series.

**Hepatitis C Management**
There is no PEP for exposure to hepatitis C.

Seek expert consultation in situations where source testing is positive for hepatitis B or C. Refer to Appendix 9 – Management of Potential Exposures to Hepatitis C and Appendix 10 – Monitoring Recommendations Following Exposures.

**Step 5 – Counselling**
Refer to Section 6 – Counselling and Follow-Up for guidelines and topics to discuss with the exposed. This includes routine counselling as well as additional recommendations for

those engaging in behaviours with ongoing risks. Appendix 6a – Patient Information Following an Exposure should be provided and reviewed with the client. When HIV PEP is provided, Appendix 6b – Patient Information for HIV PEP Kits that is found in the PEP Kits should be provided to the individual.

Regardless of HIV status, assess and assist with access to medical care, social support services, and risk-reduction counselling. Refer to Appendix 13 – Expert Consultation Resources for contact information of various services and care providers.

Step 6 – Follow-up Testing
The client should be advised to follow-up with their family physician or the health region occupational/employee health department for follow-up assessment and testing as outlined in Appendix 10 – Monitoring Recommendations Following Exposures.

NOTE: Public Health will also follow-up with all non-health region staff that have experienced an occupational exposure to ensure they are aware of the follow-up required with their primary care provider.

Step 7 – Reporting Requirements
• Refer to Appendix 12 – Reporting Requirements.
• Ensure the Exposure Incident Report Form (Appendix 3) is completed and submitted to the Regional Public Health Office (the Medical Health Officer or Communicable Disease Coordinator) who will submit necessary reporting elements to the Ministry.
• The HIV PEP Kit Replacement Form (Appendix 4) must be completed and Page 1 must be sent to Ministry of Health. Page 2 must be sent to Royal University Hospital (RUH) Pharmacy to have another kit dispensed to the HIV PEP Kit location.
• Workers Compensation Board Forms\(^{13}\) that must be completed include:
  ➢ the employers report of injury (E1);
  ➢ the physician’s report to WCB.
• Employees should follow their employing agencies incident reporting protocols.

Non-Occupational (Community) Exposures

Non-Occupational exposures are any direct mucosal, percutaneous, or intravenous contact with potentially infectious body fluids that occurs outside perinatal or occupational situations. Examples of non-occupational exposure situations:

- needlestick injury from needle found in the community;
- individuals exposed to blood and body fluids;
- physical altercations where exposure to blood or body fluids may occur;
- penetrating injury following an assault;
- tattoos, body piercing or other body modification procedures;
- accidents;
- bite injury:
  - penetrating percutaneous injury;
  - mucosal exposure.
- sexual exposure (refer to the Section 5a – Sexual Exposures for additional information about sexual exposures and recommendations)
- lifestyle factors (see Section 5b – Lifestyle Exposures):
  - needle sharing;
  - serodiscordant couples;
  - unprotected consensual sexual exposure.

The rationale for using human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP) follows a similar logic to that of occupational exposure. Although data from the studies and case reports do not provide definitive evidence of the efficacy of HIV PEP after sexual, injection drug use, and other non-occupational exposures to HIV, the cumulative data demonstrate that antiretroviral therapy initiated soon after exposure and continued for 28 days might reduce the risk for acquiring HIV.

**Step 1 – History of the Incident**
Take a history of the incident – complete Exposure Incident Report Form (Appendix 3) and refer to Appendix 15 – Collection Use and Disclosure of Information. The history may identify a potential for exchange of fluids (e.g. physical altercation). Both individuals in these exposures should be assessed from the perspective of being both the exposed and the source. Determine the time elapsed since the exposure. Human immunodeficiency virus PEP is most beneficial if started within 2 hours. If the exposure occurred greater than 72 hours from presentation, HIV PEP is not recommended.
Step 2 – Risk Assessment – Refer to Section 2 – Risk Assessment.
   a. Exposure Fluid.
   b. Type of Exposure.

Step 3 – Classify the level of risk for HIV – Refer to Section 2 – Risk Assessment.
   High-risk.
   Low-risk.

Step 4 – Management of Exposure
   a. Wound/exposure site management.
   b. Tetanus vaccination or tetanus immune globulin should be provided based on the assessment of the injury and immunization history.
   c. Baseline laboratory evaluation of exposed person. See Appendix 10 – Monitoring Recommendations Following Exposures.
      ▪ HIV testing;
      ▪ serologic testing for hepatitis B and hepatitis C.
   d. Testing of source if available.

In the instance of sexual exposure, refer to Section 5a – Non-Occupational – Sexual Exposures for other considerations.

HIV Management – Refer to Section 3 – Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis.

Hepatitis B Management
I. Review Hepatitis B Immunization History and Immune Status.
   During office hours on Monday to Friday, the local public health office may be contacted to review immunization history.

II. Arrange for Administration of Appropriate Hepatitis B Immunological Agents.
   Hepatitis B vaccine and/or hepatitis B immune globulin (HBlg) should be provided as per the algorithm in Appendix 8 – Management of Potential Exposures to Hepatitis B.
Community needlestick injury exposures (when the source is unknown) are low-risk and should be managed with hepatitis B vaccine only as per Uninfected (HBsAg-) or Low-Risk Source in Appendix 8.

If indicated, HBIg should be provided within 48 hours after an exposure. The efficacy of HBIg decreases significantly after 48 hours but may be given up to 7 days after exposure. This allows time to review the necessity for the immune globulin and to access it from Canadian Blood Services (if it is not already available in the facility/region).

Individuals requiring immunization may be referred to Public Health (if time allows) or be given the first dose of hepatitis B immunization in the ER and referred to Public Health for completion of immunization series.

**Hepatitis C Management**

There is no PEP for exposure to hepatitis C.

Seek expert consultation in situations where source testing is positive for hepatitis B or C. Refer to Appendix 9 – Management of Potential Exposures to Hepatitis C and Appendix 10 – Monitoring Recommendations Following Exposures.

**Step 5 – Counselling**

Refer to Section 6 – Counselling and Follow-Up for guidelines and topics to discuss with the exposed. This includes routine counselling as well as additional recommendations for those engaging in behaviours with ongoing risks. Appendix 6a – Patient Information Following an Exposure should be provided and reviewed with the client. When HIV PEP is provided, Appendix 6b – Patient Information for HIV PEP Kits that is found in the PEP Kits should be provided to the individual.

Regardless of HIV status, assess and assist with access to medical care, social support services, and risk-reduction counselling. Refer to Appendix 13 – Expert Consultation Resources for contact information of various services and care providers.

**Step 6 – Follow-up Testing**

The client should be advised to follow-up with their family physician for follow-up assessment and testing as outlined in Appendix 10 – Monitoring Recommendations Following Exposures.
Non-Occupational (Community) Exposures

Guidelines for the Management of Exposure to Blood and Body Fluids

NOTE: Public Health will also follow-up with all non-occupational exposures to ensure they are aware of the follow-up required with their primary care provider.

Step 7 – Reporting Requirements
- Refer to Appendix 12 – Reporting Requirements.
- Ensure the Exposure Incident Report Form (Appendix 3) is completed and submitted to the Regional Public Health Office (the Medical Health Officer or Communicable Disease Coordinator) who will submit necessary reporting elements to the Ministry.
- The HIV PEP Kit Replacement Form (Appendix 4) must be completed and Page 1 must be sent to Ministry of Health. Page 2 must be sent to Royal University Hospital Pharmacy to have another kit dispensed to the HIV PEP Kit location.
In dealing with cases of sexual assault, multiple factors need to be considered in each case, before a decision is made regarding the use of human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP). Generally the occurrence of transmission under these circumstances is thought to be low (U.S. Centers for Disease Control and Prevention, 2010). The following factors are pertinent to the decision making process:

- the known or unknown HIV status of the assailant(s);
- the risk profile of the assailant(s);
- the nature and extent of mucosal exposure that occurred;
- the presence of clinical conditions that may enhance transmission such as lacerations or sexual transmitted infections (STIs);
- the possibility of multiple events particularly in cases where children are involved.

**NOTE:** HIV PEP should not be considered if more than 72 hours after the exposure.


In addition to assessing for HIV, the following should also be considered:

- consider screening (unlikely to be positive in first 72 hours) and prophylaxis for other STIs;
- pregnancy testing, as appropriate;
- assess need for emergency contraception.

With all the above in mind, a considered process is followed and a recommendation can be made regarding the use of HIV PEP. In cases where the matter is not clear, consultation with an infectious disease Specialist or Medical Health Officer is recommended.

In all cases, routine follow-up procedures and management for blood borne pathogen exposure are to be followed as outlined in [Section 5 – Non-Occupational (Community) Exposures](http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx). Specific testing and follow up for STIs as per the Canadian Guidelines on Sexually Transmitted Infections14 and the Saskatchewan Communicable Disease Control Manual15 should occur.

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15 [http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx](http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx)
Fischer et al. (2006) provides recommendations and considerations for HIV PEP based on the nature of exposure and what information is known about the HIV status and risks of the source.

Table 5.1 Recommendations for HIV PEP based on Source Status and Nature of Exposure

<table>
<thead>
<tr>
<th>Sexual Exposure</th>
<th>HIV Status of source</th>
<th>Source individual is known to be HIV positive</th>
<th>Source has high-risk behaviour and/or is from an area of high HIV prevalence</th>
<th>Source does not have high-risk behaviour nor is from an area of high HIV prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive anal sex</td>
<td>Source individual is known to be HIV positive</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Considered</td>
</tr>
<tr>
<td>Insertive anal sex</td>
<td>Source individual is known to be HIV positive</td>
<td>Recommended</td>
<td>Considered</td>
<td>Not recommended</td>
</tr>
<tr>
<td>Receptive vaginal sex</td>
<td>Source individual is known to be HIV positive</td>
<td>Recommended</td>
<td>Considered</td>
<td>Not recommended</td>
</tr>
<tr>
<td>Insertive vaginal sex</td>
<td>Source individual is known to be HIV positive</td>
<td>Recommended</td>
<td>Considered</td>
<td>Not recommended</td>
</tr>
<tr>
<td>Fellatio with ejaculation</td>
<td>Source individual is known to be HIV positive</td>
<td>Considered</td>
<td>Considered</td>
<td>Not recommended</td>
</tr>
<tr>
<td>Splash of semen into eye</td>
<td>Source individual is known to be HIV positive</td>
<td>Considered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellatio without ejaculation</td>
<td>Source individual is known to be HIV positive</td>
<td>Not recommended</td>
<td></td>
<td></td>
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<tr>
<td>Cunnilingus</td>
<td>Source individual is known to be HIV positive</td>
<td>Not recommended</td>
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</table>

As in all cases, the patient’s preferences should also be factored into the final decision-making process.

**Sexual Exposures and Sexually Transmitted Infections**

Uninfected persons may or may not acquire STIs when exposed to an infected individual. Many factors increase the probability of transmission including:

- the virulence of the pathogen (for example, syphilis is more virulent than gonorrhea, which is more virulent than chlamydia);
- high concentration of the pathogen in semen or other genital fluids;
- presence of another STI in either the infected or susceptible person;
- type of sexual contact (anal intercourse has higher risk than vaginal intercourse with oral sex carrying the lowest risk of transmission);
- absence of male circumcision;
- cervical ectopy;
- no condom with the sexual act;
- use of spermicides;
- trauma associated with the sexual act.
Sexual transmitted infection prophylaxis should be considered in sexual assault/abuse cases. Offer STI prophylaxis if:

- it is known that the assailant is infected or at high-risk for an STI;
- requested by the patient/parent/guardian;
- the patient has signs or symptoms of an STI;
- in addition, it may be appropriate to offer prophylaxis in situations where vaginal, oral or anal penetration has occurred because most sexual assault victims do not return for follow-up visits.

The efficacy of STI antibiotic prophylaxis has not been studied in sexual assault. Prophylaxis should be as recommended for treatment of specific diseases as outlined in the Canadian Guidelines on Sexually Transmitted Infections.\(^\text{16}\)

Recommendations for testing and treatments are provided for Sexual Abuse in Peripubertal and Prepubertal Children at: [http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-lcdcits/section-6-5-eng.php](http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-lcdcits/section-6-5-eng.php). A pediatrician should be consulted in all of these instances.

Recommendations for testing and treatment are provided for Sexual Assault in Postpubertal Adolescents and Adults at: [http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-lcdcits/section-6-6-eng.php](http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-lcdcits/section-6-6-eng.php).

Despite providing prophylaxis, clients should be tested for STIs again in 10 days to 2 weeks.

**Hepatitis B Management**

I. Review Hepatitis B Immunization History and Immune Status.
   During office hours on Monday to Friday, the local public health office may be contacted to review immunization history.

II. Arrange for Administration of Appropriate Hepatitis B Immunological Agents.
   Hepatitis B vaccine and/or hepatitis B immune globulin (HBIG) should be provided as per the algorithm in [Appendix 8 – Management of Potential Exposures to Hepatitis B](http://www.phac-aspc.gc.ca/std-mts/sti-its/guide-lignesdir-eng.php).

If indicated, HBIg should be provided within 48 hours after an exposure. The efficacy of HBIg decreases significantly after 48 hours but may be given up to 7 days after exposure. This allows time to review the necessity for the immune globulin and to access it from Canadian Blood Services (if it is not already available in the facility/region). In the event of a sexual exposure HBIg may be considered for up to 14 days following exposure.

Individuals requiring immunization may be referred to Public Health (if time allows) or be given the first dose of hepatitis B immunization in the ER and referred to Public Health for completion of immunization series.
Non-Occupational – Lifestyle Exposures

Non-occupational exposures include those where an individual’s lifestyle places them in situations where they may be exposed to human immunodeficiency virus (HIV). Some examples:

- **Single or episodic exposure without taking precautions**
  - tattoo, piercing;
  - fight in a bar;
  - consensual sex;
  - initial experimentation with drugs.

- **Single or episodic exposure with a background of protected chronic exposure**
  - regular, ongoing consensual protected sex with an intimate HIV positive partner and there is condom failure (slips, breaks or fail to use on that occasion);
  - sex workers who would normally use a condom and there is condom failure or sexual assault;
  - an injection drug user who is consistent in using appropriate harm reduction measures who mixes up drug use equipment with another user.

- **Single or episodic exposure with a background of unprotected chronic exposure**
  - individual who has regular, ongoing consensual unprotected sex with an intimate HIV positive partner, is sexually assaulted by their partner or someone else, or has another type of exposure such as a needlestick injury.

- **Chronic exposure without taking precautions or inconsistent use of precautions**
  - injection drug users (IDU) repeatedly sharing needles/works with users with known or unknown HIV status;
  - domestic abuse.

When clients present for an incident for which their lifestyle has placed them at risk, the incident for which they are presenting should be assessed on its own merits. In addition to the risk assessment of the exposure, additional referrals and supports should be offered to the client with ongoing risks. Opportunities to link the client with other supportive services should not be missed.

Although the most effective way to prevent HIV transmission is to protect against exposure, HIV post-exposure prophylaxis (PEP) offers the possibility of preventing HIV transmission when exposure to HIV has occurred. It is likely to be most effective when treatment of high-risk exposures is combined with a strong educational component that emphasizes prevention of future exposures. However there are situations of chronic exposures where use of HIV PEP is not recommended.
Eligibility for HIV PEP should be based on the relevance of HIV PEP to prevent HIV infection from a single exposure and should never be a judgment of behaviour or exposure patterns of the individual. An assessment of an individual’s exposure pattern should be based on client self-reporting.

Concerns have been raised about the potential risks of using HIV PEP as an intervention for people whose lifestyle places them in situations where they may be exposed to HIV. These include:

- possible decrease in risk-reduction behaviours resulting from a perception that post-exposure treatment is available;
- the occurrence of serious adverse effects from antiretroviral treatment in otherwise healthy persons;
- potential selection for resistant virus (particularly if adherence is poor during the HIV PEP course).

Evidence indicates that these theoretical risks might not be major problems:

- Several studies indicate that while individuals may not decrease their at-risk behaviour, they do not increase risky behaviour knowing that HIV PEP is available.
- Most people taking HIV PEP will experience side effects but severe side effects and toxicities appear to be infrequent. Refer to Section 3 - Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis.
- Additional information is included in Appendix 5 – Antiretrovirals in HIV PEP Kits and in Section 6 – Counselling and Follow-Up.

Step 1 – History of the Incident

Take a history of the discreet incident for which the client is presenting. Complete the Exposure Incident Report Form (Appendix 3) and refer to Appendix 15 – Collection Use and Disclosure of Information. Determine if the individual falls into a chronic or episodic exposure category as outlined on page 1.

Determine the time elapsed since the exposure. This may be difficult to determine based on the ongoing risks the individual may be exposed to. Human immunodeficiency virus PEP is most beneficial if started within 2 hours. If the exposure occurred greater than 72 hours from presentation, HIV PEP is not recommended.
If a significant exposure has occurred, then additional considerations for use of HIV PEP for individuals whose lifestyle places them in situations where they may be exposed to HIV include:

- Is this an isolated or infrequent exposure?
- Is this a frequent, recurrent exposure?
- Is there genuine intent to change behaviour?

Human immunodeficiency virus PEP is recommended in situations in which there is an isolated or infrequent exposure (sexual, needle, or trauma) or a lapse in previous risk-reduction practices. Situations that may prompt a request for HIV PEP include condom slippage, breakage, or lapse in use by serodiscordant partners; unsafe needle sharing; or other episodic exposure to blood.

Persons who engage in behaviours that result in frequent, recurrent exposures that would require sequential or near-continuous courses of antiretroviral medications (e.g., discordant sex partners who rarely use condoms or injection-drug users who often share injection equipment) should not have HIV PEP recommended. Follow-up in these situations should still involve offering of HIV testing so early treatment can be commenced if they are identified to be HIV positive.

However, HIV PEP should not be absolutely dismissed solely on the basis of repeated risk behaviour or repeat presentation for HIV PEP. If there is genuine intent to change behaviour, or to leave a domestic violence situation, (and the individual is HIV negative) HIV PEP can be offered for that exposure episode along with supportive education and prevention interventions.

If there is no intent/ability to change exposure, or if high-risk behaviour resumes despite appropriate intervention +/- use of HIV PEP, the risk (potential medication toxicity, adherence factors, potential resistance, and cost) outweighs the benefit of repeated use of HIV PEP. Human immunodeficiency virus PEP is not recommended for persons who continue to engage in high-risk behaviours resulting in frequent, recurrent exposures and who appear to rely on HIV PEP as the sole intervention for HIV prevention.

For individuals who continue to engage in risky behaviour, consultation with an infectious disease Specialist may be warranted to discuss alternative measures that may be available, for example the possible use of pre-exposure prophylaxis. Pre-exposure prophylaxis is not currently funded in Saskatchewan.
Non-Occupational – Lifestyle Exposures

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Step 2 – Risk Assessment – Refer to Section 2 – Risk Assessment.
   a. Exposure Fluid.
   b. Type of exposure.

Consider HIV point of care test for the Exposed as outlined in Section 2 – Risk Assessment, HIV Tests for Exposed Individuals.

Step 3 – Classify the level of risk for HIV – Refer to Section 2 – Risk Assessment.
   High-risk.
   Low-risk.

Step 4 – Management of Exposure
   a. Wound/exposure site management.
   b. Tetanus vaccination or tetanus immune globulin should be provided based on the assessment of the injury and immunization history.
   c. Baseline laboratory evaluation of exposed person. See Appendix 10 – Monitoring Recommendations Following Exposures.
      ▪ HIV testing;
      ▪ serologic testing for hepatitis B and hepatitis C.
   In the instance of sexual exposure, the following should also be considered:
      ▪ consider screening (unlikely to be positive in first 72 hours) and prophylaxis for other sexually transmitted infections;
      ▪ pregnancy testing, as appropriate;
      ▪ assess need for emergency contraception.
   d. Testing of source if available. Refer to Table 2.6.

HIV Management – Refer to Section 3 – Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis.

Hepatitis B Management
I. Review Hepatitis B Immunization History and Immune Status.
II. During office hours on Monday to Friday, the local public health17 office may be contacted to review immunization history.


Guidelines for the Management of Exposure to Blood and Body Fluids
III. Arrange for Administration of Appropriate Hepatitis Immunological Agents.
Hepatitis B vaccine and/or hepatitis B immune globulin (HBIg) should be provided as per the algorithm in Appendix 8 – Management of Potential Exposures to Hepatitis B.

If indicated, HBIg should be provided within 48 hours after an exposure. The efficacy of HBIg decreases significantly after 48 hours but may be given up to 7 days after exposure. This allows time to review the necessity for the immune globulin and to access it from Canadian Blood Services (if it is not already available in the facility/region). In the event of a sexual exposure HBIg may be considered for up to 14 days following exposure.

Individuals requiring immunization may be referred to Public Health (if time allows) or be given the first dose of hepatitis B immunization in the ER and referred to Public Health for completion of immunization series.

**Hepatitis C Management**
There is no PEP for exposure to hepatitis C. Refer to Appendix 9 – Management of Potential Exposures to Hepatitis C.

**Sexually Transmitted Infection (STI) Management for Sexual Exposures**
Offer STI prophylaxis if:
- it is likely that the patient will not return for follow-up;
- it is known that the source individual is infected or at high-risk for an STI;
- it is requested by the patient/parent/guardian;
- the patient has signs or symptoms of an STI.

**Step 5 – Counselling**
Refer to Section 6 – Counselling and Follow-Up. In addition, all individuals in chronic risk situations should receive intensified education and prevention interventions, including assessment of their intent to change behaviour or, in the case of domestic violence, their ability to prevent chronic exposure. The attending physician/RN(NP) can deliver this counselling and/or should refer the client to the appropriate agency. See Section 6 – Counselling and Follow-Up.

The fact sheet in Appendix 6a – Patient Information Following an Exposure should be provided and reviewed with the client. When HIV PEP is provided, Appendix 6b – Patient Information for HIV PEP Kits that is found in the PEP Kits should be provided to the individual.
For those who are engaging in behaviours with ongoing risk, refer to Section 6 – Counselling and Follow-Up for additional information and services that the individual may benefit from a referral to.

Regardless of HIV status, assess and assist with access to medical care, social support services, and risk-reduction counselling. Refer to Appendix 13 – Expert Consultation Resources for contact information of various services and care providers.

Step 6 – Follow-up Testing
The client should be advised to follow-up with their family physician for follow-up assessment and testing as outlined in Appendix 10 – Monitoring Recommendations Following Exposures.

**NOTE:** Public Health will also follow-up with all non-occupational exposures to ensure they are aware of the follow-up required with their primary care provider.

Step 7 – Reporting Requirements
- Refer to Appendix 12 – Reporting Requirements.
- Ensure the Exposure Incident Report Form (Appendix 3) is completed and submitted to the Regional Public Health Office (the Medical Health Officer or Communicable Disease Coordinator) who will submit necessary reporting elements to the Ministry.
- The HIV PEP Kit Replacement Form (Appendix 4) must be completed and Page 1 must be sent to Ministry of Health. Page 2 must be sent to Royal University Hospital Pharmacy to have another kit dispensed to the HIV PEP Kit location.
- Ensure any referrals that are required have been made.
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Guidelines for the Management of Exposure to Blood and Body Fluids

Individuals who have experienced an exposure to blood and body fluids may be anxious about the potential of human immunodeficiency virus (HIV) transmission. This can lead to prolonged absence from work or an interference with performance. It is important that individuals be counselled about their potential risk of infection, the reasons for recommending or not recommending antiretroviral therapy, and the avoidance of potential HIV transmission to others. It may be difficult for individuals who have suffered an exposure to absorb all the information provided in counselling at the time of the incident. It is therefore important that counselling be repeated at the initial follow-up visit by public health, occupational health services or with their family physician, and as needed thereafter.

The fact sheet in Appendix 6a – Patient Information Following an Exposure should be provided and reviewed with the client. When an HIV post-exposure prophylaxis (PEP) Kit is provided, Appendix 6b – Patient Information for HIV PEP Kit should be provided to the individual. Note, this information sheet can be found within the PEP Kit.

Counselling must be "client-centered." Risk-reduction messages must be personalized and realistic. Counselling should be culturally relevant, sensitive to issues of sexual identity, and information provided at a level of comprehension that is consistent with the learning skills of the person being served. Routine pre- and post-test counselling recommendations are included in the Canadian Guidelines on Sexually Transmitted Infections.  

Pre-test counselling must include a personalized client-risk assessment. Client acceptance of risk is a critical component of this assessment. Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all pre-test counselling.

General Guidelines for Initial Counselling

Confidentiality

Individuals should be assured that all test results will be treated in a strictly confidential manner. They should be informed of who test results will be sent to. See Appendix 15 – Collection Use and Disclosure. They should be informed that HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) are all reportable diseases in Saskatchewan and positive test results will be shared with the Medical Health Officer.

Guidelines for the Management of Exposure to Blood and Body Fluids

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Guidelines for the Management of Exposure to Blood and Body Fluids

Risk of HIV infection after exposure
The risk of HIV seroconversion can be roughly estimated in some circumstances based on the exposure and the probability that the source person is HIV positive. See Tables 2.1, 2.2 and 2.4.

Symptoms of acute retroviral syndrome
Counsel the exposed individual about the signs and symptoms of acute retroviral syndrome (flu-like syndrome), and the need to come in for additional testing should these develop.

Symptoms generally appear 2-4 weeks after initial infection and are often nonspecific or mild. They are usually self-limited, lasting 1-2 weeks, but may last several months. The spectrum of symptoms may include an acute mononucleosis-like illness, fever and skin rash. Meningoencephalitis or aseptic meningitis may occur. Less commonly, AIDS-defining conditions such as Pneumocystis jiroveci (formerly carinii) pneumonia (PCP or PJP) or oroesophageal candidiasis may occur (Public Health Agency of Canada, 2008).

Reasons for taking HIV PEP
The following rationale may encourage individuals who are reluctant to take the medications for prophylaxis:

- Early use of antiretroviral therapy (ART) can prevent infection with HIV.
- Antiretroviral therapy can reduce the risk of transmission by 86% (BC Centre for Excellence in HIV/AIDS, 2009).
- A multi-drug regime is used to increase protection and overcome the risk of the source virus being resistant to one of the HIV PEP medications.
- Antiretroviral therapy taken for 28 days is considered to have few long-term side effects despite the morbidity in the short term and rare mortality.
- If HIV PEP is taken and HIV infection still occurs, the early use of antiretrovirals may favourably alter the course of subsequent infection.

Potential adverse effects
Refer to Section 3 – Antiretroviral Therapy (ART) for HIV Post-Exposure Prophylaxis (HIV PEP), and Appendix 5 – Antiretrovirals in HIV PEP Kits.
Evidence that antiretroviral drugs can prevent HIV transmission

Although it is not ethical or practical to obtain evidence of the effectiveness of HIV PEP in humans through a randomized controlled clinical trial, there is strong indirect evidence of effectiveness:

- An international case-control study of health-care workers exposed to HIV found that the odds of HIV infection among those who took zidovudine (ZDV, AZT) were reduced by approximately 81%.
- Animal studies found that HIV PEP administered within 24 to 36 hours of infection was effective in preventing transmission; when HIV PEP was initiated 48-72 hours after exposure, infection occurred in some animals (Canadian HIV/AIDS Legal Network, 2001).

How long before an exposed person can be reasonably sure that they have not been infected?

The HIV Window Period is explained in Section 2 – Risk Assessment. The majority of persons infected will seroconvert within 3 months of the exposure. Testing is recommended as per Appendix 10 – Monitoring Recommendations Following Exposures.

Precautions to avoid transmission to others

Until test results are obtained (at the 3 month point following exposure) the following precautions should be taken to prevent potential transmission of HIV to others:

- abstain from sexual intercourse or use a latex condom at all times during intercourse;
- do not donate blood, plasma, organs, tissue or sperm;
- do not share toothbrushes, razors, needles or other implements which may be contaminated with blood or body fluids;
- do not become pregnant for 3 months.

If breastfeeding, it should be suspended for 3 months (or until HIV infection can be ruled out). Interruption of breastfeeding may be suggested if there remains a risk of HIV transmission (New York State Department of Health AIDS Institute, 2012). The risk of transmission to others is extremely small and should be discussed with a consultant familiar with HIV transmission.

The precautions indicated below should be followed on a regular basis as safe handling and disposal of sharps and items soiled with blood:

- dispose of articles with blood (e.g., tampons, pads, Kleenex) appropriately;
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Guidelines for the Management of Exposure to Blood and Body Fluids

- dispose of sharp items (e.g., razors) in hard-sided containers, taped shut. Refer to Saskatchewan Biomedical Waste Management Guidelines (2008).

**Counselling specific to hepatitis B**

If the exposed person is immune to HBV, no further precautions are necessary. For those who are having HBIg and/or the hepatitis B vaccine series, a discussion leading to an informed decision may be undertaken on issues regarding safer sex and notifying sexual partner(s).

If a breastfeeding mother experiences an exposure hepatitis B, she should be assessed and managed as per Appendix 8 – Management of Potential Exposures to Hepatitis B. In addition to vaccination for the mother, her baby should be provided with HBIg and hepatitis B vaccine even though the risk of HBV through breast milk is low. Once completed, breastfeeding may continue (BC Centre for Disease Control, 2010).

**Counselling specific to hepatitis C**

Persons potentially infected with HCV should advise sexual partners of the potential risk, although the risk of sexual transmission of HCV appears to be lower than that of HBV or HIV. Individuals should be provided with information on safer sex practices and should ensure precautions are taken for 6 months following the exposure.

Current data indicate that transmission of HCV from mother to infant is rare. Hepatitis C virus is not transmitted by breastfeeding. There is a theoretical risk if the mother’s nipples are cracked and bleeding however.

**Follow-up recommendations**

Follow-up is required for all persons receiving antiretroviral therapy with the individual’s family physician in consultation with an infectious disease Specialist.

Follow-up is also required for individuals having had a probable high-risk exposure to HIV. Public Health will follow-up on all reports of exposures to blood and body fluids to provide counselling and to assist the attending physician to ensure follow-up with the individual’s family physician is reinforced with the exposed individual. If the exposed person does not have a family physician, a designated physician may be identified for follow-up.

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Active steps should be taken to address failure to return for post-test counselling. Counsellors should routinely assess whether clients require additional post-test counselling sessions.

Reference may be made to the following articles on the subject of counselling:

- HIV Pre and Post Test Guidelines, British Columbia Centre for Disease Control, September 2011.\(^{20}\)
- Guidelines for HIV Counselling and Testing, Ontario Ministry of Health and Long Term Care, March 2008.\(^{21}\)
- HIV Pre and Post Test Counselling Guidelines, U.S. Department of Health and Human Services, (2010).\(^{22}\)

**Behavioural and risk reduction counselling**

Human immunodeficiency virus PEP is not as effective as avoidance of high-risk behaviors. Discussion of safer/less-risky behaviors is the most important part of post-exposure counselling for lifestyle exposures. Clinicians can engage individuals with services, dependent on the need (urgent vs. non-urgent).

**Recommendations**

Clinicians should be familiar with community prevention resources, including peer education and support, and should make this information readily available in the clinical setting.

Clinicians should refer substance-using patients to treatment programs or other substance use services that best meet the patient’s needs. Some individuals may be participating in risky behaviours (sexual or drug-using) but are unable or unwilling to adopt and maintain safer practices. Clinicians may choose to refer these patients for more intensive prevention counselling.

Individuals presenting with needle sharing exposure as the risk behaviour should be provided with opportunities for intervention to address repeated high-risk behaviours. The local Public Health Office can provide a list of needle exchange programs for the area: [http://www.saskatchewan.ca/residents/health/understanding-the-health-care-system/saskatchewan-health-regions/regional-public-health-offices](http://www.saskatchewan.ca/residents/health/understanding-the-health-care-system/saskatchewan-health-regions/regional-public-health-offices).


\(^{22}\) [http://aids.gov/hiv-aids-basics/prevention/hiv-testing/pre-post-test-counseling/index.html](http://aids.gov/hiv-aids-basics/prevention/hiv-testing/pre-post-test-counseling/index.html)
Counselling and Follow-Up

Patients who do not have a stable social situation often will not be receptive to prevention messages because issues such as housing, food, and access to medical care are the focus of their attention. Clinicians should maximize the use of supportive services and community resources to help stabilize the patient’s social situation. Forming relationships with staff at local programs will facilitate subsequent referrals.

Provincial Regional Health Authority Mental Health and Addictions

Individuals can contact the HealthLine after regular business hours to obtain more information regarding their mental health and substance use. Initial risk assessments are also available for clinicians to utilize at HealthLine Online at:

http://www.saskatchewan.ca/residents/health/accessing-health-care-services/healthline

A list of Mental Health Intake phone numbers can be located at:


If an individual is expressing a need to enter into a detox facility, attempts can be made to encourage a self-referral or assist the individual with entering a facility. Individuals who express a desire to address their substance abuse can be referred to an outpatient addiction counsellor for an assessment. For contact information regarding detoxification and inpatient facilities and outpatient addiction counsellors, go to:


First Nations Inuit Health (FNIH) Mental Health and Addictions

Treatment and Substance Abuse Centres:


Addictions Programming on Reserve:


Mental Health and Wellness:


Suicide Prevention:


Indian Residential Schools Resolution Health Support program:


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Appendix 1 – Acronyms and Definitions

October, 2013

Acronyms
ART – antiretroviral therapy
BBP – blood-borne pathogen
CrCl – creatinine clearance
EDS – Exception Drug Status
HBIg – hepatitis B immune globulin
HBsAg – hepatitis B surface antigen
HBV – hepatitis B virus
HCV – hepatitis C virus
HCW – health care worker
HIV – human immunodeficiency virus
ID – infectious disease
IDU – injection drug use/user
MHO – Medical Health Officer
MSM – men who have sex with men. This includes men who report either homosexual or bisexual contact (Public Health Agency of Canada, 2010)
MSM/IDU – men who have had sex with men and who have injected drugs (Public Health Agency of Canada, 2010)
NIHB – Non-Insured Health Benefits
PCR – polymerase chain reaction
PEP – post-exposure prophylaxis
PIP – Pharmaceutical Information Program
POC – point of care HIV test
PrEP – pre-exposure prophylaxis
qam – every morning
qpm – every evening
STI – sexually transmitted infection
WCB – Workers’ Compensation Board

Definitions
Blood-borne pathogen – any pathogen that can be transmitted from one person to another via blood. Such pathogens may also be transmitted by other body fluids; this varies depending on the pathogen and type of body fluid.

Blood or body fluid exposure – an event where blood or other potentially infectious body fluid comes into contact with non-intact skin, mucous membranes, or subcutaneous tissue (via percutaneous injury), (BC Centre for Disease Control, 2010).
Appendix 1 – Acronyms and Definitions

CD4 count – CD4 cells are T Cells, a subset of white blood cells (leukocytes) found in blood, lymph nodes, and other organs that play a role in the body’s immune function. These "helper" cells initiate the body's response to infections and are a marker for HIV disease progression and risk of opportunistic infections.

Chronic exposure pattern – occurring regularly, for example regular and ongoing unprotected sex with an intimate partner or ongoing needle sharing practices. The identification of repeated or chronic exposure to HIV should lead to greater emphasis on prevention.

Episodic exposures – occurring occasionally. High-risk single or episodic exposure (such as rape by a stranger or needlestick injury) may occur against a background of potential chronic exposure.

Exposed person – the person who came in contact with another person’s blood or body fluids.

Exposure

1. The fluid the person was exposed to is capable of transmitting blood borne pathogens.
   See Guidelines for Management of Exposures to Blood or Body Fluids, Table 2.2.

   AND

2. The fluid contacted the exposed person in such a way that would allow for transmission of blood borne pathogens:
   a. an object with the body fluid punctured or broke the skin of the exposed person
      OR
   b. the fluid came in contact with mucous membrane of the exposed person (e.g., occupational – splashes into eye, mouth or onto broken skin or non-occupational – sexual exposure).

HIV Point of Care Test – screening tests for HIV antibodies that typically provide results within minutes.

HIV Standard Test – the current standard method of HIV testing uses ELISA with confirmatory testing using Western Blot. These standard tests can take several days for results to be available (Saskatchewan Ministry of Health, 2010).

Injection drug users – persons who inject drugs.
Appendix 1 – Acronyms and Definitions

Invasive procedures – procedures which involve penetration of the skin or mucosa during which transmission of HBV, HCV, and/or HIV from health care workers to patients are most likely to occur.

Non-intact skin exposure – blood or body fluids comes in contact with a wound < 3 days old, or with skin having compromised integrity (e.g., dermatitis, abrasions, scratches, burns), (BC Centre for Disease Control, 2010).

Non-occupational (Community) exposure – exposure to blood or body fluids potentially contaminated with a blood-borne pathogen that occurs outside of a work setting. This may involve sexual exposures or needle-sharing activities.

Occupational exposure – exposure to potentially HIV contaminated blood or body fluids, or concentrated virus in an occupational setting. This includes any workplace setting such as health care setting, corrections and policing services or sanitation workers.

Percutaneous injury – blood or body fluids from one person is potentially introduced into the bloodstream of another person through the skin via needlestick, tattooing, body piercing, electrolysis, acupuncture, or other sharps injury.

Permucosal exposure – blood or body fluids from one person is introduced into the bloodstream of another person through contact with mucous membranes lining body cavities such as the eyes, nose, mouth, vagina, rectum and urethra.

Pre-exposure prophylaxis – may be part of comprehensive HIV prevention services in which HIV negative people who are at high risk, take antiretroviral medication daily to try to lower their chances of becoming infected with HIV if they are exposed to it. To date, PrEP has only been shown to be effective in MSM and transgendered women who have sex with men. Studies are underway to evaluate whether it is safe and effective in reducing HIV infection among heterosexual men and women as well as injection drug users, but those results are not yet available (U.S. Centers for Disease Prevention and Control, 2012).

In instances of chronic exposure patterns, PEP is likely not appropriate, however PrEP may be useful in selected circumstances. These cases should be referred to an ID Specialist for consideration.
Routine Practices/Standard Precautions – Routine Practices are the infection prevention and control protocols for use in the routine/daily care of all clients at all times. Principles of Routine Practices include:

- Protecting clients and health care workers (HCWs) and everyone in the health care facility.
- Considering all blood, body fluids, secretions, excretions, drainage, and tissues of all clients potentially infective.
- Conducting a Point of Care Risk Assessment to determine the precautions required when providing care.

Routine Practices include:
1. Hand hygiene.
2. Point of Care Risk Assessment.
3. Use of personal protective equipment – (gloves, mask/respiratory/eye protection, face shields and gowns) when splashes or sprays of blood, body fluids, secretions, or excretions are possible.
4. Respiratory hygiene (cough etiquette).

Sexual exposure – vaginal, anal or oral sexual contact that involves exposure to blood or body fluids, including semen or vaginal secretions. The exposure may be voluntary (consensual) or involuntary (as in an assault).

Source person – the individual whose blood or body fluids came in contact with another person.

Susceptible contact – an individual who does not possess sufficient resistance to a particular infectious agent to prevent contracting infection or disease when exposed to that agent. Interpretations for susceptibility for the blood-borne pathogens discussed in this guideline are identified below:

- HIV – no history of prior anti-HIV positive test.
- HBV – those who have not demonstrated protective antibody levels following completion of a hepatitis B vaccine series OR have no history of a chronic HBV infection.
- HCV – no history of a prior anti-HCV positive test.

Viral load – measurement of the amount of human immunodeficiency virus in the blood expressed as copies per milliliter. Plasma viremia is used to guide treatment decisions and monitor response to treatment.
Appendix 1 – Acronyms and Definitions

References


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<td>Shaunavon Hospital 660 Fourth Street East Shaunavon SK S0N 2M0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-297-2644 F: 306-297-2502</td>
<td>Health Services Manager</td>
</tr>
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<td>Cypress</td>
<td>Maple Creek Hospital 575 Highway #21 South Maple Creek SK S0N 1N0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-662-2611 F: 306-662-3210</td>
<td>Health Services Manager</td>
</tr>
<tr>
<td>Cypress</td>
<td>Leader Hospital 423 Main Street East Leader SK S0N 1H0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-628-3845 F: 306-628-4413</td>
<td>Acute Health Services Manager</td>
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<tr>
<td>Five Hills</td>
<td>Pharmacy Dept. Moose Jaw Union Hospital 455 Fairfield Street East Moose Jaw SK S6H 1H3</td>
<td>3 DAY 3 KITS</td>
<td>P: 306-694-0396 or 306-694-0200 F: 306-694-0325</td>
<td>Director, Pharmacy Access to PIP available</td>
</tr>
<tr>
<td>Five Hills</td>
<td>Pharmacy Department. Assiniboia Union Hospital P. O. Box 1120 Assiniboia SK S0H 0B0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-642-9401 or 306-642-3351 F: 306-642-9459</td>
<td>Director of Care Access to PIP available</td>
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<tr>
<td>Five Hills</td>
<td>Pharmacy Department St. Joseph’s Hospital 216 Bettez Street Mail Bag 50 Gravelbourg SK S0H 1X0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-648-3185 F: 306-648-3440</td>
<td>Director of Client Services Access to PIP available</td>
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<tr>
<td>Heartland</td>
<td>Kindersley Integrated Health Care Facility 1003-1st Street West Kindersley SK S0L 1S0</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-463-2611 F: 306-463-6914</td>
<td>Pharmacist Access to PIP available</td>
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<tr>
<td>Heartland</td>
<td>Unity Hospital P. O. Box 741 Unity SK S0K 4L0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-228-2666 F: 306-228-2292</td>
<td>Care Team Manager Access to PIP available</td>
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<tr>
<td>Heartland</td>
<td>Biggar Hospital P. O. Box 130 Biggar SK S0K 0M0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-948-3323 F: 306-948-2011</td>
<td>Care Team Manager Access to PIP available</td>
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## Appendix 2 – Saskatchewan Post-Exposure Prophylaxis (PEP) Kit Sites

<table>
<thead>
<tr>
<th>Health Region</th>
<th>Location</th>
<th># of Kits</th>
<th>Phone/Fax</th>
<th>Contact</th>
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<td>Kerrobert Integrated Health Center &lt;br&gt;Kerrobert SK S0L 1R0</td>
<td>3 DAY&lt;br&gt;1 KIT</td>
<td>P: 306-834-2646&lt;br&gt;F: 306-834-1007</td>
<td>Care Team Manager&lt;br&gt;&lt;br&gt;Access to PIP available</td>
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<tr>
<td>Heartland</td>
<td>Davidson Health Centre &lt;br&gt;Davidson SK S0G 1A0</td>
<td>3 DAY&lt;br&gt;1 KIT</td>
<td>P: 306-567-2801&lt;br&gt;F: 306-567-2346</td>
<td>Care Team Manager&lt;br&gt;&lt;br&gt;Access to PIP available</td>
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<tr>
<td>Heartland</td>
<td>Heartland Health Region P.H. &lt;br&gt;P. O. Box 1300&lt;br&gt;Rosetown SK S0L 2V0</td>
<td>3 DAY&lt;br&gt;1 KIT</td>
<td>P: 306-882-2672&lt;br&gt;F: 306-882-4683</td>
<td>Clinical Supervisor&lt;br&gt;&lt;br&gt;Public Health Nursing&lt;br&gt;&lt;br&gt;Access to PIP available</td>
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<tr>
<td>Heartland</td>
<td>Outlook &amp; District Health Centre &lt;br&gt;P. O. Box 309&lt;br&gt;Outlook SK S0L 2N0</td>
<td>3 DAY&lt;br&gt;1 KIT</td>
<td>P: 306-867-8676&lt;br&gt;F: 306-867-9449</td>
<td>Care Team Manager&lt;br&gt;&lt;br&gt;Access to PIP available</td>
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<td>Rosetown District Health Centre P. O. Box 850&lt;br&gt;Rosetown SK S0L 2V0</td>
<td>3 DAY&lt;br&gt;1 KIT</td>
<td>P: 306-882-2672&lt;br&gt;F: 306-882-3335</td>
<td>Assistant Head RNs&lt;br&gt;&lt;br&gt;Access to PIP available</td>
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<td>Athabasca, Keewatin, Yatthé &amp; Mamawetan Churchill River*</td>
<td>St. Joseph’s Health Center &lt;br&gt;P. O. Box 219&lt;br&gt;Ile a la Crosse SK S0M 1C0</td>
<td>6 DAY&lt;br&gt;1 KIT</td>
<td>CD /Immunization Coordinator &lt;br&gt;(AHA, KYRHA &amp; MCRRHA)</td>
<td>&lt;br&gt;P: 306-425-8587&lt;br&gt;F: 306-425-8530&lt;br&gt;&lt;br&gt;AND&lt;br&gt;&lt;br&gt;Executive Assistant to MHO</td>
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<td>Athabasca, Keewatin, Yatthé &amp; Mamawetan Churchill River*</td>
<td>La Loche Health Centre &lt;br&gt;Bag Service # 1&lt;br&gt;La Loche SK S0M 1G0</td>
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<td>La Ronge Health Centre &lt;br&gt;P. O. Box 6000&lt;br&gt;La Ronge SK S0J 1L0</td>
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<td>Buffalo Narrows Health Centre &lt;br&gt;P. O. Box 40&lt;br&gt;Buffalo Narrows SK S0M 0J0</td>
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<td>Health Region</td>
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<td>Athabasca, Keewatin Yatthé &amp; Mamawetan Churchill River*</td>
<td>Pinehouse Health Centre P. O. Box 296 Pinehouse SK S0J 2B0</td>
<td>6 DAY 1 KIT</td>
<td>CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA) CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA)</td>
<td>Pinehouse Health Centre P. O. Box 296 Pinehouse SK S0J 2B0</td>
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<td>Sandy Bay Health Centre General Delivery Sandy Bay SK S0P 0G0</td>
<td>6 DAY 2 KITS</td>
<td>CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA) CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA)</td>
<td>Sandy Bay Health Centre General Delivery Sandy Bay SK S0P 0G0</td>
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<td>Athabasca, Keewatin Yatthé &amp; Mamawetan Churchill River*</td>
<td>Yutthé Dene Nakohodi Athabasca Health Facility P. O. Box 124 Black Lake SK S0J 0H0</td>
<td>6 DAY 1 KIT</td>
<td>CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA) CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA)</td>
<td>Yutthé Dene Nakohodi Athabasca Health Facility P. O. Box 124 Black Lake SK S0J 0H0</td>
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<td>Athabasca, Keewatin Yatthé &amp; Mamawetan Churchill River*</td>
<td>Uranium City Health Centre P. O. Box 360 Uranium City, SK S0J 2W0</td>
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<td>CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA) CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA)</td>
<td>Uranium City Health Centre P. O. Box 360 Uranium City, SK S0J 2W0</td>
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<td>Athabasca, Keewatin Yatthé &amp; Mamawetan Churchill River*</td>
<td>Population Health Unit P. O. Box 1920 La Ronge, SK S0J 1L0</td>
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<td>CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA) CD /Immunization Coordinator (AHA, KYRHA &amp; MCRRHA)</td>
<td>Population Health Unit P. O. Box 1920 La Ronge, SK S0J 1L0</td>
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<td>Kelsey Trail</td>
<td>Melfort Hospital Pharmacy Department P. O. Box 1480 Melfort SK S0A 1A0</td>
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<td>Melfort Hospital Pharmacy Department P. O. Box 1480 Melfort SK S0A 1A0</td>
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<td>Kelsey Trail</td>
<td>Nipawin Union Hospital Pharmacy Department P. O. Box 2134 Nipawin SK S0E 1E0</td>
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<td>Nipawin Union Hospital Pharmacy Department P. O. Box 2134 Nipawin SK S0E 1E0</td>
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<td>Kelsey Trail</td>
<td>Tisdale Union Hospital P. O. Box 1630 110th Avenue West Tisdale SK S0E 1T0</td>
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<td>Tisdale Union Hospital P. O. Box 1630 110th Avenue West Tisdale SK S0E 1T0</td>
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<td><strong>Kelsey Trail</strong></td>
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<td>3 DAY</td>
<td>P: 306-327-4711</td>
<td>Pharmacy Technician Access to PIP available</td>
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<tr>
<td></td>
<td>P. O. Box 70</td>
<td>1 KIT</td>
<td>F: 306-327-5115</td>
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<td>512-1st Avenue South</td>
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<td>Porcupine Plain</td>
<td>3 DAY</td>
<td>P: 306-278-2211</td>
<td>Pharmacy Technician Access to PIP available</td>
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<tr>
<td></td>
<td>P. O. Box 70</td>
<td>1 KIT</td>
<td>F: 306-278-3088</td>
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<td>330 Oak Street</td>
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<td>Porcupine Plain SK  S0E 1H0</td>
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<td><strong>Kelsey Trail</strong></td>
<td>Cumberland House Health Centre</td>
<td>6 DAY</td>
<td>P: 306-888-2244</td>
<td>Nurse in charge Access to PIP available</td>
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<td></td>
<td>P. O. Box 8</td>
<td>1 KIT</td>
<td>F: 306-888-2269</td>
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<td>Cumberland House SK  S0E 050</td>
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<td><strong>Northern Intertribal Health Authority</strong></td>
<td>Birch Narrows First Nation Annie Bagg Memorial Nursing Station</td>
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<td>P: 306-894-2112</td>
<td>Senior Health Nurse Birch Narrows Health Center</td>
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<td>General Delivery</td>
<td>1 KIT</td>
<td>F: 306-894-2088</td>
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<td>Turnor Lake SK  S0M 3E0</td>
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<td>P: 306-284-2132</td>
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<td><strong>Northern Intertribal Health Authority</strong></td>
<td>Canoe Narrows/Lake Health Centre and Nursing Station</td>
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<td>Senior Health Nurse Canoe Lake Health Center</td>
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<td>Deschambault Lake SK  S0P 0C0</td>
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<td><strong>Northern Intertribal Health Authority</strong></td>
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<td>1 KIT</td>
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<td><strong>Northern Intertribal Health Authority</strong></td>
<td>English River Health Center General Delivery</td>
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<td>P: 306-396-2072</td>
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<td>Patuanak SK  S0M 2H0</td>
<td>1 KIT</td>
<td>F: 306-396-2047</td>
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# Appendix 2 – Saskatchewan Post-Exposure Prophylaxis (PEP) Kit Sites

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<th># of Kits</th>
<th>Phone/Fax</th>
<th>Contact</th>
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<td>Northern Intertribal Health Authority*</td>
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<td>P: 306-758-2063</td>
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<td>Southend SK S0J 2L0</td>
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<td>Pelican Narrows SK S0P 0E0</td>
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<td>Stanley Mission SK S0J 2P0</td>
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<td>Northern Intertribal Health Authority*</td>
<td>Public Health Unit P. O. Box 787</td>
<td>6 DAY</td>
<td>P: 306-953-0670</td>
<td>Nurse Epidemiologist</td>
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<td>3601 – 5th Avenue East Prince Albert SK S6V 5S4</td>
<td>1 KIT</td>
<td>F: 306-922-0166</td>
<td>Northern Intertribal Health Authority</td>
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<td>Prairie North</td>
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<td>3 DAY</td>
<td>P: 306-446-6590</td>
<td>Pharmacist</td>
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<td>North Battleford SK S9A 1Z1</td>
<td>5 KITS</td>
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<td>Prairie North</td>
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<td>3 DAY</td>
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<td>Lloydminster SK S9V 1Y5</td>
<td>2 KITS</td>
<td>F: 306-820-6222</td>
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<td>Maidstone Health Complex P. O. Box 160</td>
<td>3 DAY</td>
<td>P: 306-893-2622</td>
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<td>Maidstone SK S0M 1M0</td>
<td>1 KIT</td>
<td>F: 306-893-2922</td>
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<td>Riverside Health Complex P. O. Box 10</td>
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<td>Meadow Lake Hospital 711 Centre Street</td>
<td>3 DAY</td>
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<td>Meadow Lake SK S9X 1E6</td>
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<td>Prince Albert Parkland</td>
<td>Victoria Hospital Pharmacy Department.</td>
<td>6 DAY</td>
<td>P: 306-765-6006</td>
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<td>100 – 24th Street West Prince Albert SK S6V 5T4</td>
<td>2 KITS</td>
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<tr>
<td>Prince Albert</td>
<td>Victoria Hospital ER Department</td>
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<td>Prince Albert</td>
<td>Collaborative Emergency Center</td>
<td>6 DAY 1 KIT</td>
<td>P: 306-883-2133 F: 306-883-4440</td>
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<td>Parkland</td>
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<td>Regina</td>
<td>Regina General &amp; Pasqua Hospital Emergency Departments</td>
<td>3 DAY 15 KITS</td>
<td>P: 306-766-2521 F: 306-766-2772</td>
<td>Pharmacy Technician Central Purchasing (PH)</td>
</tr>
<tr>
<td>Qu’Appelle</td>
<td>Regina SK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Nations Healing Hospital</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-332-3613 F: 306-332-2581</td>
<td>Nursing Supervisor Access to PIP available</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 300 450 – 8th Street Fort Qu’Appelle SK SOG 150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southeast Integrated Care Centre, Moosomin Bag #1</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-435-6265 F: 306-435-4245</td>
<td>Manager, Rural Pharmacy Services Access to PIP available</td>
</tr>
<tr>
<td></td>
<td>601 Wright Road Moosomin SK SOG 3N0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Balcarres Integrated Care Centre</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-334-6260 F: 306-334-2674</td>
<td>Facility Manager or Facility Care Coordinator Access to PIP available</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 340 100 South Elgin Street</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Balcarres SK SOG 0C0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Broadview Union Hospital</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-696-5500 F: 306-696-5501</td>
<td>Facility Manager or Patient Care Coordinator Access to PIP available</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 100 901 Nina Street Broadview SK SOG 0K0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indian Head Hospital</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-695-2272 F: 306-695-2525</td>
<td>Facility Manager or Patient Care Coordinator Access to PIP available</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 340 300 Hospital Street Indian Head SK SOG 2K0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wolseley Hospital</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-698-2213 F: 306-698-2041</td>
<td>Facility Manager or Patient Care Coordinator Access to PIP available</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 458 801 Ouimet Street Wolseley SK SOG 5H0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2 – Saskatchewan Post-Exposure Prophylaxis (PEP) Kit Sites

<table>
<thead>
<tr>
<th>Health Region</th>
<th>Location</th>
<th># of Kits</th>
<th>Phone/Fax</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saskatoon</td>
<td>Royal University Hospital 103 Hospital Drive Saskatoon SK S7N 0W8</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-655-1362 F: 306-655-1011</td>
<td>Manager of Nursing/ER Services Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>Saskatoon City Hospital Emergency 701 Queen Street Saskatoon SK S7K 0M7</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-655-8230 F: 306-655-8759</td>
<td>Manager of Nursing/ER Services Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>St. Paul’s Hospital Emergency 1702 – 20th Street Saskatoon SK S7K 0Z9</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-655-5110 F: 306-655-5963</td>
<td>Manager of Nursing/ER Services Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>Borden Primary Health Centre P. O. Box 90 Borden SK S0K 0N0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-997-2110 F: 306-997-2114</td>
<td>Nurse Practitioner Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>Delisle Primary Health Centre P. O. Box 119 Delisle SK S0K 0N0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-493-2810 F: 306-493-2812</td>
<td>Nurse Practitioner Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>Rosthern Hospital P. O. Box 309 Rosthern SK S0K 3R0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-232-4811 F: 306-232-4887</td>
<td>Manager, Rosthern Hospital Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>Lanigan Hospital Lanigan SK S0K 2M0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-365-1411 F: 306-365-2589</td>
<td>Clinical Nurse Leader Access to PIP available</td>
</tr>
<tr>
<td>Saskatoon</td>
<td>Humboldt District Hospital 515 14th Ave. Humboldt SK S0K 2A0</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-682-8118 F: 306-682-4461</td>
<td>Department Head, Pharmacy Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Canora Hospital P. O. Box 749 Canora SK</td>
<td>3 DAY 2 KIT</td>
<td>P: 306-563-5621 F: 306-563-5571</td>
<td>Health Services Manager Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Invermay Health Centre P. O. Box 160 Invermay SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-593-2133 F: 306-593-4566</td>
<td>Health Services Administrator Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Kamsack Hospital P. O. Box 429 Kamsack SK</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-542-2635 F: 306-542-4360</td>
<td>Health Services Manager Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Norquay Health Centre P. O. Box 190 Norquay SK S0A 2V0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-594-2133 F: 306-594-2488</td>
<td>Health Services Administrator Access to PIP available</td>
</tr>
<tr>
<td>Health Region</td>
<td>Location</td>
<td># of Kits</td>
<td>Phone/Fax</td>
<td>Contact</td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
<td>-----------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Preeceville Hospital P. O. Box 469 Preeceville SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-547-2102 F: 306-547-2223</td>
<td>Health Services Manager Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>St. Anthony’s Hospital P. O. Box 280 Esterhazy SK</td>
<td>3 DAY 2 KITS</td>
<td>P: 306-745-3973 F: 306-745-3388</td>
<td>Facility Administrator Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Pioneer Health Care Centre P. O. Box 13 Ituna SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-795-2622 P: 306-795-2622 F: 306-795-3592</td>
<td>Health Services Manager Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>St. Peter’s Hospital Pharmacy Department P. O. Box 1810 Melville SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-728-5407 F: 306-728-4870</td>
<td>Pharmacy Department Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Foam Lake Jubilee Home P. O. Box 460 421 Alberta Avenue East Foam Lake SK S0A 1W0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-272-4141 F: 306-272-4973</td>
<td>Health Services Manager Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Langenburg Health Centre P. O. Box 370 Langenburg SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-743-2661 F: 306-743-2844</td>
<td>Health Services Administrator Access to PIP available</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Yorkton Regional Health Centre Pharmacy Department 270 Bradbrooke Drive Yorkton SK S3N 2K6</td>
<td>3 DAY 4 KITS</td>
<td>P: 306-786-0451 F: 306-782-0452</td>
<td>Pharmacy Access to PIP available</td>
</tr>
<tr>
<td>Sun Country</td>
<td>Weyburn General Hospital Weyburn SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-842-8442 F: 306-842-0064</td>
<td>Regional Director of Pharmacy Access to PIP available</td>
</tr>
<tr>
<td>Sun Country</td>
<td>St. Joseph’s Hospital Estevan SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-637-2413 F: 306-637-2486</td>
<td>Pharmacy Manager Access to PIP available</td>
</tr>
<tr>
<td>Sun Country</td>
<td>Wawota Memorial Health Centre Wawota SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-739-2306 F: 306-739-2479</td>
<td>Health Services Manager Access to PIP available</td>
</tr>
<tr>
<td>Sun Country</td>
<td>Weyburn Public Health Weyburn SK</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-842-8627 or 306-842-8699 F: 306-842-8638</td>
<td>CD/Immunization Coordinator</td>
</tr>
<tr>
<td>Sun Country</td>
<td>Radville Marian Health Center P. O. Box 310 310 Railway Avenue Radville SK S0C 2G0</td>
<td>3 DAY 1 KIT</td>
<td>P: 306-869-2224 F: 306-869-2653</td>
<td>Facility Manager Access to PIP available</td>
</tr>
</tbody>
</table>
Guidelines for the Management of Exposures to Blood and Body Fluids
Appendix 2 – Saskatchewan Post-Exposure Prophylaxis (PEP) Kit Sites

<table>
<thead>
<tr>
<th>Health Region</th>
<th>Location</th>
<th># of Kits</th>
<th>Phone/Fax</th>
<th>Contact</th>
</tr>
</thead>
</table>
| Sun Country   | Arcola Health Centre  
P. O. Box 419  
607 Prairie Avenue  
Arcola SK  S0C 0G0 | 3 DAY  
1 KIT | P: 306-455-2771  
F: 306-455-2397 | Facility Manager  
Access to PIP available |
| Sun Country   | Galloway Health Centre  
P. O. Box 268  
917 Tupper Street  
Oxbow SK  S0C 2B0 | 3 DAY  
1 KIT | P: 306-483-2956  
F: 306-483-5178 | Facility Manager  
Access to PIP available |

*Replacement kits for sites in Athabasca, Keewatin Yatthé, and Mamawetan Churchill River RHAs and Northern Inter-Tribal Health Authority (NITHA) should be sent to La Ronge and Prince Albert respectively. They will arrange for distribution to the individual sites.*
Please see the following pages for the Exposure Incident Report Form.
### A. EXPOSED INDIVIDUAL (enter dates as yyyy/mm/dd)

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (name of First Nations reserve if living on reserve)</td>
<td></td>
<td>Female □ Male □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Card Number</th>
<th>Home phone number</th>
<th>Cell phone number</th>
<th>Work phone number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Care Provider (MD/RN(NP)/none)</th>
</tr>
</thead>
</table>

#### EXPOSED INDIVIDUAL’S PREVIOUS HISTORY (enter dates as yyyy/mm/dd)

<table>
<thead>
<tr>
<th>Prior Hepatitis B vaccination</th>
<th>□ No □ Yes □ Unknown</th>
<th>If yes, specify number of doses (please circle) Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B surface antibody immune (Anti-HBs ≥10 IU/L)</td>
<td>□ No □ Yes Date:</td>
<td>Unknown</td>
</tr>
<tr>
<td>Prior Hepatitis B surface antigen (HBsAg) status</td>
<td>□ Positive □ Negative Date:</td>
<td>Unknown</td>
</tr>
<tr>
<td>Prior Hepatitis C antibody status (anti-HCV)</td>
<td>□ Positive □ Negative Date:</td>
<td>Unknown</td>
</tr>
<tr>
<td>Prior HIV antibody status (anti-HIV)</td>
<td>□ Positive □ Negative Date:</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

| Previous PEP kit usage | □ No □ Yes Date: | □ Unknown |

#### B. DETAILS OF EXPOSURE

**1. Type of Exposure and Injury**

<table>
<thead>
<tr>
<th>Exposure Setting:</th>
<th>□ Occupational Employer:</th>
<th>□ Non-Occupational (Community) □ Lifestyle □ Sexual Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Exposure:</td>
<td>□ Percutaneous □ Insertive Penile-Anal intercourse □ Receptive Penile-Vaginal intercourse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Mucous membrane □ Receptive Penile-Anal intercourse □ Non-intact skin exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Bite □ Insertive Penile-Vaginal intercourse □ Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extent of Injury:</th>
<th>□ Trauma at site □ Fresh/visible blood on the device □ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Deep injury □ Direct injection into a vein or artery</td>
</tr>
</tbody>
</table>

#### 2. Type of Source Fluid

| □ Blood, serum, plasma or other biological fluids visibly contaminated with blood |
| □ Pleural, amniotic, pericardial, peritoneal, synovial and cerebrospinal fluids |
| □ Semen, vaginal secretions |
| □ Saliva contaminated with blood |
| □ Saliva not contaminated with blood |
| □ Lab specimens containing concentrated HBV, HCV, or HIV |
| □ Organ and tissue transplants |
| □ Breast milk |
| □ Unknown (e.g., needle found on street) |
| Other (describe) |
C. SOURCE INDIVIDUAL (complete below)

- Unknown
- Known (first two letters of the first and last names and Date of Birth)

<table>
<thead>
<tr>
<th>Initials</th>
<th>DOB (yyyy/mm/dd)</th>
<th></th>
</tr>
</thead>
</table>

SOURCE INDIVIDUAL’S PREVIOUS HISTORY (enter dates as yyyy/mm/dd)

<table>
<thead>
<tr>
<th>Prior Hep B vaccination</th>
<th>□ No</th>
<th>□ Yes</th>
<th>□ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, specify number of doses (please circle)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hepatitis B surface antibody immune (Anti-HBs ≥10IU/L)</th>
<th>□ No</th>
<th>□ Yes</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Hepatitis B surface antigen (HBsAg) status</th>
<th>□ Positive</th>
<th>□ Negative</th>
<th>□ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Hepatitis C antibody status (anti-HCV)</th>
<th>□ Positive</th>
<th>□ Negative</th>
<th>□ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If HCV antibody positive, HCV PCR status</th>
<th>□ Positive</th>
<th>□ Negative</th>
<th>□ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior HIV antibody status (anti-HIV)</th>
<th>□ Positive</th>
<th>□ Negative</th>
<th>□ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family Physician &/or Infectious Disease Specialist

If known HIV positive:

<table>
<thead>
<tr>
<th>CD4 Count:</th>
<th>Viral Load:</th>
<th>Current ARV Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HIV POC Test Date: Date: ___________________ Result: □ Reactive □ Non-reactive □ Indeterminate

RISK ASSESSMENT OF SOURCE IF HIV NEGATIVE OR UNKNOWN

Consideration of risk is based on source’s IV drug use, participation in high-risk sexual practices, hepatitis C status, and if he or she is from an HIV endemic country.

Refer to Section 2 – Risk Assessment and Appendix 14 – Source Patient Risk Assessment

| Indicate if assessment of source risk is considered to be High or Low |
|-------------------------------------------------------------|-----------------------------|
| High | Low |

D. Baseline Blood Test results

If the baseline test results are not be available on the day of the exposure, the physician or RN(NP) providing follow-up may complete the following later, and will also decide regarding further follow-up testing as per Appendix 10.

<table>
<thead>
<tr>
<th>SOURCE’S BASELINE RESULTS</th>
<th>□ Not available for testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B surface Antigen (HBsAg)</td>
<td>□ Positive □ Negative</td>
</tr>
<tr>
<td>Hepatitis C antibody (anti-HCV)</td>
<td>□ Positive □ Negative</td>
</tr>
<tr>
<td>HIV antibody (anti-HIV)</td>
<td>□ Positive □ Negative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPOSED BASELINE RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B surface antibody (anti-HBs)</td>
</tr>
<tr>
<td>HIV antibody (anti-HIV)</td>
</tr>
<tr>
<td>Hepatitis C antibody (anti-HCV)</td>
</tr>
<tr>
<td>Hepatitis B surface antigen (HBsAg)</td>
</tr>
</tbody>
</table>
To be completed by attending ER physician / RN(NP):

### FOLLOW-UP PROVIDED AT TIME OF ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEP Kit Provided Date and Time of first dose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Consultation with ID Specialist(Identify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing PEP Prescription Provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to other supportive services (i.e. Mental Health/Addictions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBIG provided</td>
<td>DOSE</td>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>1st Dose of hepatitis B Immunization Given</td>
<td>DOSE</td>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>STI Testing/Treatment (identify Tx given)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td Vaccine provided</td>
<td>DOSE</td>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>Discussion about follow-up blood work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faxed to Regional MHO (Do not await baseline test results before faxing) pages 1, 2, 3, 4 &amp; 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form faxed to ID Specialist when consult is required, pages 1, 2, 3 &amp; 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form faxed to Exposed Family Physician (pages 1, 2, 3, &amp; 4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed by: ____________________________ Date: ____________

To be completed by public health or occupational health nurse providing follow-up:

### PUBLIC HEALTH OR OCCUPATIONAL HEALTH FOLLOW-UP

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposed Individual Contacted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form faxed to RHA Occupational/Employee Health Department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form faxed to FNHIHB/NITHA for individuals living on reserve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verified prescription filled (if prescribed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to other supportive services (i.e. Mental Health/Addictions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion about follow-up blood work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk reduction counselling provided</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed by: ____________________________ Date: ____________
Unless the source provides consent, this page should only be faxed to the MHO. Refer to Appendix 15 – Collection Use and Disclosure of Information. If in the professional opinion of the attending physician, the ID Specialist requires the source’s identifying information, and consent has not been provided, documentation of the rationale should be included.

Source identifying information should be severed from the exposed person’s health record.

### Consent obtained to share identifying information with ID Specialist

☐ Yes  ☐ No

Information Faxed:

Date Faxed to ID Specialist _____________

Additional comments: ____________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Signature ________________________________
Please see the following pages for the HIV PEP Kit Replacement Form.
Please complete for all HIV PEP kits used and/or expired medications.

This information is collected for invoicing purposes and for replacement of HIV PEP kits. For more information, please refer to The Guidelines for the Management of Exposures to Blood and Body Fluids, Saskatchewan Ministry of Health at https://www.ehealthsask.ca/services/Manuals/Pages/hiv-guidelines.aspx.

**NOTE:** Replacement medications or kits will not be released without all the information below.

<table>
<thead>
<tr>
<th>Health Region:</th>
<th>Site/Facility:</th>
</tr>
</thead>
</table>

**Type:**
- 3 day kit
- 6 day kit (2x3 day kits)

**Replacement for expired medication:** (Please indicate expiry dates of both medications)
- Combivir® with expiry date of: ____________________________
- Kaletra® with expiry date of: ____________________________

**PEP kit used on (date):**

**Exposed Person Name:**

**Date of Birth (DD/MM/YYYY):**

**Health Card Number:**

**Exposure Category:**
- Non-Occupational
- Occupational

Physician/Nurse Signature: ________________________________

Print Name: ________________________________ Contact #: __________________

**After completion:**
- **FAX Page 1 to** (306) 787-9576 - Saskatchewan Ministry of Health.
- **FAX Page 2 to** (306) 655-6388 - Manufacturing Area, RUH Pharmacy, Saskatoon.

Please press hard for multiple copies.

**REMOVE AND COMPLETE FORM BEFORE DISPENSING KIT**
Please complete for all HIV PEP kits used and/or expired medications.

This information is collected for invoicing purposes and for replacement of HIV PEP kits. For more information, please refer to The Guidelines for the Management of Exposures to Blood and Body Fluids, Saskatchewan Ministry of Health at https://www.ehealthsask.ca/services/Manuals/Pages/hiv-guidelines.aspx

NOTE: Replacement medications or kits will not be released without all the information below.

Health Region: | Site/Facility:
---|---

Type: 3 day kit  | 6 day kit (2x3 day kits)

Replacement for expired medication: (Please indicate expiry dates of both medications)

Combivir® with expiry date of: ____________________________

Kaletra® with expiry date of: ______________________________

PEP kit used on (date):  | Exposure Date:
---|---

Exposure Category:

- Non-Occupational
- Occupational

Physician/Nurse Signature: ______________________________

Print Name: ______________________________ Contact #: __________________

After completion:
- **FAX Page 1 to** (306) 787-9576 - Saskatchewan Ministry of Health.
- **FAX Page 2 to** (306) 655-6388 - Manufacturing Area, RUH Pharmacy, Saskatoon.

<table>
<thead>
<tr>
<th>Attach shipping label here:</th>
<th>Date/Time Shipped:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMBIVIR 150/300</td>
</tr>
<tr>
<td></td>
<td>KALETRA 200/50</td>
</tr>
</tbody>
</table>

RuH USE ONLY
Prior to prescribing antiretrovirals (ARV), please refer to the following pages for information on side effects, drug interactions, renal dosing, pediatric dosing, etc.

**NOTE**: Dosing of ARVs for prophylaxis is the same as treatment of HIV positive individuals.

**Adults/Children more than 40 kg:**
1. **Kaletra®** (lopinavir 200mg/ritonavir 50mg) **TWO Tablets po TWICE Daily** (i.e. 400mg lopinavir/100mg ritonavir)

**PLUS**
2. **Combivir®** (zidovudine 300mg/lamivudine 150mg) **ONE Tablet po TWICE Daily**
   - If HIV PEP is continuing for 4 weeks and the client has renal dysfunction, adjust dosing as soon as possible as per the Compendium of Pharmaceuticals and Specialties:
     - If creatinine clearance (CrCl) less than 50mL/min, dose adjustment of lamivudine required
     - If CrCl less than 15mL/min, dose adjustment of zidovudine and lamivudine required

**Children and Individuals 40 kg and less** (discussion with a Pediatric ID Specialist is required):
Use the medications provided in HIV PEP kit for the first 24 - 48 hours (*a pill cutter should be used*) until oral solutions of ARVs can be obtained if necessary. Details of oral suspension dosing provided on page 3.

1. **Kaletra®** (lopinavir 200mg/ritonavir 50mg per tablet) – Adapted from BC Centre for Excellence in HIV/AIDS, 2009 *Therapeutic Guidelines*.

<table>
<thead>
<tr>
<th>Weight</th>
<th># of Kaletra® 200mg/50mg Tablets from HIV PEP Kit</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 kg to less than 11 kg</td>
<td>½ tablet TWICE Daily</td>
</tr>
<tr>
<td>11 kg to less than 17 kg</td>
<td>¾ tablet TWICE Daily</td>
</tr>
<tr>
<td>17 kg to less than 22 kg</td>
<td>1 tablet TWICE Daily</td>
</tr>
<tr>
<td>22 kg to less than 27 kg</td>
<td>1¼ tablet TWICE Daily</td>
</tr>
<tr>
<td>27 kg to less than 32 kg</td>
<td>1½ tablet TWICE Daily</td>
</tr>
<tr>
<td>32 kg to less than 40 kg</td>
<td>1¾ tablets TWICE Daily</td>
</tr>
<tr>
<td>40 kg or greater</td>
<td>2 tablets TWICE Daily (adult dose)</td>
</tr>
</tbody>
</table>

**PLUS**
2. **Combivir®** (zidovudine 300mg/lamivudine 150mg per tablet)

<table>
<thead>
<tr>
<th>Age/Weight</th>
<th># of Combivir® tablets from HIV PEP Kit</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 kg to 8.9 kg</td>
<td>½ tablet TWICE Daily</td>
</tr>
<tr>
<td>9 kg to 14.9 kg</td>
<td>¼ tablet qam &amp; ½ tablet qpm</td>
</tr>
<tr>
<td>15 kg to 17.9 kg</td>
<td>½ tablet TWICE Daily</td>
</tr>
<tr>
<td>18 kg to 21.9 kg</td>
<td>½ tablet qam &amp; ¾ tablet qpm</td>
</tr>
<tr>
<td>22 kg to 24.9 kg</td>
<td>¾ tablet TWICE Daily</td>
</tr>
<tr>
<td>25 kg to 29.9 kg</td>
<td>¾ tablet qam &amp; 1 tablet qpm</td>
</tr>
<tr>
<td>30 kg or more</td>
<td>1 tablet TWICE Daily (adult dose)</td>
</tr>
</tbody>
</table>
### Appendix 5 – Antiretrovirals in HIV PEP Kits

**October, 2013**

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**Additional medication information for review PRIOR to prescribing**

<table>
<thead>
<tr>
<th>Antiretroviral Agent</th>
<th>Dose</th>
<th>Possible Side Effects</th>
<th>Additional Information (Significant drug interactions, side effects, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaletra® (lopinavir/ritonavir, LPV/RTV)</strong></td>
<td>Adults/Children more than 40 kg: lopinavir 400mg/ritonavir 100mg po TWICE Daily (i.e. Two 200mg/50mg tablets TWICE Daily)</td>
<td>* Diarrhea, nausea * Perioral tingling * Headache * Rash * ↑cholesterol &amp; triglycerides * Hyperglycemia (long-term use)</td>
<td>* Film coated Tablets &amp; Oral Solution should be taken with food. * Refrigeration not required as prophylaxis is less than 1 month  ++ <strong>Drug Interactions</strong> due to potent CYP3A4 inhibition <strong>Avoid:</strong> (Not all inclusive. Consult pharmacist and/or ID Specialist) * Fentanyl – Respiratory depression * Fluticasone (i.e. Advair®, Flovent®) – Cushing’s syndrome * Simvastatin, lovastatin – severe rhabdomyolysis, myopathy * Rifampin – ↓ lopinavir-treatment failure * Midazolam, triazolam - respiratory depression * Pimozide – cardiac toxicity, Torsades, MI * Ergot derivatives – ergotism * St. John’s wort – ↓ lopinavir-treatment failure * Voriconazole, etc, etc. <strong>Caution:</strong> (Not all inclusive) * Amiodarone – hypotension, etc. * Anticonvulsants (Phenytoin, phenobarbital, carbamazepine, valproic acid) * Oral contraceptives – ↓ effect OCPs * Statins - ↑ myopathy</td>
</tr>
<tr>
<td><strong>Oral Solution</strong></td>
<td>Oral Solution for individuals less than 40 kg: 7 kg to 14.9kg: 12mg/kg lopinavir/3mg/kg ritonavir po TWICE Daily 15 kg to less than 40kg: 10mg/kg lopinavir/2.5mg/kg ritonavir po TWICE Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Combidir®</strong></td>
<td>Adult/Children more than 30 kg: 1 tablet po TWICE Daily</td>
<td>* See Retrovir® &amp; 3TC® later in this table</td>
<td>* See Retrovir® &amp; 3TC® later in this table</td>
</tr>
<tr>
<td>Supplied as: Tablets</td>
<td>CrCl less than 50mL/min, adjust lamivudine component</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- zidovudine 300mg/ lamivudine 150mg</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Guidelines for the Management of Exposure to Blood and Body Fluids**
Appendix 5 – Antiretrovirals in HIV PEP Kits

October, 2013

Guidelines for the Management of Exposure to Blood and Body Fluids

<table>
<thead>
<tr>
<th>Antiretroviral Agent</th>
<th>Dose</th>
<th>Possible Side Effects</th>
<th>Additional Information</th>
</tr>
</thead>
</table>
| Zidovudine (ZDV, AZT) – *Retrovir®* | Adults/Children **30 kg or more:** 300mg po TWICE Daily  
**Oral Solution for individuals less than 30 kg:**  
4kg to less than 9kg: 12mg/kg TWICE Daily  
9kg to less than 30kg: 9mg/kg TWICE Daily  
CrCl less than 15mL/min, dosage adjustment required | * Nausea, headaches, malaise, anorexia, anemia, neutropenia, myopathy  
* Rare: hepatotoxicity, lactic acidosis | * May take with or without food  
* Caution when used with other bone marrow suppressing drugs |
| PLUS | Lamivudine – *3TC®* | Adults/Children **40 kg or more:** 150mg po TWICE Daily  
OR 300mg po ONCE Daily  
**Oral Solution for individuals less than 40 kg:**  
4 mg/kg TWICE Daily (Maximum 150 mg/dose)  
CrCl less than 50mL/min, dosage adjustment required | * Well tolerated  
* Headache, nausea, diarrhea, abdominal pain and insomnia  
* Rare: rash, pancreatitis, lactic acidosis | * May take with or without food |

Guidelines for the Management of Exposure to Blood and Body Fluids
Appendix 5 – Antiretrovirals in HIV PEP Kits

October, 2013

References


Appendix 6a – Patient Information Following an Exposure to Blood or Body Fluids

October, 2013 Page 1 of 3

Please see the following pages for Patient Information Following an Exposure to Blood or Body Fluids.
Patient Information Following an Exposure to Blood and Body Fluids

Should I be worried about my exposure?

- Risk of transmission from the exposure is only possible if:
  - an object with blood or a body fluid punctured or broke your skin (such as a needle stick), OR
  - the blood or body fluid came in contact with broken skin, your mouth, your genitals or your eyes (mucous membranes) AND
  - you were exposed to a fluid that can transmit the virus:

<table>
<thead>
<tr>
<th>What fluids can transmit the virus:</th>
<th>Human Immunodeficiency Virus (HIV)</th>
<th>Hepatitis B Virus (HBV)</th>
<th>Hepatitis C Virus (HCV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood, blood products or other biological fluids visibly contaminated with blood;</td>
<td>Blood, blood products or other biological fluids visibly contaminated with blood;</td>
<td>Blood, blood products or other biological fluids visibly contaminated with blood;</td>
</tr>
<tr>
<td></td>
<td>Semen, vaginal secretions;</td>
<td>Semen, vaginal secretions;</td>
<td>Semen, vaginal secretions;</td>
</tr>
<tr>
<td></td>
<td>Saliva (only if contaminated with blood);</td>
<td>Saliva;</td>
<td>Saliva;</td>
</tr>
<tr>
<td></td>
<td>Breastmilk.</td>
<td>Breastmilk (only if contaminated with blood).</td>
<td>Breastmilk (only if contaminated with blood).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the virus and how can it affect me?</th>
<th>Human Immunodeficiency Virus (HIV)</th>
<th>Hepatitis B Virus (HBV)</th>
<th>Hepatitis C Virus (HCV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It affects the immune system.</td>
<td>It infects the liver.</td>
<td>It infects the liver.</td>
</tr>
<tr>
<td></td>
<td>Over time, it wears down the immune system and makes it harder to fight infections.</td>
<td>About 90% of adults will completely recover from the infection after 6 months.</td>
<td>About 25% of people will clear the virus on their own</td>
</tr>
<tr>
<td></td>
<td></td>
<td>About 8-10% of people will be at risk for long-term complications because of the ongoing damage to the liver (e.g. cirrhosis, or liver cancer).</td>
<td>The other 75% of people will remain chronically infected unless they receive antiviral therapy which can clear the virus in about 45-80% of individuals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Without treatment, 15-25% will be at risk for long term complications.</td>
</tr>
</tbody>
</table>
**Communicable Disease**

<table>
<thead>
<tr>
<th>Human Immunodeficiency Virus (HIV)</th>
<th>Hepatitis B Virus (HBV)</th>
<th>Hepatitis C Virus (HCV)</th>
</tr>
</thead>
</table>
| **What is the risk from the exposure with a positive source?** | • The estimated risk of HIV transmission from a needle-stick injury is approximately 0.3%.  
• Exposures to mucous membranes is approximately 0.1%. | • If you responded to previous vaccinations, the risk of infection is virtually 0%.  
• If you have not been immunized or did not respond to vaccines, and did not receive HBlg, the risk from a needle-stick is between 5-30%. | • The estimated risk of HCV transmission from a needle-stick is approximately 3-10%. |
| **Is there a vaccine for it?** | • No | • Yes | • No |
| **What follow-up is required?** | • Blood tests at 1 and 3 months after the exposure. | • Blood tests at 3 months after exposure. | • Blood tests at 1, 3 and 6 months after the exposure. |
| **What is the treatment following a high risk exposure?** | • There are medications that help prevent infection. If you received these, refer to the information sheet. | • Hep B immune globulin and vaccine for those who are not immune. See Hep B Fact Sheet. | • There is no preventive treatment.  
• Monitoring for infection will allow for early treatment of infection. |

**How do I protect others while I am waiting for my status to be confirmed through the testing?**  
All of these viruses are transmitted through blood and body fluids so it is important to:

- Practice safer sex – use condoms for vaginal, anal and oral sex
- Do not donate blood, blood products or tissues
- Do not share personal items such as razors, toothbrushes, etc.
- Do not share needles or drug use equipment
- Ensure proper disposal of any items contaminated with blood
- Do not get pregnant and do not breastfeed

**What happens now?**
Public health will contact you to answer any questions you have and to remind you about the follow-up tests that are required and who you should go to for these tests to be completed. Each of these diseases are reportable in Saskatchewan. If any of your blood tests return with positive results, your family physician and public health will contact you to do any necessary follow-up.

*For more information contact:*
*Your local public health office*
*OR your physician or nurse practitioner*
*OR HealthLine at 811.*
Appendix 6b – Patient Medication Information for HIV Post-Exposure Prophylaxis (HIV PEP)

Please see the following pages for Patient Medication Information for HIV Post-Exposure Prophylaxis (HIV PEP).
What is the risk of HIV infection after an exposure?

- **Most exposures do not result in infection.** The risk varies with the type of exposure and factors such as the amount of blood involved and the amount of virus in the infected material.
  - The average risk of getting HIV after exposure to known HIV-infected blood through a needlestick or cut is about one chance in 300 exposures.
  - The risk from a mucocutaneous (e.g., eye, nose or mouth) exposure to known HIV-infected blood is much less – about one chance in 1,000 exposures.

Why should PEP be considered?

- A study in healthcare workers following exposure to HIV-infected blood suggested early short term zidovudine (an antiretroviral medication) was associated with a significantly decreased risk of getting HIV. Combinations of antiretrovirals are likely even more effective.

What medications are recommended for PEP?

- Combivir® and Kaletra® are antiretroviral medications used in the treatment of individuals with HIV. They work by slowing the rate of HIV multiplication in the body.

<table>
<thead>
<tr>
<th>Adults/Children 40kg or over:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Combivir® ONE tablet every 12 hours (150mg lamivudine + 300mg zidovudine per tablet) <strong>plus</strong></td>
</tr>
<tr>
<td>- Kaletra® TWO tablets every 12 hours (200mg lopinavir + 50mg ritonavir per tablet)</td>
</tr>
</tbody>
</table>

**Less than 40kg:** Refer to Ministry of Health website [http://www.ehealthsask.ca/services/manuals/Pages/hiv-guidelines.aspx](http://www.ehealthsask.ca/services/manuals/Pages/hiv-guidelines.aspx), Guidelines for the Management of Exposures to Blood and Body Fluids for recommendations using the adult tablets (Appendix 5).

How should these medications be taken?

- Treatment should be started promptly, preferably within 1-2 hours after the exposure.
- If the source is found to be HIV negative, these medications should be stopped.
- The medications in the kit are provided at no charge, however, if you are to complete the recommended 4 weeks (28 days) course, your doctor will provide you with an outpatient prescription. The Workers’ Compensation Board (WCB) covers the medication cost if the exposure is work-related so the appropriate paperwork must be initiated ASAP. If non work-related, the medications are covered by the Saskatchewan Drug Plan and the doctor (or pharmacist) must apply for EDS – Exception Drug Status indicating “for PEP”, or through the Non-Insured Health Benefits Branch for patients who have federal drug coverage.

**IMPORTANT NOTICE**

- It may take up to two days for a community pharmacy to obtain these medications, so take your prescription to the pharmacy as soon as possible.
- If you are unable to obtain the medications, contact the doctor immediately. If after hours, return to the Emergency Department to avoid missing doses.

- To ensure effectiveness, avoid missing doses. Take each dose as close to the scheduled time as possible to maintain the levels in your body. Do not skip doses. Consider setting an alarm as a reminder and place the medications in a dosette.
- Take with a meal or light snack to minimize side effects.
What should you do if you forget a dose?
• Take it as soon as you remember, then continue with your regular dosing schedule.

What are the side effects of Combivir® and Kaletra®?
• Some people experience allergic reactions to medications. If you have any of the following symptoms soon after taking a dose, STOP taking the medication and tell your doctor, or go to an Emergency Department immediately.
  ➢ sudden wheeziness, chest pain or tightening;
  ➢ swelling of eyelids, face or lips;
  ➢ fever, chills, shortness of breath, heart palpitations;
  ➢ “hives” or severe rash.
• Combivir® – Common side effects are generally mild and temporary and may include headache, nausea, loss of appetite, stomach cramps, insomnia and muscle weakness.
• Kaletra® – Common side effects are nausea, diarrhea, headache, rash. NOTE: It may reduce effectiveness of birth control pills and interact with many other medications (cholesterol lowering medications, steroid inhalers, fentanyl patches, etc.). Check with your pharmacist.

If any side effect is concerning, please call your doctor.

What other precautions should you follow while using antiretrovirals?
• Advise sexual partners of potential risk. Practice safer sex (e.g. use a condom).
• Avoid pregnancy.
• Stop breastfeeding.
• Avoid donating blood.
• Do not share razors, toothbrushes, or needles.
• Doses of medications may need to be adjusted depending on your health history.
  Tell your doctor if you:
  ➢ had or have a problem with your kidneys;
  ➢ had or have any liver disease, particularly hepatitis;
  ➢ have any other medical conditions or illnesses;
  ➢ are pregnant, plan on becoming pregnant, or are breast-feeding;
  ➢ are taking ANY other medication (prescription, non-prescription, herbals, etc.).

Ensure your pharmacist and/or doctor confirms the medications you take do not impair the benefit of these medications (i.e. interact), or lead to unwanted or severe side effects.
Do not start other medications without first discussing them with your doctor or pharmacist.

How should these medications be stored?
• Store in tightly closed containers in a cool (15-30°C), dry place protected from light.
• Avoid storage in high heat and/or humidity as this may decrease the activity of the medications.
• Keep out of reach of children.

If you have any questions or concerns about these medications, please discuss them with your pharmacist, doctor or nurse.
(Adapted from Vancouver Coastal)
Use of routine infection control precautions in health care and personal care settings and use of harm reduction measures for individuals who engage in risky behaviours can help to reduce the risk of exposure to all BBPs.

**Vaccination**

**Hepatitis B**
Hepatitis B vaccination for all at-risk HCWs is a very important and necessary preventive measure against HBV transmission in the health care delivery environment.

a. Health care workers, emergency service workers and others with potential occupational exposure to blood, blood products and bodily fluids that may contain HBV (Public Health Agency, 2012). Workers at "significant" risk can be determined on an agency-by-agency basis, **but should always include those performing invasive procedures** (Health Canada Infection Control Guidelines, 2002).

b. The Saskatchewan Immunization Manual provides eligibility criteria and recommendations for hepatitis B vaccine for HCW\(^1\). Other employing agencies or occupational groups (e.g. corrections or policing) may have hepatitis B vaccine recommendations for their staff.

c. Post-HBV immunization antibody testing should be conducted as outlined in the Canadian Immunization Guide or the Saskatchewan Immunization Manual\(^2\).

In the community, HBV universal immunization program began in Saskatchewan in 1995 for individuals born in or after 1984. The immunization is provided to children in Grade 6. Refer to Saskatchewan Immunization Manual.\(^3\)

**Hepatitis C**
There is no vaccine for hepatitis C; therefore, it is incumbent on individuals to ensure that they are taking personal protective measures to reduce their risk of exposure.

**HIV**
There is no vaccine for HIV; therefore, it is incumbent on individuals to ensure that they are taking personal protective measures to reduce their risk of exposure.


\(^{2}\) [http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx](http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx)

Appendix 7 – Prevention of Bloodborne Pathogens

October, 2013

References


Appendix 8 – Management of Potential Exposures to Hepatitis B

October, 2013

Please see the following pages for the Management of Potential Exposures to Hepatitis B.
a) Management of individuals with percutaneous or mucosal exposure to an infected or high risk source

- **vaccinated**
  - 3 doses responder²
    - no action required
      - >10 IU/L
        - no action required
        - >10 IU/L
          - Consider responder in future¹¹
        - <10 IU/L
          - HBig²
    - <10 IU/L
      - Test for anti-HBs²
        - when anti-HB's result known
          - >10 IU/L
            - HBig²
          - <10 IU/L
            - complete 2nd vaccine series⁵
          - <10 IU/L
            - Test for anti-HB's 6 months later⁵
              - >10 IU/L
                - HBig²
              - <10 IU/L
                - complete 2nd vaccine series⁵
  - 3 doses response unknown
    - test for anti-HBs²
      - 2nd vaccine series³
        - >10 IU/L
          - no action required
        - unknown after 48 hours
          - 1 vaccine booster
        - <10 IU/L
          - HBig² + 1 dose
          - Test for anti-HB's result known
            - >10 IU/L
              - HBig²
            - <10 IU/L
              - consider as responder in future¹¹
          - <10 IU/L
            - HBig²
          - <10 IU/L
            - consider immune⁶
          - >10 IU/L
            - complete vaccination⁶
    - 2 series of 3 doses
      - Non-responder
        - HBig² + 2d vaccine series³
      - HBig² + 2d vaccine series³
        - >10 IU/L
          - no action required
        - unknown after 48 hours
          - 1 vaccine booster
        - <10 IU/L
          - HBig² + 1 dose
          - Test for anti-HB's result known
            - >10 IU/L
              - HBig²
            - <10 IU/L
              - consider immune⁶
            - <10 IU/L
              - consider immune⁶
          - <10 IU/L
            - consider immune⁶
          - >10 IU/L
            - complete vaccination⁶
  - 2 doses
    - 1 dose
      - Test for anti-HBs² + HBig⁵ + 1 dose of vaccine
      - complete vaccination⁶

- **exposed person²**
  - unvaccinated
A known source is high risk if the person comes from a region highly endemic for HB; has sexual relations with multiple partners; has a partner infected with HB or at high risk of being so; is in close family contact with an infected person; uses injection drugs; or received blood or blood products prior to 1970. Wherever possible, the source should be tested. In the case of an unknown source, background circumstances may provide some indication of the degree of risk.

Interventions are not required if the exposed person is known to be immune following HBV infection.

Responder with a documented anti-HBs titre of at least 10 IU/L on prior testing.

Determine anti-HBs titre as soon as possible. HBIg should be administered to susceptible individuals within 48 hours after exposure. The benefit of HBIg given more than 7 days after exposure is unknown.

Omit administration of HBIg if the source is tested within 48 hours and the result is negative. Follow the non-infected source algorithm (refer to b).

Give the second dose of HBIg 1 month after the first dose.

Complete the vaccine series regardless of the anti-HBs titre. The anti-HBs titre may reassure the exposed individual about the immediate risk of becoming infected.

Omit administration of HBIg if it is possible to obtain anti-HBs serology within 48 hours and a titre of at least 10 IU/L is confirmed.

Determine anti-HBs titre 1 to 6 months after completion of the vaccine series.

Determination of anti-HBs titre should be delayed for 6 months to allow HBIg antibodies to wane.

Except if person is immunocompromised, has chronic renal failure or is on dialysis in which case repeat serologic testing may be needed.

References

b) Management of Individuals with percutaneous or mucosal exposure to an uninfected or low risk source

Exposed Person

Vaccinated

- 3 doses responder
  - no action required
  - ≥10 IU/L
    - no action required
    - < 10 IU/L
      - 1 vaccine booster
        - test for anti-HBs
          - 1 month later
            - ≥10 IU/L
              - complete 2nd course of vaccine
            - < 10 IU/L
              - no action required
              - consider as responder in the future
          - test for anti-HBs
            - 2nd course of vaccine
              - no action required

Unvaccinated

- 3 doses response unknown
  - test for anti-HBs

- 3 doses non-responder
  - 2nd course of vaccine
    - no action required
    - ≥10 IU/L
      - complete 2nd course of vaccine
    - < 10 IU/L
      - no action required

- 2 series of 3 doses non-responder
  - complete schedule as required

- vaccinated 1 or 2 doses
  - no action required

1. Interventions are not required if the exposed person is known to be immune to hepatitis B infection.
2. Determine anti-HBs titre 1 to 6 months after completion of the vaccine series.
3. Except if the person is immunocompromised, has chronic renal failure or is on dialysis in which case repeat serologic testing may be needed.

References

Appendix 9 – Management of Potential Exposures to Hepatitis C

October, 2013

Please see the following pages for the Management of Potential Exposures to Hepatitis C.
2. Management of Exposures to Body Fluids Potentially Infected with Hepatitis C

No effective post-exposure prophylaxis is available for HCV at this time (Winter 2012)

Source

Anti-HCV +ve

OR

Anti-HCV status unknown

Exposed

Anti-HCV –ve or status unknown

Initial test of exposed –ve but source +ve or has high risk behaviour

PCR at 4 weeks

if PCR -ve

Retest exposed Anti-HCV at 3 & 6 months

if PCR +ve

Initial test of exposed –ve and source -ve or unknown

Follow-up with physician
- clinical management
- risk reduction counselling
- consult ID for possible treatment
Appendix 10 – Monitoring Recommendations Following Exposures

Monitoring For Infection
The table below outlines the recommended tests for monitoring for infection with a blood borne pathogen that should be conducted on a person who was exposed to blood and body fluids. The approach depends on baseline test results for both the source and the exposed person at the time of the incident:

- If the source’s baseline results are negative and he/she has no risk factors, then follow-up testing of the exposed person is not required.
- If the source’s baseline results are positive or are unknown, follow up of the exposed person is outlined in this chart:

<table>
<thead>
<tr>
<th></th>
<th>Baseline (at time of exposure)</th>
<th>Month 1</th>
<th>Month 3</th>
<th>Month 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B Surface Antigen (HBsAg)</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Hep B Antibody (anti-HBs)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep C Antibody (anti-HCV)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hep C PCR (HCV PCR)</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

- If the source tests positive on baseline testing, ensure the source receives appropriate counseling and follow-up.
- If the exposed person becomes positive for any BBP on follow-up testing, an ID Specialist should be consulted for any follow-up recommendations.

NOTE: ALL Positive results of source and exposed must be reported to the MHO as per The Public Health Act, 1994.

Monitoring While on PEP
In addition to testing for BBP infection as above, people on PEP for 28 days will require monitoring for side effects and blood tests for renal and liver function. Discuss with the ID Specialist for recommendations.

1 Antibody testing is recommended at 1-6 months after completion of a vaccine series.
2 Hepatitis C PCR is recommended if source is known Hepatitis C positive. If not known, antibody testing is recommended.
Appendix 10 – Monitoring Recommendations Following Exposures

October, 2013

Guidelines for the Management of Exposure to Blood and Body Fluids

References


Appendix 11 – Roles and Responsibilities

Guidelines for the Management of Exposure to Blood and Body Fluids
If HIV PEP is Prescribed

- Review client’s current medications on the PIP.
- Prescribe and provide exposed person the HIV PEP starter kit.
- Contact ID Specialist to discuss whether ongoing HIV PEP is required. This must be completed before the exposed person is “discharged from care” and recommendations of ID Specialist must be communicated to the exposed.
- If ID Specialist determines HIV PEP is needed for 28 days:
  - ER or family physician will write the prescription and fax to the pharmacy of client’s choice. Write on the prescription: “PEP” and name of the ID Specialist who was contacted.
  - Fax pages 1, 2 and 3 of the Exposure Incident Report Form to ID Specialist to facilitate ID Specialist follow-up.

- Pharmacy may contact the physician to complete EDS or First Nation client approval forms.
- Complete WCB claim form and submit to WCB.
- Complete the HIV PEP Kit Replacement Form (enclosed within the kit) and send Page 1 to Ministry of Health and Page 2 to the Pharmacy Department, Royal University Hospital (as indicated on the form).

Family Physician

- Conduct follow-up on exposed and/or source patient in consultation with the ID Specialist.
- Complete outstanding Risk Assessment or lab testing.
- Make referral to Public Health for hepatitis B vaccination (if applicable).
- Prescribes the ongoing HIV PEP if required and not already provided by the ER physician. Application for EDS should be made to the Saskatchewan Drug Plan or to the Non-Insured Health Benefits Branch for those patients who have federal drug coverage.

Regional Occupational Health/Employee Health Services

- Receive all Exposure Incident Report Forms for health region staff experiencing an occupational exposure.
- Complete WCB claim form and submit to WCB.
- Track occupational exposures and do a root cause analysis and implement measures to prevent future incidents.
- Provide employees with support and counselling as appropriate.
Appendix 11 – Roles and Responsibilities

October, 2013

Guidelines for the Management of Exposure to Blood and Body Fluids

• Ensure follow-up tests of the employee are conducted in partnership with the family physician.
• Ensure health care workers have access to pre-exposure hepatitis B immunization.
• Maintain staff immunization records including anti-HBs test results.
• Facilitate hepatitis B vaccinations for staff who were non-immune at the time of the exposure.
• Facilitate coverage with WCB.
• Provide the Regional MHO with a summary of incidents on an annual basis (or as directed by the Regional MHO).

Regional Communicable Disease Coordinator or Designate
• Receive all Exposure Incident Report Forms.
• Redirect forms regarding Health Region staff exposures to the Regional Occupational Health/Employee Health Services.
• Redirect forms regarding First Nations individuals living on reserve to FNIHB/NITHA as appropriate.
• Tracks the number of exposures, HIV PEP Kit initiation and ongoing HIV PEP usage by exposure setting and reports to the Ministry on an annual basis (see Appendix 12 – Reporting Requirements).
• Follow-up with the exposed individuals in all non-occupational (community) settings and all occupational settings (excluding health region staff exposures).
• Reinforce education provided in the ER and in the patient information sheet(s) (Appendix 6a – Patient Information Following an Exposure to Blood and Body Fluids and Appendix 6b – Patient Information for HIV PEP). Refer to Section 6 – Counselling and Follow-Up.
• Ensure the exposed is aware of the recommended follow-up as outlined in Patient Information Following an Exposure to Blood and Body Fluids and direct them to follow-up with a physician of their choice.
• Fax Exposure Incident Report Form to exposed person’s family physician.
• Facilitate referral to other supportive services and harm reduction services as necessary.
• Provide hepatitis B immunization records on request.
• Assist in arranging/providing hepatitis B immunizations as necessary.
• May work with the HIV Case Manager to assist the client in any follow-up that they require (e.g., follow-up testing, referrals to other agencies, etc).
• Ensure all reporting elements are included on the Exposure Incident Report Form.
Appendix 11 – Roles and Responsibilities

Medical Health Officer
- To provide advice to the ER physician on the initiation of HIV PEP upon request by the physician.
- To receive summary reports of occupational exposures from the Regional Occupational/Employee Health Services on an annual basis or as directed by the Regional MHO.
- To track all non-occupational (community) and occupational exposures (involving non-health region staff) in the health region.
- To provide statistics to the Ministry of Health on an annual basis (see Appendix 12 – Reporting Requirements).

ID Specialist
- To provide consultation to family physicians or ER physicians upon request and to authorize the ongoing use of HIV PEP.
- To provide ongoing follow-up of individuals requiring the 28 day course of HIV PEP.

Community Pharmacist
- To fill HIV PEP prescriptions for the client.
- To apply for EDS from the Saskatchewan Drug Plan (306-787-8744 or 1-800-667-2549 if after hours) if this has not already been done by the ER or family physician.
  - The Drug Plan will need to know the prescription is for PEP and the name of the ID Specialist who has authorized the need for ongoing PEP.

Workers’ Compensation Board
- To cover the cost of HIV PEP Kits and ongoing medications for circumstances where the exposure occurred while the person was working.
- Receives WCB claims and assigns file number to each individual WCB claim.
- Provides Ministry of Health with claim numbers to enable the Ministry to process invoices.
- Submits payment to Ministry of Health for the cost of HIV PEP starter kits prescribed for WCB clients.

Royal University Hospital Pharmacy
- To assemble HIV PEP Kits on behalf of the Ministry of Health and to distribute to HIV PEP Kit sites upon receipt of HIV PEP Kit Replacement Form. Includes copy of HIV PEP Kit Replacement request with the shipment.

Guidelines for the Management of Exposure to Blood and Body Fluids
Appendix 11 – Roles and Responsibilities

October, 2013 Page 5 of 5

Maintains record of expired kits and HIV PEP kits used by health region and sends monthly record to Population Health Branch, Ministry of Health.

Invoices Population Health Branch, Ministry of Health for HIV PEP kits assembled and distributed. Details included in the summary of use:
- date shipped;
- site shipped to;
- date the kits were used or expired;
- if a complete kit or in the instance of a partial kit, which medication was replaced;
- cost of the replacement;
- reference number from the HIV PEP Kit Replacement Form.

Provide an annual record of HIV PEP medication distribution within regions at the end of April including:
- the date of medication distribution;
- the medication name and the quantity of the medication (in tablets) that were distributed; and
- the name of the site to which the medications or kits were sent to.

Ministry of Health
- Covers the cost of HIV PEP Kits and ongoing HIV PEP medication when non-occupational exposures occur.
- Reviews and updates the program to ensure that it reflects the most current guidelines and protocols.
- Invoices WCB or other worker insurer for the cost of starter HIV PEP kit prescribed for high risk exposures in the workplace.
- Compiles aggregate data on HIV PEP Kit usage based on statistics submitted by Health Regions and First Nations jurisdictions and reports back to the regional health authorities and the HIV Provincial Leadership Team on an annual basis.
I. Reports to the Regional Medical Health Officer
   Exposures that have been assessed by the attending physician must be reported to the Regional MHO when the following criteria are met:
   1. The fluid the person was exposed to is capable of transmitting blood borne pathogens. See Guidelines for Management of Exposures to Blood or Body Fluids, Table 2.2.
   AND
   2. The fluid contacted the exposed person in such a way that would allow for transmission of blood borne pathogens:
      a. An object with the body fluid punctured or broke the skin of the exposed person
      OR
      b. the fluid came in contact with mucous membrane of the exposed person (e.g., occupational – splashes into eye, mouth or onto broken skin or non-occupational – sexual exposure).

   In order to meet the reporting requirements, the Exposure Incident Report Form must be faxed to the MHO.

II. Reports to the Ministry of Health
   A summary of the following information by exposure setting (occupational, non-occupational, sexual, lifestyle) shall be submitted by the MHO on the attached report form to the Ministry of Health on an annual basis:
   • number of exposures;
   • number of exposures where a PEP Kit was provided; and
   • number of exposures where ongoing PEP was provided.

   Reporting timeframe is for exposures from January 1 to December 31. Reports should be submitted by March 15.

   In addition to the above reporting, it is expected that regions will evaluate the use of HIV PEP kits within their region to ensure appropriate use of kits.
# Annual Report on Blood and Body Fluid Exposures (Jan 1-Dec 31)

Reporting Authority: ___________________________  Year: ______

<table>
<thead>
<tr>
<th>Exposure Setting</th>
<th>Exposures</th>
<th>PEP Kit Initiation</th>
<th>Ongoing PEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-occupational</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Totals: 0 0 0 0

Submitted By: _____________________________________________
## Appendix 13 – Expert Consultation Resources

<table>
<thead>
<tr>
<th>Expert Consultation Resources</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional MHOs’ on call</td>
<td>Contact regional hospital for appropriate on call number</td>
</tr>
<tr>
<td>ID Specialist on call</td>
<td>Contact regional hospital for appropriate on-call number</td>
</tr>
<tr>
<td>Saskatchewan Health Line</td>
<td>811</td>
</tr>
<tr>
<td>Royal University Hospital Pharmacy Information Services (re: HIV PEP Kits)</td>
<td>306-655-6666</td>
</tr>
<tr>
<td>Workers’ Compensation Board</td>
<td>306-787-4370 or 1-800-667-7590</td>
</tr>
<tr>
<td>Regional Occupational Health and Safety Department</td>
<td>Contact regional hospital for appropriate number</td>
</tr>
</tbody>
</table>
| Mental Health and Addiction Services | Contact regional hospital for appropriate on call number  
Or see [Section 6 – Behavioral Support Risk Reduction](#) |
| Traumatic Events Response Team | Contact regional hospital for appropriate number |
| Sexual Assault Response Team  | Contact regional hospital for appropriate number |
| Regina Qu’Appelle Health Region Infectious Diseases Clinic | 306-766-3915 Monday-Friday office hours; after hours 306-766-4444 for ID Specialist on call |
| Saskatoon Health Region Infectious Diseases Clinic (Positive Living Program) | 306-655-8008 for ID Specialist on call |
This tool is designed to be used by the health care provider to help assess the risk that the source has a blood borne pathogen. The information gained is intended to assist with decision-making by attending health care providers only and must not be shared with the exposed person.

Ensure the source understands the information will be:
- used determine if the source is considered high risk for a blood borne pathogen
- shared with the exposed person’s care provider so the most appropriate follow-up of the exposed can be provided.

The source should be informed that confidentiality of this information will be maintained and will not be shared with the exposed person.

1. Has the source ever had a tattoo, ear or skin piercing, acupuncture, electrolysis, needle stick injury, skin graft or come into contact with someone else’s blood? □ Yes □ No
2. Has the source moved to Canada? □ Yes □ No
   If yes, where did they come from? __________________
   NOTE to Health Care Practitioner: Consider if source country is endemic for hepatitis B or HIV.
3. Has the source:
   - had sex, even once, with someone who has had multiple sexual partners? □ Yes □ No
   - had sex, even once, for which they paid, or accepted, money or drugs? □ Yes □ No
   - had syphilis, chlamydia, gonorrhea, or any other STI? □ Yes □ No
   - if male, had sex with another male, even once? □ Yes □ No
   - shared needles or taken street drugs by needle? □ Yes □ No
   - had sex with anyone who has shared needles or taken street drugs by needle? □ Yes □ No
   - been the sexual partner of someone who has HIV/AIDS, hepatitis B or C? □ Yes □ No
   - been in prison? □ Yes □ No
4. Has the source ever had jaundice (other than at birth), hepatitis or liver disease or had a positive test for hepatitis B or C? □ Yes □ No
5. Has the source had an HIV/AIDS test before? □ Yes □ No
   If yes, when? ________________
   What was the result? □ Positive □ Negative
6. In the last 12 months, has the source had any of the following symptoms which are continuous and unexplained? □ Yes □ No
   - weight loss, night sweats, fever, diarrhea or cough
   - lumps in the armpits, neck or groin
   - coloured patches on skin or inside mouth

Results of the Risk Assessment are to be documented on the corresponding box on page 2 of the Exposure Incident Report Form

<table>
<thead>
<tr>
<th>RISK ASSESSMENT OF SOURCE IF HIV NEGATIVE OR UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration of risk is based on source’s IV drug use, participation in high-risk sexual practices, hepatitis C status, and if he or she is from an HIV endemic country. Refer to Section 2 – Risk Assessment and Appendix 14 – Source Patient Risk Assessment</td>
</tr>
<tr>
<td>Indicate if assessment of source risk is considered to be High or Low</td>
</tr>
<tr>
<td>High</td>
</tr>
</tbody>
</table>

Guidelines for the Management of Exposure to Blood and Body Fluids
Exposed Person’s Information

The exposed person must be informed of the purpose for the collection of information requested on the Exposure Incident Report Form and who the information will be disclosed to.

The purpose for collecting information (about the exposure and the source, serology for the diseases, and risk factors) of the exposed person is to:
1. Determine what course of treatment is required following the exposure.
2. Determine what additional services or resources the individual may benefit from.
3. Determine what follow-up is required (education, hepatitis B vaccination, and follow-up serology).
4. Monitor exposures using de-identified information and determine if prevention programs can be implemented.

Follow-up services are provided by various health care providers. In order to provide follow-up of the exposed person, information will be disclosed to:
1. The local MHO when it meets the definition of an exposure.
2. The MHO will redirect the information as appropriate to:
   a. The MHO for the area in which the exposed person resides (FNIHB, NITHA, or another region), OR
   b. In the event of an occupational exposure of a health region employee, to the Health Region Occupational Health/Employee Health Department.
3. The exposed person’s family physician or nurse practitioner.
4. An ID Specialist as part of the referral (only when referral is necessary).

An HIV PEP Kit Replacement Form is completed and returned to the Ministry of Health when the exposed person has been provided an HIV PEP Kit.

The information collected on this form includes:
- Exposed persons name, Health Services Number,
- Exposure category (occupational or non-occupational)
- Exposure date
- Health Region
- PEP Kit Site
- WCB #

This information is used by the Ministry of Health for accounting purposes and to provide required information to WCB and NIHB for exposures that are eligible for coverage.
Source Patient Information

The source person, when identified and available for interviewing, must provide informed consent for collection, use and disclosure of their personal health information. They must be informed of how the information collected will be used and who it will be disclosed to. The Appendix 16 - Consent for Source Patient Testing Following a Blood/Body Fluid Exposure should be used to obtain informed consent.

The purpose for collecting information (risk assessment questions and blood test results) is to determine the most appropriate treatment of the exposed person.

Identifying information (e.g. name, date of birth, health services number) of the source person will only be disclosed to:
1. The exposed person’s attending physician in order to conduct the risk assessment of the source.
2. The Regional MHO (Exposure Incident Report Form) as part of the consultation in managing the exposed person.

NOTE: Identifying information of the source will not be disclosed by the health care provider to the exposed person or the exposed person’s family physician. In the event that the source person is HIV positive, a Consent for Release of Information should be obtained in order for the source person’s physician to share additional information about the source (e.g. viral loads, CD4 counts, current treatment, etc.) with the exposed person’s ID Specialist in order to provide the most appropriate treatment to the exposed.

Results of the risk assessment and blood tests pertaining to the source person will be disclosed to:
1. The exposed person's family physician to determine the most appropriate care of the exposed person.
2. The Regional MHO (Exposure Incident Report Form) as part of the consultation in managing the exposed person.
3. In the event of an exposure of a health region employee, with the regional Occupational/Employee Health Department to determine follow-up required for the exposed employee.
4. Shared as part of the referral to the exposed person’s ID Specialist so they can determine the most appropriate ongoing follow-up for the exposed person (i.e. if any change in HIV PEP medications is required).
5. The exposed person so they can make an informed decision of the treatment to proceed with based on the risk of the exposure.

If, in the professional opinion of the care provider, it is deemed that disclosure without consent fits the criteria of section 27(4)(a) of The Health Information Protection Act, information may be disclosed to appropriate care providers. In these instances, the rationale for the need to disclose this information must be documented. Documentation must also include details of who the information was disclosed to.
Appendix 16 – Consent for Source Patient Testing Following a Blood/Body Fluid Exposure

December, 2014 Page 1 of 2

The source must express an understanding of the following:

- An individual has been exposed to the source’s blood/body fluids.
- In order to assist in the care and management of the exposed person, the source will be asked a number of personal questions to assess if there is a risk for hepatitis B, hepatitis C and human immunodeficiency virus (HIV) which causes AIDS.
- A blood test is requested to determine if there is risk for the exposed person.
- The source’s attending physician will inform them of the test results and arrange appropriate follow-up.
- Results of the risk assessment and blood test will be sent to the care providers of the exposed person (their attending physician in the Emergency Department, family physician and the Occupational Health/Employee Health Department [if it is health region employee involved in a workplace injury]). These care providers will notify the exposed person of the results so they can obtain necessary treatment and follow-up.
- Identifying information (name, date of birth, health services number) will not be shared with the exposed individual, nor with their family physician or the occupational health/employee health department.
- Identifying information will be shared with the MHO as a consultant in conducting the risk assessment.
- Physicians are required by The Public Health Act, 1994 to report information including name, gender, age and risk factors to the MHO of positive tests. Current and past sexual/drug use partners of positive cases will be offered a test.

The source should also be provided with general information for informed consent which includes:

Testing process:
- description of HIV infection, transmission and the window period;
- meaning of positive and negative HIV test results;
- need for further testing based on risks.

Reasons to be tested:
- allows earlier access to services and care;
- helps people live longer healthier lives with treatment;
- helps people become actively involved in their own care;
- decreases worry about possible infection;
- helps prevent the spread of HIV to others.
Appendix 16 – Consent for Source Patient Testing Following a Blood/Body Fluid Exposure

December, 2014

Guidelines for the Management of Exposure to Blood and Body Fluids

Other considerations:
- how the results will impact the client;
- support, assistance, care and treatment options are available and will be offered;
- how to contact the client when results are ready;
- assess risk factors and develop a plan to minimize potential for transmission while awaiting results; and
- the client has the right to refuse testing.

Consent is verbal, informed, voluntary and documented.
Appendix 17 – Decision Making

Please see the following pages for the Decision-Making Algorithms.
FOLLOW-UP

- HBV post-exposure prophylaxis (vaccination and HBIG if indicated)
- Refer the exposed person to their Family physician
- If source is known positive for HIV, HBV or HCV or their status is unknown complete follow-up testing as per table below
- Send completed Exposure Incident Report Form to MHO
- For Health Region Employee, refer to Regional Occupational/Employee Health Department

BASELINE TESTING:
- HIV antibodies (pre-test counselling required)
- Hepatitis B & C serology (anti-HBs, HBsAg, anti-HCV)

EDUCATION
- Safer sex education
- Patients should have protected sex with partners until their results of final HIV antibody testing is known to be negative
- Blood and Body Fluid Precaution Education (to take precautions until final HIV test result is known). See Section 6 – Counselling and Follow-Up

DISCUSS WITH ID SPECIALIST AT TIME OF INCIDENT TO DETERMINE THE NEED FOR ONGOING HIV PEP AND FOLLOW-UP

HIV PEP
- Assess and manage as per Canadian Immunization Guide See Appendix 8

BASELINE BLOODS
- HIV antibodies
- Hepatitis B & C serology (anti-HBs, HBsAg, anti-HCV)
- Routine biochemistry & LFTs
- Complete blood count & differential
- Pregnancy test if applicable

EDUCATION
- Likely side-effects of HIV PEP. See Appendix 5
- The need for 100% adherence
- Signs and symptoms of HIV seroconversion illness
- Blood and Body Fluid Precautions See Section 6 – Counselling and Follow-Up
- Patients should have protected sex with partners until results of final HIV antibody testing is known

FOLLOW-UP
- Refer exposed person to Family Physician and/or ID Specialist
- Send completed Exposure Incident Report Form to MHO

Table:

<table>
<thead>
<tr>
<th>Follow-up Testing</th>
<th>Month 1</th>
<th>Month 3</th>
<th>Month 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBsAg</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Anti-HCV</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Hep C PCR</td>
<td>* - See App 10</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

The HIV PEP Kit may be started if there is a delay in obtaining source information

SOURCE DETAILS

HIV STATUS OF SOURCE UNKNOWN
- If available and consents:
  - Test for HIV, HBV & HCV
    - Consider possibility of source window period

HIV STATUS OF SOURCE KNOWN TO BE POSITIVE
- Information that is helpful for the ID Specialist:
  - HIV viral load
  - Current and past anti-HIV drug therapy AND reasons for stopping/changing regimen
  - HBV & HCV status

If HIV positive source, administer 1st dose of HIV PEP regimen to the exposed person (if not already given)

EXPOSED PERSON’S DETAILS
- Medical history including all drugs
- Review for drug interactions on PEP
- Vaccination history for HBV
- Previous HIV test results
- In women, ask about pregnancy or breast feeding

The time from exposure to HIV PEP is < 72 hours

The source is KNOWN to be HIV positive
- CONSIDER HIV PEP IF THE FOLLOWING CONDITIONS ARE MET:
  - When did exposure occur
  - Nature of exposure (type of fluid and amount)
  - Duration of exposure
  - If there is exposure of NON-INTACT skin or mucous membrane by blood or other body fluids (excluding urine, saliva & faeces) AND
  - The source is KNOWN to be HIV positive OR
  - The source is at HIGH RISK for HIV AND
  - The patient consents to PEP AND
  - The time from exposure to HIV PEP is < 72 hours

The source is at MOUTH, EYES or SKIN & MUCOUS MEMBRANE by blood or other body fluids (excluding urine, saliva & faeces)
- CONSIDER HIV PEP IF THE FOLLOWING CONDITIONS ARE MET:
  - When did exposure occur
  - Nature of exposure (type of fluid and amount)
  - Duration of exposure
  - If there is exposure of NON-INTACT skin or mucous membrane by blood or other body fluids (excluding urine, saliva & faeces) AND
  - The source is KNOWN to be HIV positive OR
  - The source is at HIGH RISK for HIV AND
  - The patient consents to PEP AND
  - The time from exposure to HIV PEP is < 72 hours

Consider HIV PEP NO

Consider HIV PEP YES

SKIN & MUCOUS MEMBRANE EXPOSURE

FIRST AID
- Skin – wash site liberally with soap and water
- Eyes – irrigate gently with sterile saline
- Mouth – rinse with water
  - Tooth brushing is NOT recommended

Exposed individuals should be assessed URGENTLY
- If indicated, HIV PEP should commence as soon as possible within 2 hours of an exposure

RISK ASSESSMENT
- When did exposure occur
- Nature of exposure (type of fluid and amount)
- Duration of exposure

- If there is exposure of NON-INTACT skin or mucous membrane by blood or other body fluids (excluding urine, saliva & faeces)
  - CONSIDER HIV PEP IF THE FOLLOWING CONDITIONS ARE MET:
    - When did exposure occur
    - Nature of exposure (type of fluid and amount)
    - Duration of exposure
  - If there is exposure of NON-INTACT skin or mucous membrane by blood or other body fluids (excluding urine, saliva & faeces) AND
  - The source is KNOWN to be HIV positive OR
  - The source is at HIGH RISK for HIV AND
  - The patient consents to PEP AND
  - The time from exposure to HIV PEP is < 72 hours

- If there is exposure of NON-INTACT skin or mucous membrane by blood or other body fluids (excluding urine, saliva & faeces) AND
  - The source is at MOUTH, EYES or SKIN & MUCOUS MEMBRANE by blood or other body fluids (excluding urine, saliva & faeces)
  - CONSIDER HIV PEP IF THE FOLLOWING CONDITIONS ARE MET:
    - When did exposure occur
    - Nature of exposure (type of fluid and amount)
    - Duration of exposure
  - If there is exposure of NON-INTACT skin or mucous membrane by blood or other body fluids (excluding urine, saliva & faeces) AND
  - The source is KNOWN to be HIV positive OR
  - The source is at HIGH RISK for HIV AND
  - The patient consents to PEP AND
  - The time from exposure to HIV PEP is < 72 hours

Follow-up Testing:
- Month 1
- Month 3
- Month 6

Follow-up Testing Table:

<table>
<thead>
<tr>
<th>Follow-up Testing</th>
<th>Month 1</th>
<th>Month 3</th>
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- * - See App 10
**Guidelines for the Management of Exposures to Blood and Body Fluids**

**NEEDLE STICK INJURY (NSI)**

**FIRST AID**
- Allow the wound to bleed freely
- Wash liberally with soap & water

Exposed individuals should be assessed URGENTLY

If indicated, HIV PEP should commence as soon as possible, preferably within 2 hours of an exposure.

**RISK ASSESSMENT**
- When did exposure occur
- Geographic location of exposure (e.g. hospital versus community)
- Nature and extent of the injury
  - Deep penetrating injury
  - Superficial injury
  - Through clothing/gloves
  - Volume of blood in syringe
  - Was the needle/syringe freshly used

**Risk of HIV infection**

**USUALLY HIV PEP IS NOT INDICATED FOR COMMUNITY NSIs.**

**FOR HEALTH CARE NSIs HIV PEP MAY BE CONSIDERED IF THE FOLLOWING CONDITIONS ARE MET:**

- The syringe has been freshly used/discarded
- There is visible fresh blood on the needle or syringe
- The source is KNOWN to be HIV positive
- The source is at HIGH-RISK for HIV
- The patient consents to PEP

The time from exposure to PEP is < 72 hours;

Consider HIV PEP NO

Consider HIV PEP YES

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**Follow-up Testing**

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</table>

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The HIV PEP Kit may be started if there is a delay in obtaining source information.

**SOURCE DETAILS**

**HIV STATUS OF SOURCE UNKNOWN**

If available and consents:
- Test for HIV, HBV & HCV
  - Consider possibility of source window period

**HIV STATUS OF SOURCE KNOWN TO BE POSITIVE**

Information that is helpful for the ID Specialist:
- HIV viral load
- Current and past anti-HIV drug therapy AND reasons for stopping/changing regimen
- HBV & HCV status

If HIV positive source, administer 1st dose of HIV PEP regimen to the exposed person (if not already given)

**EXPOSED PERSON'S DETAILS**

- Medical history including all drugs
- Review for drug interactions on PEP
- Vaccination history for tetanus and HBV
- Previous HIV test results
- In women, ask about pregnancy or breast feeding

DISCUSS WITH ID SPECIALIST AT THE TIME OF THE INCIDENT TO DETERMINE THE NEED FOR ONGOING HIV PEP

**HBV PEP**

- Assess the need for HBlg and hepatitis B vaccine for all percutaneous exposures using the flowcharts in Appendix B
- See Appendix B (b)

**TETANUS PROPHYLAXIS**

- If the exposure was from a sharp object that may have had contact with soil, tetanus vaccination should be confirmed and prophylaxis offered as per standard practice

**BASELINE BLOODS**

- HIV antibodies
- Hepatitis B & C serology (anti-HBs, HBsAg, anti-HCV)
- Routine biochemistry & LFTs
- Complete blood count & differential
- Pregnancy test if applicable

**EDUCATION**

- Likely side-effects of HIV PEP. See Appendix 5
- The need for 100% adherence
- Signs and symptoms of HIV seroconversion illness
- Blood and Body Fluid Precautions See Section 6 – Counselling and Follow-Up
- Patients should have protected sex with partners until results of final HIV antibody testing is known

**FOLLOW-UP**

- Refer exposed person to Family Physician and/or ID Specialist
- Send completed Exposure Incident Report Form to MHO
**Guidelines for the Management of Exposures to Blood and Body Fluids**

**SEXUAL EXPOSURE**
(assault or consensual* exposure)
* Refer to Sections 5a and 5b

**FIRST AID**
- Rectum or vagina – douching is NOT recommended
- Mouth – rinse with water
  - Tooth-brushing is NOT recommended

Exposed individuals should be assessed URGENTLY
If indicated, HIV PEP should commence as soon as possible, preferably within 2 hours of an exposure.

**RISK ASSESSMENT**
- Date & time of exposure
- Nature of exposure (eg. oral, vaginal, anal)
- Concurrent STI in exposed or source
- Trauma from the exposure

**CONSIDER HIV PEP IF THE FOLLOWING CONDITIONS ARE MET:**
- Unprotected anal or vaginal sex
- AND/OR
- Unprotected receptive oral sex with ejaculation
- AND
- The source is KNOWN to be HIV positive
- OR
- The source is at HIGH RISK for HIV
- AND
- The patient consents to PEP
- AND
- The time from exposure to PEP is < 72 hours

**NOTE:** Unprotected sex is defined as no condom used or condom slippage/breakage

**Follow-up Testing**

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**The HIV PEP Kit may be started if there is a delay in obtaining source information**

**SOURCE DETAILS**

**HIV STATUS OF SOURCE UNKNOWN**
If available and consents:
- Test for HIV, HBV & HCV
  - Consider possibility of source window period

**HIV STATUS OF SOURCE KNOWN TO BE POSITIVE**
Information that is helpful for the ID Specialist:
- HIV viral load
- Current and past anti-HIV drug therapy AND reasons for stopping/changing regimen
- HBV & HCV status (anti-HBs, HBsAg, anti-HCV)
- Any concurrent STI

If HIV positive source, administer 1st dose of HIV PEP regimen to the exposed person (if not already given)

**EXPOSED PERSON’S DETAILS**
- Medical history including all drugs.
- Review for drug interactions on PEP
- Vaccination history for HBV
- Previous HIV test results
- In women, ask about pregnancy or breast feeding

**DISCUSS WITH ID SPECIALIST AT TIME OF THE INCIDENT TO DETERMINE THE NEED FOR ONGOING HIV PEP**

**HBV PEP**
- Assess and manage as per Canadian Immunization Guide See Appendix 8

**BASELINE BLOODS**
- HIV antibodies (pre-test counselling required)
- Hepatitis B & C serology (anti-HBs, HBsAg, anti-HCV)
- STI Screening
- Routine biochemistry & LFTs
- Complete blood count & differential
- Pregnancy test if applicable

**EDUCATION**
- Likely side-effects of HIV PEP. See Appendix 5
- The need for 100% adherence
- Signs and symptoms of HIV seroconversion illness
- Blood and Body Fluid Precautions See Section 6 – Counselling and Follow-Up
- Patients should have protected sex with partners until results of final HIV antibody testing is known

**FOLLOW-UP**
- Refer exposed person to Family Physician and/or ID Specialist.
- Send completed Exposure Incident Report Form to MHO
- Follow-up STI Screening

**BASELINE TESTING:**
- HIV antibodies (pre-test counselling required)
- Hepatitis B & C serology (anti-HBs, HBsAg, anti-HCV)
- STI screening

**EDUCATION**
- Referral for supportive and/or behavioural counselling
- Safer sex education
  - Patients should have protected sex with partners until their results of final HIV antibody testing is known to be negative
- Blood and Body Fluid Precaution Education (to take precautions until final HIV test result is known). See Section 6 – Counselling and Follow-Up

**FOLLOW-UP**
- HBV post-exposure prophylaxis (vaccination and HB Ig if indicated)
- Refer the exposed person to their Family physician
- Repeat STI Screening
- If source is known positive for HIV, HBV or HCV or their status is unknown, complete follow-up testing as per table below
  - Send completed Exposure Incident Report Form to MHO
NEEDLE SHARING EVENT
(Refer to Lifestyle Exposure Section 5b pg 2-3)

FIRST AID
- Allow the wound to bleed freely
- Wash liberally with soap & water

Exposed individuals should be assessed URGENTLY
If indicated, HIV PEP should commence as soon as possible, preferably within 2 hours of an exposure.

RISK ASSESSMENT
- When did exposure occur
- Nature of exposure (from the event they are concerned about)

CONSIDER PEP IF THE FOLLOWING CONDITIONS ARE MET
There has been an episode of needle sharing
AND The syringe has been freshly used
AND There is visible blood on the needle or syringe
AND The source is known to be HIV positive
OR The source is at HIGH RISK for HIV
AND The patient consents to PEP
AND The time from the event of concern to PEP is < 72 hours

Consider HIV PEP NO
Consider HIV PEP YES

Follow-up Testing

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The HIV PEP Kit may be started if there is a delay in obtaining source information

SOURCE DETAILS
HIV STATUS OF SOURCE UNKNOWN
If available and consents:
- Test for HIV, HBV & HCV
  - Consider possibility of source window period

HIV STATUS OF SOURCE KNOWN TO BE POSITIVE
Information that is helpful for the ID Specialist:
- HIV viral load
- Current and past anti-HIV drug therapy AND reasons for stopping/changing regimen
- HBV & HCV status

If HIV positive, administer 1st dose of HIV PEP regimen to the exposed person (if not already given)

EXPOSED PERSON'S DETAILS
- Medical history including all drugs
- Review for drug interactions on PIP
- Vaccination history for HBV
- Previous HIV test results
- In women, ask about pregnancy or breast feeding

DISCUSS WITH ID SPECIALIST WITHIN 24 HOURS TO DETERMINE THE NEED FOR ONGOING HIV PEP

HBV PEP
- Assess and manage as per Canadian Immunization Guide See Appendix 8

BASELINE BLOODS
- HIV antibodies (pre-test counselling required)
- Hepatitis B & C serology
- Routine biochemistry & LFTs
- Complete blood count & differential
- Pregnancy test if applicable

EDUCATION
- Likely side-effects. See Appendix 5
- The need for 100% adherence
- Signs and symptoms of HIV seroconversion illness
- Safer injecting education (Harm Reduction Education)
- Blood and Body Fluid Precautions See Section 6 – Counselling and Follow-Up
- Patients should have protected sex with partners until results of final HIV antibody testing is known

FOLLOW-UP
- Refer exposed person to Family Physician and/or ID Specialist
- Send completed Exposure Incident Report Form to MHO

The guidelines for the Management of Exposures to Blood and Body Fluids provide a comprehensive approach to managing potential exposures, including PEP, baseline testing, follow-up, and education. This resource is essential for health professionals to ensure informed and timely management of such incidents.