Guidelines for post-incident testing orders and authorisations

Part 8, Division 5 of the *Public Health and Wellbeing Act 2008*

VICTORIA State Government | Department of Health

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Purpose

This document (the guidelines) has been prepared by the Department of Health to assist caregivers and custodians and their employers[1] to understand Part 8, Division 5 of the *Public Health and Wellbeing Act 2008* (the post-incident testing provisions) concerning examination and testing of specified persons following an incident that may have resulted in the transfer of a 'specified infectious disease[2], (currently prescribed in the Public Health and Wellbeing Regulations 2019 as HIV and any form of hepatitis which may be transmitted by blood or body fluid[3]).

Employers of caregivers and custodians are encouraged to have processes in place to respond to exposure incidents. This includes protocols for determining who at the organisation is responsible for the actions outlined in these guidelines (a clinician responsible).

The guidelines lay out possible actions available to responsible clinicians following an exposure incident. Clinicians will need to consider each incident on its own merits and apply their usual professional and ethical judgments to decide on a reasonable course of action that accords with the principles of the *Public Health and Wellbeing Act 2008* (the Act) and is compliant with the legislation.

The vast majority of orders or authorisations will involve incidents where the potential source lacks capacity to consent for testing. This situation can be managed by the health service's Authorised Senior Medical Officer, provided that all the other requirements of the post-incident testing provisions have been met.

If a health service does not have an Authorised Senior Medical Officer, then requests for orders or authorisation can be made to the Chief Health Officer of the Department of Health.

Very infrequently the potential source will have capacity but will not consent to testing. In such a circumstance every effort should be made to resolve any concerns the potential source has in relation to testing. Reaching an agreement to test is by far the preferred position as it impacts least on the rights of all involved, potentially inflicts the least harm on the potential source, maintains the best possible relationship between the health service and the potential source, may prove more timely and efficient, and poses least danger to staff who are required to take the blood sample.

If, after all efforts, consent has not been granted, then the clinician responsible may consider making a request to the Chief Health Officer for an order or authorisation to evaluate the serostatus of the potential source against their will.

The post-incident testing provisions do apply to prison officers, however another more suitable mechanism exists: namely for a principal medical officer to direct a prisoner to submit to tests under s. 29 of the *Corrections Act 1986*.

Incidents involving members of Victoria Police also fall under the post-incident testing provisions, however the appropriate processes to follow are not detailed in these guidelines. Victoria Police members should speak with their occupational health and safety unit about any incidents.

1 *Public Health and Wellbeing Act 2008*, s. 134(10)
2 *Public Health and Wellbeing Act 2008*, s. 3
3 Public Health and Wellbeing Regulations 2019, reg. 103AA

In summary, the post-incident testing provisions in the Act provide that:

- the Chief Health Officer may order or authorise testing for a specified infectious disease (prescribed in the Public Health and Wellbeing Regulations 2019), in certain circumstances[4]
- the Chief Health Officer may examine, use and disclose relevant health information held by the Department of Health or a health service provider, in certain circumstances[5], to assist in rapid diagnosis and clinical management and, where appropriate, treatment
- specified health services may appoint a senior medical officer (Authorised Senior Medical Officer) to exercise the same powers as the Chief Health Officer in certain circumstances[6]
- Authorised Senior Medical Officers may order or authorise testing for a specified infectious disease, in certain circumstances, where the tested person ('the possible source') lacks capacity to consent or has died[7]
- a pathologist who conducts a test requested by an Authorised Senior Medical Officer or the Chief Health Officer must without delay report that test result to the Authorised Senior Medical Officer or the Chief Health Officer[8]
- test results must be provided (by the Authorised Senior Medical Officer or Chief Health Officer without delay) to any of the persons to whom the disease(s) could have been transmitted, who have been counselled and consented to be tested, ('the potentially exposed person(s)'), and the possible source[9]
- the Authorised Senior Medical Officer or Chief Health Officer must ensure, if they have made an order or authorisation for testing, that counselling regarding the test results[10] is provided to the possible source and to a potentially exposed person by a medical practitioner. If the possible source is dead or does not have, or is unlikely to regain, capacity, counselling must be provided to a parent if a child is involved, or to the medical treatment decision maker for the person tested within the meaning of the *Medical Treatment Planning and Decision Act 2016*.
- registered medical practitioners who take samples, conduct tests or provide information or counselling in accordance with the post-incident testing provisions are protected from legal action[11]

Health services and other relevant institutions and agencies should incorporate these guidelines into their internal protocols and policy documents.

These guidelines include the record-keeping requirements for documents created under the provisions (see page 12). All health services must comply with these directions. Any updates to the guidelines and directions about orders and authorisations under s. 141 of the Act will be provided to health services via the hospital circular system and will be made available on the Chief Health Officer's website: https://www.health.vic.gov.au/chief-health-officer/publications.

4 *Public Health and Wellbeing Act 2008*, ss. 134 and 135
5 *Public Health and Wellbeing Act 2008*, s. 136
6 *Public Health and Wellbeing Act 2008*, s. 137
7 *Public Health and Wellbeing Act 2008*, s. 137(3)
8 *Public Health and Wellbeing Act 2008*, ss. 139(1) and 139(3)
9 *Public Health and Wellbeing Act 2008*, s. 139(2)
10 *Public Health and Wellbeing Act 2008*, s. 138
11 *Public Health and Wellbeing Act 2008*, s. 142

When these guidelines apply

The post-incident testing provisions of the Act apply only when:

- an incident has occurred, while a caregiver or custodian is acting in their capacity as a caregiver or custodian, in which, if any of those involved in the incident were infected with a specified infectious disease, the disease could have been transmitted to any of the other persons involved; and
- any of those persons to whom the disease could have been transmitted—
  - has been counselled by a person of a prescribed class about the risk of transmission of the disease in the particular circumstances and about the medical and social consequences of being infected with the disease; and
  - has consented to be tested for that disease; and
- any of those persons who, if he or she were infected with the disease, could have transmitted it—
  - has been offered counselling, irrespective of whether the offer was accepted, and has refused to be tested for the disease; or
  - is unconscious or otherwise does not have the capacity to consent to be tested for the disease; and
- the making of the order is necessary in the interest of rapid diagnosis and clinical management and, where appropriate, treatment for any of those involved.

Definition of caregivers and custodians

For the purposes of testing orders and authorisations, the Act defines caregivers and custodians to mean:[12]

1. a person who is employed or engaged by, or performs work at, a health service
2. a registered medical practitioner
3. a person registered under the Health Practitioner Regulation National Law
   (i) to practise in the dental profession as a dentist (other than as a student), and
   (ii) in the dentists division of that profession
4. a nurse or a midwife
5. a student who is registered under the Health Practitioner Regulation National Law by the Medical Board of Australia, the Dental Board of Australia, the Nursing and Midwifery Board of Australia or the Paramedicine Board of Australia
6. a person registered under the Health Practitioner Regulation National Law to practise in the paramedicine profession as a paramedic (other than as a student)
7. a person who is employed or engaged by, or performs work at, a pathology service
8. a person who
   (i) removes human tissue from a person, whether alive or dead, or
   (ii) handles human tissue

in accordance with the *Human Tissue Act 1982*

12 *Public Health and Wellbeing Act 2008*, s. 134(10)

9. a person who carries out an activity of a kind referred to in s. 42(1) of the *Human Tissue Act 1982*
10. a legal custodian of a person who is in legal or protective custody and any person who is employed or engaged by the legal custodian in the course of keeping that person in legal or protective custody
11. a police officer
12. a person who is prescribed to be a caregiver or custodian for the purposes of s. 134 of the Act[13]

Legal custodians also include persons who are responsible for a person in protective custody, for example, persons who are legally responsible for a person who is a security or forensic resident[14] within the meaning of the *Disability Act 2006* or a patient within the meaning of the Mental Health and Wellbeing Act 2022. In addition, this also includes an authorised person who has taken a person into care and control under parts 5.2 and 5.3 of the Mental Health and Wellbeing Act 2022. An authorised person under the Mental Health and Wellbeing Act 2022 includes a police officer, a registered paramedic employed by an ambulance service, a protective services officer, a registered medical practitioner employed engaged by a designated mental health service, an authorised mental health practitioner, or a member of a prescribed class of person.

Location of an incident

The post-incident testing provisions apply irrespective of where the incident occurs, so long as the incident involves a caregiver or custodian acting in their capacity as a caregiver or custodian.[15]

An incident may, for example, occur at a hospital or at the home of a patient being attended by a registered nurse, paramedic or registered medical practitioner in the course of their employment.

Where an incident occurs at a prison and the prisoner involved refuses, or lacks capacity to consent to testing, the prison's principal medical officer may direct the prisoner to undergo testing in accordance with the *Corrections Act 1986*.[16] Where the provisions of the *Corrections Act 1986* do not apply, if for example, a prison officer involved in an incident refuses or is unable to consent to testing, an application may be made to the Chief Health Officer for an order requiring that person to be tested (see the section 'If the caregiver or custodian is the possible source' below).[17]

13 At time of publication of these guidelines no such category of person has been prescribed by regulation

14 A security resident is a person with an intellectual disability who, under s. 166 of the *Disability Act 2006*, has been transferred by the Secretary to the Department of Justice and Community Safety from lawful detention in a prison to a residential treatment facility or residential institution. A forensic resident is a person with an intellectual disability who is remanded in custody or committed to custody by a supervision order in a residential service under s. 3 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. They also include persons with an intellectual disability detained in prison under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* and then transferred to a residential treatment facility under s. 180 of the *Disability Act 2006*.

15 *Public Health and Wellbeing Act 2008*, s. 134(1)(a)

16 *Corrections Act 1986*, s. 29(2)

17 *Public Health and Wellbeing Act 2008*, ss. 134, 135, 137

Incapacity or refusal to consent to testing

Where a person who could have transmitted the disease does not have capacity to consent to testing or is deceased, an application may be made to the Authorised Senior Medical Officer for an order requiring the person to be tested.[18]

Where blood has already been collected from such a person for another purpose, an application may be made to the Authorised Senior Medical Officer for authority to test the blood already collected.[19]

Where a health service does not have an Authorised Senior Medical Officer, and the person who could have transmitted the disease lacks capacity to consent to testing, an application may be made to the Chief Health Officer for an order requiring the person to be tested.[20] Where blood has already been collected for another purpose, an application may be made to the Chief Health Officer for authority to test the blood already collected.[21] However, health services are strongly encouraged to appoint the requisite officer to undertake the orders or authorisations detailed in these guidelines.

Health services need to ensure clinical staff involved in pre-test counselling following an exposure incident are able to assess a person's capacity to consent. This may range from patients recovering from a general anaesthetic to those in the emergency department who may be under the influence of drugs or alcohol or suffering from a head injury.

For the purposes of the post-incident testing provisions, a person is to be treated as not having the capacity to consent[22] to be tested even if:

(a) the lack of capacity is due to a temporary cause, or

(b) there is another person who has the capacity to consent to testing on that person's behalf (for example, a 'medical treatment decision maker' as defined in s3 of the Medical Treatment Planning and Decision Act 2016).

In the case of an adult who lacks capacity to consent for testing, both the Authorised Senior Medical Officer and the Chief Health Officer are able under the Act to make an order or authorisation. It should be noted that even if there is a spouse or next of kin or other person capable of consenting to testing on behalf of the person lacking capacity, such person cannot consent or refuse consent in this circumstance.[23]

Parents, however, are able to consent to the testing of their child where the child is considered not to have capacity. If a parent refuses then an Authorised Senior Medical Officer cannot make an order or authorisation in that instance[24] and, if required, may make an application to the Chief Health Officer.

Where a person involved in an incident has capacity and refuses to consent to testing, an application may be made to the Chief Health Officer for an order requiring the person to be tested.[25] Where blood has already been collected from such a person for another purpose, an application may be made to the Chief Health Officer for authority to test the blood already collected.[26] An Authorised Senior

18 *Public Health and Wellbeing Act 2008*, s. 137(3)(a).
19 *Public Health and Wellbeing Act 2008*, s. 137(3)(b))
20 *Public Health and Wellbeing Act 2008*, s. 134
21 *Public Health and Wellbeing Act 2008*, s. 135
22 *Public Health and Wellbeing Act 2008*, s. 134(6)
23 *Public Health and Wellbeing Act 2008*, s. 134(6)(b)
24 *Medical Treatment Planning and Decisions Act*, s 55
25 *Public Health and Wellbeing Act 2008*, s. 134(1)(c)(i)
26 *Public Health and Wellbeing Act 2008*, s. 135

Medical Officer cannot order or authorise testing where a person involved in an incident refuses to consent to testing.

Before resorting to the powers of the Chief Health Officer, all reasonable effort should be made to obtain a person's consent to testing.

An order cannot be made if more than one month has passed since the incident.[27]

If the caregiver or custodian is the possible source

In some incidents, the caregiver or custodian may be identified as the possible source of transmission. It is also possible that a person involved in an incident may be both a possible source and a potentially exposed person.

If there has been an incident where the caregiver or custodian may have been a possible source of transmission and the caregiver or custodian refuses to consent to testing, an application may be made to Chief Health Officer for an order requiring the caregiver or custodian to undergo testing, or for an authorisation to test blood already collected.

Health services and other relevant institutions and agencies should have appropriate protocols in place to ensure that decisions about post-incident testing are made by a third party and not by the affected caregiver or custodian.

Requiring and disclosing information

If the Chief Health Officer believes that the circumstances exist for the making of an order under s. 134, the Chief Health Officer may:[28]

- examine any relevant health information held by the department relating to that person
- require a health service provider to provide to the Chief Health Officer any relevant health information held by the health service provider relating to that person

The Chief Health Officer may, subject to the following conditions, disclose relevant health information obtained for the making of the order to the potentially exposed person:[29]

- the information must only be disclosed to the extent necessary in the interest of rapid diagnosis and clinical management and, where appropriate, treatment for that person, and
- the information disclosed must not include information that would identify the person to whom the relevant health information relates, and
- the person to whom the information is disclosed must not disclose, communicate or make a record of anything that would identify the person to whom the relevant health information relates,[30] and
- the information is not admissible in any action or proceedings before any court or tribunal or any board, agency or other person.

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27 *Public Health and Wellbeing Act 2008*, s. 134(7)
28 *Public Health and Wellbeing Act 2008*, s. 136(1)
29 *Public Health and Wellbeing Act 2008*, s. 136(4)
30 Section 136(5) of the *Public Health and Wellbeing Act 2008* provides that a person who contravenes this condition is guilty of an offence with a maximum penalty of 60 penalty units ($11,538.60 at time of publication)

Enforcement of an order if consent is withheld

To enforce an order, the Chief Health Officer may apply to the Magistrates' Court for an order to authorise a police officer to use reasonable force to:[31]

- take the person named in the order to the place specified in the order, or
- restrain the person named in the order so as to enable a registered medical practitioner to take a sample of blood or urine, or
- take the person named in the order to the place specified in the order and restrain the person named in the order so as to enable a registered medical practitioner to take a sample of blood or urine.

Testing blood or urine previously collected for another purpose

Under s. 135 of the Act, Authorised Senior Medical Officers or the Chief Health Officer may authorise the testing of blood or urine samples previously collected from an individual for another purpose, for any disease for which the Chief Health Officer could order the person to be tested under section 134 of the Act if:

1. all the conditions have been met that would enable the Authorised Senior Medical Officer or Chief Health Officer to order post-incident testing on that individual under s. 134 of the Act, and
2. the Authorised Senior Medical Officer or Chief Health Officer is satisfied that:
   - a sample of blood or urine from that person has been stored at any place for any purpose, and
   - the sample is appropriate for the purpose of post-incident testing, and
   - if the sample was authorised for testing, it can still be used for the purpose for which it was originally stored.

The authorisation cannot be made if more than one month has passed since the incident.[32]

The authorisation must be in writing and must include the same details required for post-incident testing orders under s. 134. Like s. 134 orders, authorisations may be made subject to appropriate conditions and may be varied or revoked.[33]

31 *Public Health and Wellbeing Act 2008*, s. 134(3)
32 *Public Health and Wellbeing Act 2008*, s. 134(7)
33 *Public Health and Wellbeing Act 2008*, s. 135(3)

Requesting an order or authorisation for testing

In the event of a sharps injury, such as needlestick, or other blood or body fluid exposure, a risk assessment based on the nature and extent of the injury or incident should immediately be undertaken to determine if the exposure has the potential to transmit a blood-borne virus.

This assessment should be undertaken by the treating medical practitioner managing the potentially exposed person, who may seek expert advice from an infectious diseases specialist.

Expert advice can be obtained from your local health service's infectious diseases unit. A select list of metropolitan infectious diseases services includes:

The Alfred Hospital (ask for Infectious Diseases Unit or on-call Infectious Diseases Physician)	(03) 9076 2000
Austin Health Infectious Diseases Unit After hours (ask for the ID registrar to be paged)	(03) 9496 6676 (03) 9496 5000
Barwon Health (ask for Infectious Diseases Unit or on-call Infectious Diseases Physician)	(03) 4215 0000
Monash Health Infectious Diseases Unit	(03) 9594 4564
Victorian Infectious Diseases Service (VIDS), Royal Melbourne Hospital	(03) 9342 7212

Where appropriate, the possible source should be counselled, as detailed in that health service's policies and procedures, in relation to the incident, and consent sought for testing. Where required, every effort should be employed to explain the medical imperative for testing. Refusal to test in these circumstances is extremely uncommon, however the situation may require the direct involvement of senior medical staff.

Possible factors leading to refusal may include: fear of the diagnosis, concerns relating to confidentiality of test results, or the impact of a positive result on immigration applications or professional practice. Such factors should be canvassed and, where possible, resolved as part of the pre-test counselling.

The clinician involved in the care of the potentially exposed person(s) may seek to review the possible source's hospital medical records for diagnosis, previous testing or risk factors for blood-borne viruses. If the potential source has a significant history at another hospital, health service or general practice, then clinicians may choose to make contact and seek relevant medical history under the Health Privacy Principles (see Health Privacy Principle 2.2(h)(i))

A request for an order or authorisation for testing from the Chief Health Officer should be sought where:

- it is determined by the treating medical practitioner, taking all factors into consideration, that appropriate management of the incident requires testing of the possible source for a specified infectious disease
- all the elements required under the Act are met
- the incident does not fall under the ambit of an Authorised Senior Medical Officer (that is, the possible sources refuse to consent) or the health service does not have an Authorised Senior Medical Officer.

Contacting the Chief Health Officer

The Chief Health Officer can be contacted as follows:

Business hours: **(03) 9668 7385** (executive assistant), or via email at OfficeofCHO@health.vic.gov.au

After hours: A public health officer is available via the department's after-hours service on **1300 651 160**.

Record keeping

In accordance with the Chief Heath Officer's Direction (see s. 141), a hospital, public health service, multipurpose service or proprietor of an approved private hospital where an Authorised Senior Medical Officer(s) has been appointed must ensure that all orders and authorisations made by Authorised Senior Medical Officer(s) are kept in a central file and that the file is able to be readily located and retrieved.

Where a notation of the incident is required to be made on other files, for example, a patient's clinical file or as part of a critical incident report, the identity of the possible source must not be disclosed, communicated or recorded in any way that would identify the person tested.[34] .

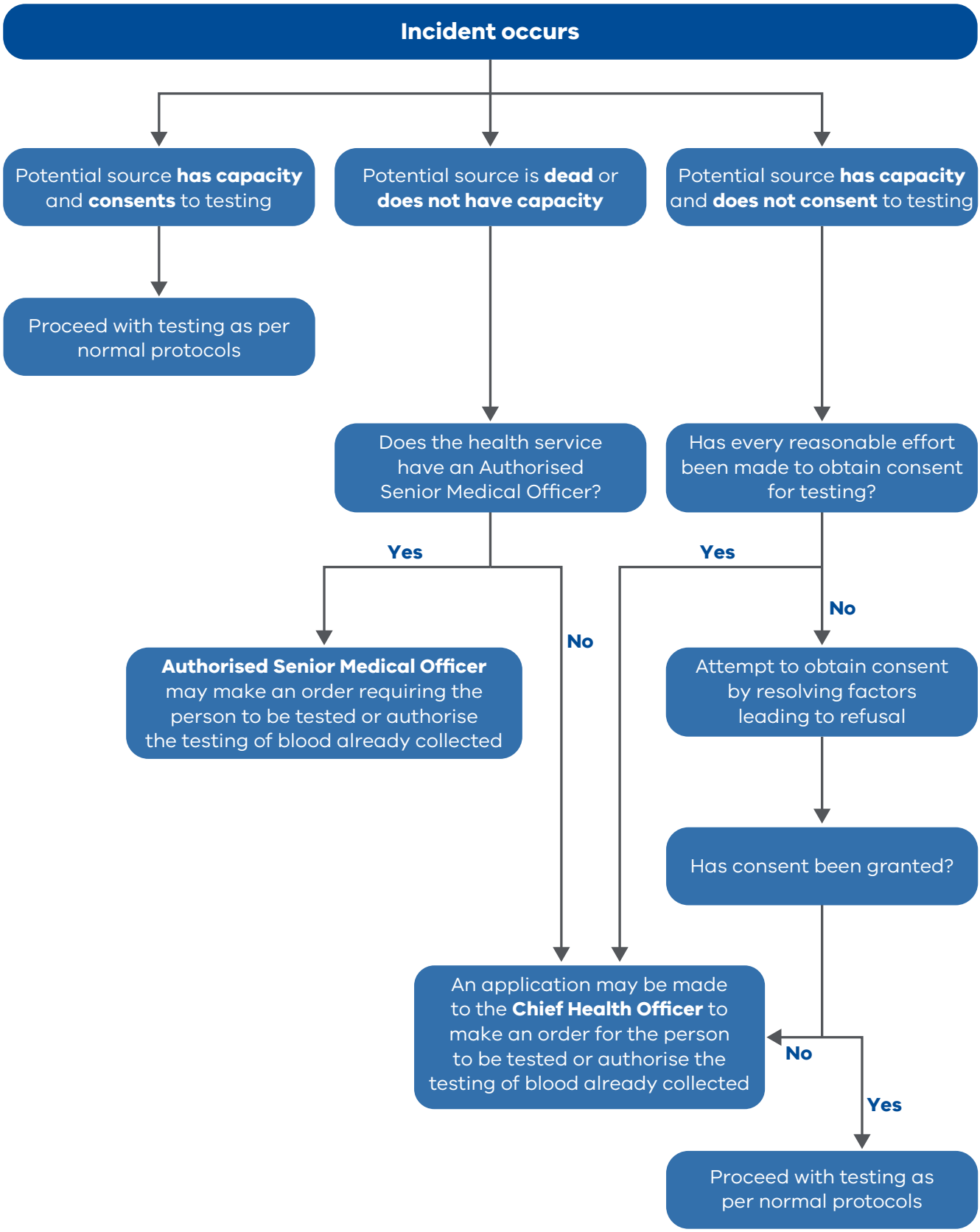
It is also important that the clinical file of the person tested (the possible source) records that a post-incident testing order or authorisation was made. This file should include the test results and any notes made about counselling, as this information may be relevant to current or future clinical services provided by the hospital.

Note: The Chief Health Officer may give directions about orders or authorisations under s. 141 of the Act. These are available on the internet at: https://www.health.vic.gov.au/chief-health-officer/publications

34 *Public Health and Wellbeing Act 2008*, s. 140(2)

Appendix

Post incident testing

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