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Bureau of Disease Control and Epidemiology,
1100 West 49th Street, Austin, Texas 78756 (512-458-7455)

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AAICC: Recommendations for Management of HIV Infection and Acquired Immunodeficiency Syndrome

TB Physician Conference-Call for Papers

AAICC: RECOMMENDATIONS FOR MANAGEMENT OF HIV INFECTION AND ACQUIRED IMMUNODEFICIENCY SYNDROME

The following recommendations, developed by the Austin Area Infection Control Committee, update the original AAICC recommendations published in PDN, Vol. 47, No. 10, March 14, 1987.

Acquired immunodeficiency syndrome (AIDS) should be regarded as a major health care concern. It is an infectious disease which is generally widespread, incurable, and misunderstood. The fear of AIDS is often disproportionate to the risk of acquiring the disease.

AIDS is a disease caused by the human immunodeficiency virus (HIV), formerly called the human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). HIV infects the lymphocytes. The body substances containing the greatest amount of virus are blood, semen, and vaginal secretions. The virus is transmitted through sexual contact, percutaneous exposure, perinatal exposure, by absorption through mucous membranes, and through nonintact mucous membranes and skin. It is not spread through ordinary social, occupational, or household contacts of a nonsexual nature.

In the health care setting, the risk of acquiring or transmitting HIV infection by patients or health care workers (HCW) is related to the degree of percutaneous contact or mucous membrane contamination with blood or other high-risk body substances. The same precautions used to prevent transmission of hepatitis B virus (HBV) are adequate to prevent the spread of HIV, as it is less hardy and is present in fewer numbers than the HBV.

PURPOSE

These recommendations for the management of AIDS were developed by the Austin Area Infection Control Committee (AAICC), a multidisciplinary group of local experts in infection control practices, to promote standardization and improvement of AIDS management in the Austin-area community. These recommendations provide a consolidation and summary of important topics, clarification or resolutions for some controversial issues, and a list of the most significant references.[1-19] As such, the recommendations are not meant to be all inclusive, but must be used in combination with the listed references. This document should be useful to agencies developing AIDS policies, procedures, and protocols.

I. AIDS PROGRAMS FOR HEALTH CARE AGENCIES

A. Each health care agency should develop an agency-specific AIDS program[1] based on these recommendations and references.

B. The program should include written policies, procedures, and protocols.

C. The major focus of the program should be to educate employees about the disease and its transmission in order for them to respect, but not fear, the disease. This will maximize their ability to rationally provide effective patient care.

D. A multidisciplinary committee should be formed to develop, implement, and evaluate the AIDS program and to serve as educators and consultants for AIDS-related issues.[1]

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II. UNIVERSAL BLOOD AND BODY SUBSTANCE PRECAUTIONS

A. Universal blood and body substance precautions should be promptly implemented for **ALL** patients. There are no additional precautions for patients with communicable bloodborne disease, including patients with AIDS, patients with HIV-positive blood, and patients undergoing diagnostic work-ups for AIDS.[5,8,14,15]

1. All body substances from any individual should be considered infectious because every individual is a potential disease carrier, and the undiagnosed case represents the greatest risk of transmission.
2. If the patient has other infections that require additional precautions, these precautions also should be implemented following CDC guidelines.[8]

B. Hands should be washed routinely after care of the patient and immediately if soiled with blood or body fluids. Note that handwashing is the only precaution necessary for many patient contacts.[14,15]

C. Gloves are recommended for all direct contact with a body substance or with items soiled with such. This is especially important if the HCW has fresh cuts or breaks in the skin. Note that gloves are an adjunct, not a substitute, for handwashing.[14,15]

1. Reusable, rubber, household or janitorial gloves are recommended for cleaning spills involving blood and other body substances. A 10% (1:10) solution of sodium hypochloride, prepared by combining one part household bleach with nine parts water, may be used as a disinfectant. Alcohol (70%) and other common hospital disinfectants are also effective against the virus.

D. Needles and sharps should be handled with extreme care and with minimal manipulation to prevent accidental punctures. **Do not recap, bend, break, or remove needles from syringes.**[8,14,15] The unsheathed needle and syringe should be placed directly into a labeled, rigid, puncture-resistant container which is located as close as possible to the area where it is used, preferably in the patient's room.

E. Gowns are recommended only if soiling with a body substance is likely.[8,14,15]

F. Masks and goggles should be available for use wherever aerosolization or splattering of a body substance is likely, eg, delivery rooms, operating rooms, emergency rooms, endoscopy rooms, pathology and other laboratories, code carts, wound irrigation areas, etc.[14,15] (See Section III).

G. For isolation purposes, a private room is not usually necessary, and patients need not be restricted to their rooms. Exceptional conditions are patients with poor hygiene, patients who are uncooperative, or patients who present risk of dispersing aerosols or splatters of body substances into the environment.[8,14,15]

H. Resuscitation equipment (including bags and airway pieces for connection to bags) should be strategically placed and readily available. HCWs should be trained in CPR classes on the use of resuscitation equipment.[14,15]

I. All laboratory specimens should be placed in leak-proof containers which are uncontaminated on the outside. The use of a bag for specimens is optional.[8]

J. Infective wastes (microbiology waste, pathology waste, blood and blood products, and contaminated sharps), in general, should be incinerated or autoclaved before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer. For disposal of needles and sharps, see Section II, D.

While any item that has had contact with a body substance is potentially infective, it is not practical or necessary to treat all such waste as infective as biologic degradation and dilutional effect rapidly reduce infectivity of blood viruses.[15]

K. After death, bodies of persons with AIDS, HIV infection, or certain other reportable communicable diseases (anthrax, brucellosis, viral hepatitis (types B, D, and non-A, non-B), plague, Q fever, rabies, Rocky Mountain spotted fever, syphilis,

tuberculosis, tularemia, or viral hemorrhagic fever) must be tagged with a card no smaller than 5x10 cm stating:

"Communicable Disease--Blood and Body Fluid Precautions Required" prior to being transported for autopsy or to the mortuary (Texas Department of Health, Rules and Regulations for the Control of Communicable Disease and Reporting of Occupational Disease, 25 TAC, Section 97.11).[17]

III. PRECAUTIONS DURING OPERATIVE, OBSTETRICAL, DENTAL, OR OTHER INVASIVE PROCEDURES AND TRAUMA CARE

A. HCWs who perform or assist in invasive procedures must follow the precautions listed below that are directed at preventing the transmission of any bloodborne disease between HCWs and clients.[13,15]

B. Appropriate precautions listed in Section II should be followed during invasive procedures, with special attention to handwashing, gloving, use of other barrier precautions (gowns, masks, goggles) when excess soiling or splattering potential exists, prevention of injuries due to needles and sharps, and being free of exudative lesions or weeping dermatitis.[13,15]

C. Gloves must be worn when touching mucous membranes or nonintact skin of patients. If gloves are torn or a needlestick or other injury occurs, the gloves must be changed, the contaminated needle or instrument must be removed from the field, and the site of injury must be cleaned vigorously as promptly as possible.[13,15]

D. HCWs should promptly report any inadvertent exposure of a patient to the blood of a HCW or exposure of a HCW to the blood of a patient during an invasive procedure.[13,15] (See Section VII).

E. HCWs with evidence of any illness that might compromise their ability to adequately and safely perform invasive procedures should be evaluated medically to determine whether they are physically and mentally competent to perform invasive procedures. Note that a confirmed positive HIV antibody test alone, just as it is for HBV carriers, is not a contraindication to performing or assisting with invasive procedures.[13,15]

F. All HCWs who perform or assist in invasive procedures must be educated in the appropriate precautions to prevent the transmission of HIV and other bloodborne diseases, including hepatitis B.[13,15] Suggested methods of education include the use of written handouts delineating desired practices, annual follow-up, and documentation of HCWs knowledge and agreement to follow precautions.

IV. PRECAUTIONS FOR OTHER DEPARTMENTS AND SERVICES

A. Other departments and services can safely provide care to AIDS/HIV clients by adopting and following the recommendations and references in this document. Specific references for specialty areas are listed below:

1. Ambulatory care services[1]
2. Clinical laboratories[4,15]
3. Educational and child-care services[7,18]
4. Eye labs and eye treatment services[12]
5. Home-care services
6. Long-term care facilities[15,16]
7. Oral surgery and dental units[3,13,14,15]
8. Perinatal departments[3,11]
9. Personal-service workers[14]
10. Prehospital emergency health care services[14]
11. Dialysis units[15]

B. Food services should follow recommended standards and practices of good personal hygiene and sanitation. There is no evidence that HIV is spread through food or

water; thus, no special precautions are indicated for dishes, and food-service personnel should not be restricted in their work because of serum antibodies to HIV (positive HIV test).[14]

C. Routine sterilization, disinfection, housekeeping, and waste disposal procedures recommended for use in hospitals are more than adequate to prevent the transmission of the HIV virus.[14,15]

V. PATIENT CONFIDENTIALITY

A. On admission of a patient with a confirmed diagnosis of AIDS, spell out "acquired immunodeficiency syndrome"; avoid the abbreviated "AIDS" label.

B. On admission of a patient whose admitting diagnosis is not confirmed, list actual symptoms or conditions and promptly place the patient on appropriate precautions for other associated communicable diseases as indicated. Do not use R/O AIDS, pre-AIDS, or ARC as an admitting diagnosis.

C. Promote confidentiality for AIDS patients without compromising the safety of HCWs by ensuring that proper precautions are clearly understood[1] but without discriminatory labeling.

D. No departmental or computerized lists of AIDS or HIV antibody-positive patients should be permitted. In addition to violating patient confidentiality, such lists may promote inappropriate techniques and false security in HCWs who should follow appropriate blood and body substance precautions with **ALL** patients.

E. Requirements for reporting confirmed AIDS cases and all HIV infections to the local health authority in a confidential manner can be obtained from local health departments or the AIDS Division at the Texas Department of Health. Request form number CDC 50.42A (Revised 8/87).

F. Reporting of any infectious disease which has serious social or legal ramifications should not be available via computer. Thus, when HIV testing is done, confirmed results should be reported directly to the medical record. A computer entry regarding HIV testing might be "HIV test--results pending" or "HIV test--Check medical record for results."

G. Confidential test results should only be released by telephone to the physician or his/her agent, charge nurse, infection control practitioner, or other specific individuals as defined by infection control policy. When telephone reports are given, the reporter should take appropriate precautions and be absolutely sure of the identity of the caller and his/her right to receive the information.

H. Make certain the ICD-9 codes on the front of each patient's chart are well-founded and accurate.

VI. HIV ANTIBODY AND ANTIGEN TESTING

A. The presence of demonstrated antibody to HIV is considered an indication that infection is present and the potential to transmit the virus exists.

B. The ELISA test is currently recommended for initial HIV antibody testing. The Western Blot test should be used to confirm repeatedly positive ELISA tests. New and improved antibody and antigen tests may replace these tests in the future.

C. There should be no mandatory HIV antibody screening, except for the screening of donated blood or other tissues or organs, specifically defined exposures (Section VII), and before certain medical procedures as defined by Texas Board of Health guidelines.[17]

D. Each agency should develop policies for HIV antibody testing of patients, specifying any agency-unique requirements for consent and confidentiality. The following guidelines should be followed:

1. Patient consent for HIV antibody testing as an adjunct to diagnosis is recommended. The consent may be the original signed permit for care or a specific verbal or written consent for testing.
2. HIV antibody test results on patients should be placed in the patient's medical record, but results should not be accessible by computer. Preliminary results from screening tests should not be placed on charts until confirmed, but should be reported to the patient's physician and the Infection Control Practitioner and/or charge nurse. (See Section V)
3. HIV antibody test results should be handled with the utmost confidentiality. Telephone reports should be avoided whenever possible. If used, precautions, as described in Section V, G, should be followed.

VII. MANAGEMENT OF ACCIDENTAL EXPOSURE TO BLOOD/BODY SUBSTANCES

A. All exposures of HCWs or clients to body substances should be reported promptly by the HCW, following agency-specific practices.[14,15] Exposure is defined as parenteral (needlestick or other penetrating puncture of the skin with a used needle or other item), mucous membrane (splatter/aerosols into the eyes, nose, or mouth), or significant contamination of an open wound or nonintact skin with a body substance.

B. General Recommendations

1. It is the right and responsibility of the agency to protect the health of the employees and patients and to properly inform them of the risk of significant infection to which they are exposed for both ethical and legal reasons.
2. Agency-specific protocols should be developed for post-exposure management that clearly specify procedures for determining the need for testing, assuring confidentiality, and specifying individual responsibility and authority and that respect both the person with the infection and the person who might be exposed to the infection. Responsibility for post-exposure management (including assessments, determining risks, counseling, and record keeping) should be clearly delegated to the Infection Control Practitioner, Infection Control Committee Chair, or other authorized person.

   The agency may wish to add to the hospital's admission consent form a statement which informs the patient that, in the event of certain exposures of an employee to the patient's blood or body fluids, blood may be drawn or other procedures used in testing for the presence of certain infections in the patient which could represent a danger to the employee(s) such as HIV, hepatitis B, tuberculosis, syphilis, etc. In the case that a patient is unable to provide consent, the usual protocol for providing medical care to this patient should be followed.
3. The following recommendations for HIV exposure are the same in principle as for other potentially infectious disease exposures:

   a. When indicated, post-exposure HIV antibody testing of both the source and the exposed individual is strongly recommended.
   b. If an employee refuses HIV antibody testing, the agency may ask that the employee sign a statement that testing was offered to the employee who refused.
   c. The source person and his physician should be informed of the incident, be made knowledgable of the procedures, (including those which describe how confidentiality is maintained), and concur with the need for testing. Postexposure HIV antibody test results on patients should be handled according to the hospital policies for maintaining confidential records (See Section VI,D). For example, the results may be placed in the medical record only with patient consent or remain a confidential infection control record.
   d. Post-exposure HIV antibody test results on employees may be placed in the Employee Health Record only if it is kept separate from the personnel files and is handled as highly confidential; otherwise, it should remain a confidential infection control record.

C. Protocols for post-exposure management should be based on the following procedural guidelines and coordinated with the attending physician.

1. The source individual should be assessed clinically and epidemiologically to determine the risk or likelihood of HIV, HBV, or other blood-transmissible infections.
2. The attending physician and the source patient (or legal representative if the individual is temporarily or otherwise incompetent) should be informed of the exposure, understand that the test results will be kept confidential, and concur with the need for testing (See Section VII,B,3,c).
3. If the source has no clinical evidence of infection, is HIV antibody-negative, and has no history of high-risk behavior, no further follow-up of source or exposed individual is indicated.
4. If the source has evidence of possible HIV infection, a confirmed positive HIV antibody test, a history of high-risk behavior, cannot be tested, or refuses to be tested, then:

   a. The exposed individual should be evaluated clinically for evidence of HIV infection, and HIV antibody testing should be recommended as soon as possible after the exposure. Refusal to submit a specimen should be documented. (See Section VII,B,3,b)
   b. If the exposed individual's baseline test is negative for antibody, he or she should have testing for HIV antibody eight weeks following exposure. Virtually all seroconversions will have occurred during this period. Additional testing no later than six months following exposure may be done based on the individual's need to know and the risk of exposure to others.
   c. Both the source and the exposed individual should be counseled.[9]

5. Post-exposure counseling should be given within two weeks of exposure and should include information on the potential risk of infection and specific measures to prevent transmission.[9,10,14,15]

6. If the source individual cannot be identified, follow-up should be based on the type of exposure and the likelihood that the source was infected based on clinical and epidemiological assessment.

VIII. EMPLOYMENT ISSUES

A. All HCWs, as indicated by their job descriptions, are expected to care for patients with all communicable diseases, including AIDS.

1. Pregnant HCWs should not be exempt from caring for AIDS patients because they are not at increased risk of acquiring AIDS, and the recommended precautions are uniformly effective.[14,15,19]
2. Physician prescriptions for exemption of pregnant HCWs are incompatible with scientific evidence and published guidelines.[14,15,19]

B. HCWs with AIDS or positive HIV antibody tests should be hired and/or retained in their jobs based on their ability to perform the job adequately and safely and on their willingness to follow standard infection control policies and procedures.

C. Alternative assignments or transfers of HCWs with AIDS or positive HIV antibody tests are rarely indicated and should be used only if a consistent, nondiscriminatory policy is developed and followed as for HBV infection. (See Section III, B, E, and F).

D. Agencies should develop specific policies for counseling and education of HCWs with known infectious agents which have a low risk of potential transmission, including HIV infections. This review should emphasize precautions for preventing the transmission of their potentially infectious disease, in this case, HIV or its associated opportunistic infections.[13,14,15]

IX. NOTIFICATION OF RECIPIENTS OF CONTAMINATED BLOOD PRODUCTS

A. Agencies that give blood products should develop a program for notifying recipients of contaminated blood products following the American Hospital Associations's "Look Back" program.[2]

REFERENCES:

1. AHA Advisory Committee on Infections Within Hospitals. Management of HTLV-III/LAV infections in the hospital. American Hospital Association, January 1986.
2. American Hospital Association. Look back program: notification of previous recipients of blood and blood components from donors who now have a confirmed positive test for antibodies to the HTLV-III virus. Memorandum, June 1986.
3. CDC. ACIP: recommendations for protection against viral hepatitis. MMWR 1985;34:313-35.
4. CDC. AIDS: precautions for clinical laboratory staffs. MMWR 1982;31:577-80.
5. CDC. AIDS: precautions for health-care workers and allied professions. MMWR 1983;32:450-1.
6. CDC. Classification systems for HTLV-III/LAV infections. MMWR 1986;35:334-9.
7. CDC. Education and foster care of children infected with HTLV-III/LAV. MMWR 1985;34:517-21.
8. CDC. Guideline for isolation precautions in hospitals. Washington DC: US Government Printing Office, 1983 (DHHS publication no. (CDC) 83-8314).
9. CDC. Public Health Service guidelines for counseling and antibody testing to prevent HIV infection and AIDS. MMWR 1987;36:509-15.
10. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.
11. CDC. Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV and AIDS. MMWR 1985;34:721-6, 731-2.
12. CDC. Recommendations for preventing possible transmission of HTLV-III/LAV from tears. MMWR 1985;34:533-4.
13. CDC. Recommendations for preventing transmission of infection with HTLV-III/LAV during invasive procedures. MMWR 1986;35:221-3.
14. CDC. Recommendations for preventing transmission of infection with HTLV-III/LAV in the workplace. MMWR 1985;34:682-6, 691-5.
15. CDC. Recommendations for prevention of HIV transmission in health-care settings. MMWR 1987;36:3S-18S.
16. Texas Department of Health. Admission of residents/patients with AIDS to long-term care facilities. Memorandum, January 17, 1986.
17. Texas Department of Health. Control of communicable disease and reporting occupational disease, 25 Texas Administrative Code, Section 97.12, 1987.
18. Texas Education Agency/Texas Department of Health. Recommended guidelines for providing education to students with AIDS, ARC, or HTLV-III infections. October 31, 1985.
19. Valenti WM. Infection control and the pregnant health care worker. Am J Inf Control 1986;14:20-7.

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STATEWIDE PHYSICIANS CONFERENCE ON TUBERCULOSIS

The Texas Department of Health, Tuberculosis Control Division will be sponsoring a Statewide Physicians Conference on Tuberculosis, June 9 and 10, 1988. The first day of the conference will concentrate on state of the art in treatment and management of the tuberculosis patient. The second day will focus on research and innovative projects currently underway in the management of the tuberculosis patient. Those individuals interested in presenting their research on tuberculosis or reporting on projects related to tuberculosis should submit their topic and a summary of their presentation to:

Andrew Rouse, MD
Assistant Bureau Chief
Bureau of Disease Control and Epidemiology
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756

All submissions must be received by April 15, 1988. Notification of acceptance for presentation will be sent by April 30, 1988.

For Additional information contact:

Charles Wallace
Assistant Director
Tuberculosis Control Division
Texas Department of Health
(512) 458-7447

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