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AUSTIN AREA INFECTION CONTROL COMMITTEE: RECOMMENDATIONS FOR MANAGEMENT OF ACQUIRED IMMUNODEFICIENCY SYNDROME IN HEALTH CARE AGENCIES

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. 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.

INTRODUCTION

Acquired immunodeficiency syndrome (AIDS) should not be regarded as a moral issue, but 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). It is transmitted through sexual contact, percutaneous exposure to blood, and perinatal exposure. It is not spread through ordinary social, occupational, or household contacts of a non-sexual nature.

In the health care setting, the risk of acquiring AIDS is related to the degree of percutaneous contact with contaminated blood. The same precautions used to prevent transmission of hepatitis B virus (HBV) are adequate to prevent the spread of AIDS, as the HIV virus is less hardy and less infectious than the HBV.

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 the listed references.

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

C. The major focus of the program should be to educate all health care workers (HCW) about AIDS and HIV infections.

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]

II. 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. Do not use R/O AIDS, pre-AIDS, or ARC as admitting diagnoses.

C. Promote confidentiality for AIDS patients without compromising the safety of HCWs by ensuring that the designation "Blood and Body Fluid Precautions" -- but not the AIDS diagnosis -- is clearly identified.[1]

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 precautions with all blood and body fluids.

E. Requirements for reporting confirmed and suspected AIDS cases to the local health authority in a confidential manner can be obtained from local health departments or the Bureau of Epidemiology at the Texas Department of Health.

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

III. BLOOD AND BODY FLUID PRECAUTIONS

A. Blood and body fluid precautions should be promptly implemented for all patients with known AIDS, patients with HIV-antibody positive blood, and patients undergoing diagnostic work-up for AIDS, as well as for patients with other communicable bloodborne diseases.[5,8,13]

1. All blood and body fluids from any individual should be considered infectious because every individual is a potential HBV and/or HIV 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.[13]

C. Gloves are recommended for all direct contact with blood, body fluids, or items soiled with blood or body fluids. 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.[13]

D. Needles and sharps should be handled with extreme care and with minimal manipulation to prevent accidental punctures. They should be placed directly into a labeled, rigid, puncture-resistant container which is located as close as possible to the area where they are used. Do not recap, bend, break, or remove needles from syringes.[8,13]

E. Gowns are recommended only if soiling with blood or body fluids is likely.[8,13]

F. Masks and goggles should be available for use wherever aerosolization or splattering of blood/body fluids is likely including delivery rooms, operating rooms, emergency rooms, trauma rooms, endoscopy rooms, pathology and other laboratories, code carts, and blood/body fluid isolation carts.[13]

G. For isolation purposes, a private room is not usually necessary, and patients need not be restricted to their rooms. Exceptions are patients with poor hygiene, who are uncooperative, or who present risk of dispersing aerosols or splatters of blood and body fluids into the environment.[8,13]

H. Resuscitation equipment (including bags and airway pieces for connection to bags) should be strategically placed and readily available, especially to prevent transmission of diseases associated with AIDS. HCWs should be trained in using mouthpieces in CPR classes.[13]

I. Isolation specimens should be placed in leak-proof containers which are uncontaminated on the outside and clearly labeled with the type of precautions -- but not the diagnosis. The use of a bag for specimens is optional.[8]

J. Articles contaminated with blood or body fluids should be discarded or bagged and labeled before being sent for decontamination and reprocessing.[8]

K. After death, bodies of persons with AIDS or HIV infections must be tagged with a card no less than 5x10 cm stating "Communicable Disease -- Blood and Body Fluid Precautions Required" prior to transporting to autopsy or mortuary.[18]

IV. PRECAUTIONS DURING OPERATIVE, OBSTETRICAL, OR DENTAL INVASIVE PROCEDURES

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.[12]

B. Appropriate blood and body fluid precautions listed in Section III should be followed during invasive procedures, with special attention to handwashing, gloving, use of other barrier precautions (gowns, masks, goggles) when indicated, prevention of injuries due to needles and sharps, and being free of exudative lesions or weeping dermatitis.[12]

C. Gloves must be worn when touching mucous membranes or non-intact 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.[12]

D. HCWs should promptly report any inadvertent exposure of a patient to the blood of a HCW during an invasive procedure.[12] (See Section VII,A.)

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 is not a contraindication to performing or assisting with invasive procedures.[12]

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.[12] Suggested methods of education include use of written handouts delineating desired practices, annual follow-up, and documentation of HCWs' knowledge and agreement to follow precautions.

V. 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]
3. Educational and child-care services[7,19]
4. Eye labs and eye treatment services[11]
5. Home-care services[13]
6. Long-term care facilities[16]
7. Oral surgery and dental units[13,3]
8. Perinatal departments[10,3]
9. Personal-services workers[13]
10. Prehospital emergency health care services[13]

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).[13]

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.[13]

VI. HIV ANTIBODY 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 tests may replace these tests in the future.

C. There should be no mandatory HIV antibody screening, except for the screening of donated blood.

D. Each agency should develop policies for HIV antibody testing of patients, specifying any agency-unique requirements for consents and confidentiality:

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.

E. HIV antibody test results should be handled with utmost confidentiality. Telephone reports should be avoided whenever possible. If used, the reporter should take appropriate precautions and be absolutely sure of the identity of the caller and his or her right to receive the information.

VII. MANAGEMENT OF ACCIDENTAL EXPOSURE TO BLOOD/BODY FLUIDS

A. All exposures of HCWs or clients to blood/body fluids should be reported promptly by the HCW, following agency-specific practices.[13] 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 or mouth), or significant contamination of an open wound with blood or body fluids.

B. General Recommendations:

1. When indicated, post-exposure HIV antibody testing of both the source and the exposed individual is strongly recommended, as 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 infection for both ethical and legal reasons.

2. If an employee refuses HIV antibody testing, the agency may ask that the employee sign a statement that testing was offered to the employee and refused.

3. Post-exposure HIV antibody test results on clients should be placed in the medical record or remain a confidential infection control record.

4. Post-exposure HIV antibody test results on employees should 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.

5. 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. Responsibility for post-exposure management (including assessments, determining risks, counseling, record keeping) should be clearly delegated to the Infection Control Practitioner, Infection Control Committee Chairman, or other authorized person.

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 likelihood of HIV or other transmissible infections.

2. The source should be informed of the incident and requested to submit to HIV antibody testing.

3. If the source has no evidence of HIV 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 HIV infection, a confirmed positive HIV antibody test, a history of high-risk behavior, or cannot be tested, then:

a. The exposed individual should be evaluated clinically for evidence of HIV infection and should be requested to submit a specimen for HIV antibody testing as soon as possible after the exposure.

b. The source and the exposed individuals should be counseled.

5. If the exposed individual's baseline test is negative for antibody, he or she should be retested for HIV antibody at 4 months following exposure.

6. Post-exposure counseling should be given within 2 to 3 weeks of exposure and should include information on the potential risk of infection and specific measures recommended by the CDC to prevent transmission.[9,13]

7. 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 epidemiologic 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 isolation precautions are uniformly effective.[13,21]

2. Physician prescriptions for exemption of pregnant HCWs are incompatible with scientific evidence and published guidelines.[13,21]

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 prescribed measures to prevent the transmission of HIV and opportunistic infections.

C. Alternative assignments or transfers of HCWs with AIDS or positive HIV antibody tests are rarely indicated based on Section VIII,B above and should be used only if a consistent, non-discriminatory policy is developed and followed.

D. Agency-specific policies for counseling and education of HCWs with AIDS or positive HIV antibody tests should be developed and should include precautions for preventing the transmission of HIV and opportunistic infections.[12,13]

E. HCWs who have exudative lesions or weeping dermatitis should not perform or assist with invasive procedures or other direct patient care activities or handle equipment used for patient care.[12]

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 Association's "Look Back" Program.[2]

These recommendations were prepared by Barbara Cohen, RN, CIC, MSN, Editor; Cece Gaffney, MT (ASCP), MEd; Earl Matthew, MD; Barbara Moody, RN, CIC; and Barbara Pearce, RN, CIC, on behalf of the Austin Area Infection Control Committee.

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MEASLES ALERT

Measles outbreaks are occurring in California, Florida, Oregon, and New Mexico; Texas will soon be added to this list. Confirmed cases have been reported sporadically throughout Texas since January 1987.

Preliminary data indicate that measles outbreaks are occurring in both Bridgeport and Center, Texas. High school students from Bridgeport and Center, including the index cases from both towns, attended a Distributive Educational Clubs of America convention in Dallas during the weekend of January 31 through February 1,1987. Students from approximately 95 schools in North Central Texas and East Texas attended this convention. Schools in the affected areas have been notified regarding the possible exposure of their students to measles during the convention.

The index measles cases in both Bridgeport and Center reported rash onset February. 15,1987. Subsequently, three cases have been reported in Center, and 20 cases have been reported in Bridgeport. Cases are occurring predominantly among high school students who were immunized with measles vaccine at about 12 months of age.

Health care providers: be alert for possible measles cases and, if possible, obtain blood specimens to identify the etiology of the rash/fever illness. Unimmunized contacts to measles cases or contacts without valid immunization histories (immunization prior to 12 months of age) should be immunized within 72 hours of exposure. Any suspected measles cases should be reported to the Immunization Division, Texas Department of Health, within 24 hours of identification by telephoning 1-800-252-9152.

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