CALIFORNIA DEPARTMENT
OF CORRECTIONS

Office of Health Care Services

EMPLOYEE GUIDELINES FOR MANAGEMENT AND PREVENTION OF AIDS

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PREFACE

The Office of Health Care Service is committed to providing employees of the California Department of Corrections with important information on how to protect themselves both on and off the job.

The management and prevention of Acquired Immune Deficiency Syndrome is an issue which is linked with much controversy, doubt and confusion. The material assembled in this handbook has been gathered from various sources and is designed to provide guidelines on situations that may warrant the need for precautions.

You will note, the Table of Contents includes a section for recording revisions. These revisions will be forwarded to you periodically, as necessary, by the Office of Health Care Services.

We are confident that by reading, adhering to and reviewing these guidelines, as necessary, you will continue to gain the knowledge required to reduce the risk of contracting AIDS.

REFERENCE:

Centers for Disease Control Guidelines

Department of Health Services, Office of AIDS

National Institute of Justice Report

American Red Cross

University of California Medical Center Guidelines

Association for Practitioners in Infection Control

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INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a disease associated with misinformation and uncertainty since it appeared in 1981.

The first AIDS case within the California Department of Corrections (CDC) was diagnosed in 1984. Since that time, the Department has been reevaluating its policies and procedures relating to the diagnosis and treatment of AIDS, housing of infected inmates, precautions against exposure and education about AIDS.

Inasmuch as many CDC employees are in regular contact with groups considered to be participating in high risk activities for this infection, accurate guidelines, information and education are essential to help alleviate some of the fear and misconception. The recommendations in these guidelines have focused on the concern for the protection of uninfected employees and inmates, as well as for inmates who are HIV-infected (i.e., inmates who have "HIV Disease," the name for the full spectrum of infection through death).

PURPOSE

To provide guidelines for:

1. Understanding the disease.
2. Precautionary measures for medical and non-medical personnel.
3. Testing, diagnosis and treatment of HIV Disease.
4. Employees who have had significant exposure to blood/body fluids.
5. Comprehensive care to infected inmates.

RESPONSIBILITIES

1. The Office of Health Care Services (OHCS) is responsible for providing and updating guidelines for the prevention of blood borne diseases.

2. Each institution is responsible for the following which is provided/directed by Office of Health Care Services:

   a) Maintain and update all AIDS information/administrative manuals.

   b) Disseminate AIDS education materials.

   Note: All AIDS education material must be approved by the Office of Health Care Services prior to use.

   c) Formalize individual AIDS education programs.

3. Employees are responsible for familiarizing themselves with the guidelines and objectives on AIDS education provided by OHCS.

DEFINITION

Acquired Immune Deficiency Syndrome (AIDS) is a disease which undermines the human body's immune system. The individual becomes susceptible to a range of "opportunistic" infections, malignancies and other diseases which would not be generally life-threatening to a person with a normally functioning immune system. AIDS can cause dementia and other disorders of the central nervous system. The virus which causes AIDS is the Human Immunodeficiency Virus (HIV).

Human Immunodeficiency Virus (HIV) is a "retrovirus" which has the ability to replicate itself in certain white blood cells, (helper T-cells and macrophages) thereby undermining that part of the body's immune system which normally combats infection and malignancies.

Initially, "AIDS" was described in three stages as Human Immunodeficiency Virus Positive (HIV Positive), AIDS Related Complex (ARC) and end-stage AIDS. The Centers for Disease Control has since changed the classification into Groups I, II, III, and IV. Group IV is further divided into subgroups A, B, C, D, and E. These groups are used for case definition and will be discussed later in these guidelines. The full range of the infection is referred to as "HIV Disease."

1. HUMAN IMMUNODEFICIENCY VIRUS POSITIVE (HIV POSITIVE).

   HIV positive means that an individual has been exposed to the HIV virus but shows no signs or symptoms of disease. The term HIV infection is not used to apply to individuals with an acquired immune deficiency for which another cause may reasonably be determined such as use of steroids and other immune suppressive therapy or certain other diseases. Persons infected with HIV are called "HIV positive", or are referred to as being "seropositive".

2. AIDS RELATED COMPLEX (ARC)

   AIDS Related Complex (ARC) is a variety of chronic symptoms and physical findings that occur in some persons who are infected with HIV but do not meet the Centers for Disease Control's definition of AIDS. Symptoms may include chronic swollen glands, recurrent fevers, unintentional weight loss, chronic diarrhea, lethargy and oral thrush. The term "ARC" is not commonly used today.

3. AIDS (End-Stage)

   The diagnosis of AIDS is based on the presence of an opportunistic disease. The two most common opportunistic diseases are pneumocystis carinii pneumonia (PCP), and Kaposi's Sarcoma (KS), a type of cancer.

   In addition, the Centers for Disease Control has added several AIDS indicator diseases that are neither infectious nor cancerous, which include AIDS dementia, HIV encephalopathy and HIV "wasting syndrome".

4. HIV DISEASE

   This is the term more commonly used to describe the full spectrum of the disease, from initial infection ("HIV Positive") through end-stage AIDS.

TRANSMISSION OF HIV

1. HIV is transmitted through exposure to contaminated blood, semen or vaginal secretions, primarily through sexual intercourse and needle sharing activities.

2. The Centers for Disease Control states that HIV is not transmitted through body fluids such as saliva or tears. There is absolutely no evidence of transmission by sneezing, coughing, breathing, hugging, handshaking, sharing eating and drinking utensils, using the same toilet facilities or any other form of nonsexual contact or activity.

HIGH RISK ACTIVITIES

There is a high concentration of the HIV virus in white blood cell producing body fluids such as blood, semen and vaginal secretions. Therefore, unsafe activities involving these body fluids, such as the following, would be considered high risk:

1. Intravenous drug use/needle sharing.

2. Vaginal and/or anal sex with female or male prostitutes and their sex partners.

3. Sexual activity with infected homosexuals, bisexuals, or heterosexuals.

4. Sexual activity with any person engaging in the above activities.

5. Exposure to contaminated blood or blood products.

SEARCHES, EVIDENCE HANDLING, ASSAULTS AND CPR

1. BODY AND CELL SEARCHES AND EVIDENCE HANDLING

   There is concern regarding searches of areas where sharp objects may be hidden from view, such as pockets and spaces beneath car seats. The following precautionary measures will help to minimize the risk of infection:

   a) Whenever possible, ask suspects to empty their own pockets, turn out waistbands and pull down socks.

   b) Whenever possible, use long-handled mirrors to search hidden areas.

   c) If it is necessary to search manually, always wear protective gloves and feel very slowly and carefully.

   d) Use puncture-proof containers to store sharp instruments and clearly marked plastic bags to store other contaminated items.

   e) Use tape, not metal staples, when packaging evidence.

   f) Use protective (disposable) gloves when there is likelihood of contact with all blood and body fluids.

   g) Use protective (disposable) gloves, disposable outer wear (i.e. water repellent jumpsuits, aprons, gowns), goggles, masks, when there is likelihood of gross contamination with blood and body fluids (i.e. suicide attempts, wrist slashing, blood splattering, etc.).

   h) Use protective (disposable) gloves when handling sanitary napkins, tampons or items containing blood or other body fluids.

   i) Wash hands for at least 15 seconds with soap and warm water after removing gloves.

2. ASSAULTS, HUMAN BITES, SCRATCHES, ABRASIONS OR SUPERFICIAL CUTS

   a) Encourage "backbleeding" by applying pressure and "milking" the wound.

   b) Wash the area for at least 15–20 seconds with soap and warm water.

   c) Cover with clean dressing.

d) Report incident to supervisor and file an incident report.

See Employee Health Section

3. CARDIOPULMONARY RESUSCITATION (CPR)

There is no evidence of transmission of HIV by saliva. However, protective masks and/or airways are available with one-way valves to prevent the patient's saliva or other fluids from entering the caregiver's mouth.

TESTING, CONSENT FOR TESTING AND COUNSELING FOR HIV SEROPOSITIVITY

1. Routine testing shall be available to all inmates upon request and upon written order of a physician. Requests for testing shall be screened by nursing personnel (RN/MTA) to determine the appropriateness of the request. Referral shall then be made to the physician who shall determine the need for testing and who shall make provision for counseling for the inmate prior to HIV testing.

2. A departmentally approved written informed consent must be obtained from each inmate prior to testing and documented counseling of the inmate regarding the testing and potential outcome must be completed prior to drawing a blood or serum sample to test for the presence of HIV antibody. Documentation shall be made by the physician in the inmate's medical file.

3. Counseling shall include, but not be limited to the following, and should be done by a certified pre and post test counselor whenever possible:

   a) Risk factors associated with HIV infection.

   b) Methods of HIV infection, transmission and individual susceptibility.

   c) The purpose and reliability of HIV antibody testing.

   d) Implications with positive test results:

      (1) There is no cure for AIDS.

      (2) An HIV seropositive person is considered to be infected and infectious for life.

      (3) Potential risk to past and future sexual contacts.

      (4) In pregnant females, the risk of maternal transmission to the fetus and the possible transmission to the neonate through breast milk.

      (5) Potential risk to persons who are involved in needle-sharing activity.

      (6) If HIV seropositive, the inmate will be screened for placement in an appropriate facility.

   e) Implications with negative test results:

      (1) Potential for false negative test results.

      (2) Potential for being in the "window phase", whereby insufficient time has elapsed from HIV exposure to the development of HIV antibodies (three weeks to six months).

      (3) Curtailment of any activity which would expose the individual to HIV (i.e., sexual contact, needle-sharing activity, etc.).

(4) Need for repeated testing at prescribed intervals (utilizing current Centers for Disease Control recommendations).

See also OCHS "Guidelines for HIV Antibody Pre- and Post-Test Counseling".

NOTIFICATION AND CONFIDENTIALITY OF HIV TEST RESULTS

1. HIV antibody tests shall be performed by local health departments or contract laboratories. Specimens shall be collected by qualified laboratory technicians employed by CDC.

2. HIV antibody results shall be given to the Chief Medical Officer (CMO) by the laboratory technologist upon receipt of the results from the reference laboratory. The CMO shall notify the appropriate attending physician of the results.

3. The inmate shall be notified of the result of the HIV test. The attending physician or another certified counselor shall provide counseling and appropriate referral for ongoing psychiatric and/or psychological services as necessary.

4. Test results shall be kept in the office of the CMO and may be kept in the inmate's health record in a "confidential" section.

5. The CMO shall make the proper arrangments for determination of the appropriate housing for the HIV-infected inmate.

6. Diagnosed AIDS is to be reported to the local public health department (HIV seropositivity is not reportable to state or local health departments).

7. Reporting and confidentiality of the inmate's health status shall be maintained and/or disclosed in accordance with California laws.

TRANSPORTING OF INMATES WITH HIV DISEASE

1. HIV-infected inmates shall be transported between units and institutions by normal transportation unless their medical condition warrants special transportation requirements. The CMO will make the necessary arrangements and notify the appropriate administrator.

2. When inmates are transported by alternative methods for medical reasons, a Medical Technical Assistant (MTA) shall accompany the inmate(s) during transport.

3. When inmates are transferred to other correctional institutions, the MTA on transport shall ensure that each inmate's health record is transported with the inmate for immediate accessibility by the medical staff at the receiving institution. All pertinent information shall be appropriately filed in the health record prior to transfer.

HOUSING

1. Identified HIV-infected inmates are screened for appropriate placement in a designated facility.

2. All inmates who require acute or long-term care are housed within the prison hospital/infirmary or transferred to local community hospitals.

3. All condemned inmates who are HIV seropositive will be maintained at San Quentin.

4. Any condemned HIV-infected inmate who becomes critically ill will be transported to a community or facility hospital as necessary.

VISITS

1. Conjugal visits are not allowed for those inmates identified with HIV Disease.

2. Regular supervised visiting privileges are permitted according to operational procedures.

EMPLOYEE HEALTH

1. Significant exposure includes:

   A) Needlesticks.

   B) Blood splattering (i.e., eyes, nose, mouth, uncovered wounds, etc.).

   C) Human bites (only if skin is broken and there is an exchange of blood from mouth to bite wound).

2. With a significant exposure, employees should:

   A) Needlesticks/human bites, etc.

      (1) Encourage "backbleeding" by applying pressure and "milking" the wound.

      (2) Wash area for at least 15–20 seconds with soap and warm water.

      (3) Cover with clean dressing.

   B) With blood splattering in eyes, rinse with luke warm or cold water.

   C) Immediately report exposure to supervisor.

   D) Go to local health department, Alternative Testing Site or personal physician for HIV test (as close to time of incident as possible). Testing is confidential.

   E) HIV and follow up testing should be done according to current Centers for Disease Control recommendations.

   F) For further information:

      (1) Call one of these toll free hotlines:

      Northern California
      415/863-AIDS
      800-For-AIDS

      Southern California
      213/876-AIDS
      800/922-AIDS

      U.S. Public Health Service
      800/342-AIDS

      (2) Talk to the medical staff at your facility or your private health care provider.

3. Current law requires that staff who have been exposed to blood or other body fluids in a manner which could transmit HIV report that incident to their supervisor and the Chief Medical Officer (Senate Bill 1913 and Proposition 96). These laws permit the employee to request the inmate(s) to undergo HIV antibody testing. See your supervisor or Chief Medical Officer for more information.

PROTECTIVE GEAR

1. Wear protective (disposable) gloves when there is likelihood of contact with all blood and body fluids.

2. Use protective (disposable) gloves, disposable outer wear (i.e., water repellent jumpsuits, aprons, gowns, goggles, masks) when there is likelihood of gross contamination with blood and body fluids (i.e., suicide attempts, wrist slashing, blood splattering).

3. Gloves should be worn when cleaning all blood/body fluid spills.

BLOOD/BODY FLUID SPILLS

1. All blood/body fluid spills (i.e., blood, feces, vomitus, urine) shall be cleaned with a 1:10 dilution of bleach and water or any Environmental Protection Agency (EPA) approved disinfectant. (Large spills should be flooded with 1:10 dilution of bleach and water or any EPA approved disinfectant before cleaning).

2. Gloves shall be worn during the cleaning process.

3. Disposable cloths or paper towels shall be used to clean up spills.

4. The disposable cloths or paper towels shall be placed in a red bag marked "infectious" and disposed of as infectious waste. (See Infectious Waste Section)

5. Wash hands for at least 15–20 seconds with soap and warm water after removing gloves.

CONTAMINATED EQUIPMENT AND SUPPLIES

1. Wear disposable gloves and use a disinfectant solution of household bleach and water diluted 1:10 or any EPA approved disinfectant to clean equipment/supplies.

2. Handcuffs, leg irons, or belly chains contaminated with blood, feces or semen should be cleaned with soap and warm water and then disinfected with a solution of household bleach and water diluted 1:10 (or any EPA approved disinfectant).

3. Flashlights, crime scene kits, and other equipment that becomes soiled with contaminated material should be cleaned with soap and warm water and wiped with a solution of household bleach and water diluted 1:10 (or any EPA approved disinfectant).

4. All disposable items contaminated with blood/body fluids should be placed in a red bag marked "infectious" and discarded as infectious waste. (See Infectious Waste Section)

5. All contaminated linen/clothing not used for evidence should be placed in a water soluble bag, then placed in a yellow bag marked "contaminated" and sent to the laundry. (See Contaminated Linen/Clothing Section)

HOUSEKEEPING AND DISINFECTION

Environmental surfaces such as walls, floors and other surfaces are not associated with transmission of infection to patients (inmates) or personnel. Therefore, extraordinary attempts to disinfect or sterilize these environmental surfaces are not necessary.

1. Routine cleaning of cells should be done with an EPA approved disinfectant.

2. Disinfectant "fogging" is not recommended. Cleaning of walls is recommended anytime they are visibly soiled.

3. Horizontal surfaces (i.e., bedside tables and hard surfaced flooring) in patient care areas are usually cleaned on a regular basis, when soiling or spills occur, and when a patient is discharged.

4. Gloves should be worn when cleaning all cells.

5. Masks are not required unless the patient is in the room and has an airborne disease (i.e., tuberculosis, meningococcal meningitis).

6. Wash hands for at least 15-20 seconds with soap and warm water after removing gloves.

CONTAMINATED LINEN/CLOTHING

1. Protective (disposable) gloves shall be worn when handling all contaminated linen/clothing.

2. All linen/clothing shall be considered contaminated if it contains visible evidence of blood/body fluids (i.e., blood, feces, semen, vaginal secretions).

3. All contaminated linen/clothing shall be double bagged utilizing a water soluble inner bag and a yellow plastic outer bag marked "contaminated" and sent to the laundry. Clothing needed for evidence should first be air-dried and then placed in a paper bag. DO NOT use staples to seal the bag.

4. Wash hands for at least 15-20 seconds with soap and warm water after removing gloves.

INFECTIOUS WASTE

1. Protective (disposable) gloves shall be worn when handling all infectious waste.

2. Waste shall be considered infectious if it contains large amounts of blood, semen or vaginal secretions (i.e., sanitary napkins, tampons, bandaids, and wound dressings). This also applies to contaminated needles/syringes/scapels, human tissue, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, microbiology specimens, laboratory waste, pathology waste, and blood specimens or blood products.

3. Bulk blood, suctioned fluids, excretions and secretions may be carefully poured down infectious waste designated drains connected to a sanitary sewer.

4. All infectious waste should be incinerated, autoclaved or contracted to an outside company certified to dispose of infectious waste.

5. Infectious waste shall be double red bagged and discarded according to institutional policy.

6. Wash hands for at least 15-20 seconds with soap and warm water after removing gloves.

CASE DEFINITION

Classification System of AIDS

1. AIDS is classified into four mutually exclusive groups, I-IV. Classification in a particular group does not have prognostic significance and does not designate severity of illness. Classification is hierarchical; persons classified in a defined group shall not be reclassified in a preceding group if clinical findings resolve. Clinical improvement does not resolve the severity of the underlying disease.

2. The term AIDS shall refer to conditions meeting the revised surveillance case definition as defined by the Centers for Disease Control.

3. Classification System for HIV Infection

   Group I. Acute Infection. Defined as a mononucleosis-like syndrome with or without aseptic meningitis, associated with seroconversion for HIV antibody. Antibody seroconversion is required as evidence of initial infection; current viral isolation procedures are not adequately sensitive to be reliable for demonstrating the onset of infection.

   Group II. Asymptomatic HIV Infection. Defined as the absence of signs or symptoms of HIV infection. To be classified in Group II, patients must have had no previous signs or symptoms that would have led to classification in Groups III or IV. Patients whose clinical findings caused them to be classified in Groups III or IV should not be reclassified in Group II if those clinical findings resolve.

   Patients in this group may be subclassified on the basis of a laboratory evaluation. Laboratory studies commonly indicated for patients with HIV infection include, but are not limited to, a complete blood count (including differential white blood cell count) and a platelet count. Immunologic tests, especially T-lymphocyte helper and suppressor cell counts, are also an important part of the overall evaluation. Patients whose test results are within normal limits, as well as those for whom a laboratory evaluation has not yet been completed, should be differentiated from patients whose test results are consistent with defects associated with HIV infection (e.g., lymphopenia, thrombocytopenia, or decreased number of helper T-lymphocytes).

   Group III. Persistent Generalized Lymphadenopathy (PGL). Defined as palpable lymphadenopathy (lymph node enlargement of 1 cm or greater) at two or more extrainguinal sites persisting for more than three months in the absence of a concurrent illness or condition other than HIV infection to explain the findings. Patients in this group may also be subclassified on the basis of a laboratory evaluation, as is done for asymptomatic patients in Group II. Patients with PGL whose clinical findings caused them to be classified in Group III should not be reclassified in Group II if those other clinical findings resolve.

   Group IV. Other HIV Disease. The clinical manifestations of patients in this group may be designated by assignment to one or more subgroups (A through E) listed below. Within Group IV, subgroup classification is independent of the presence or absence of lymphodenopathy. Each subgroup may include patients who are minimally symptomatic, as well as patients who are severely ill. Increased specificity for manifestations of HIV infection, if needed for clinical or research purposes or for disability determinations, may be achieved by creating additional divisions within each subgroup.

   Subgroup A. Constitutional disease. Defined as one or more of the following: fever persisting more than one month, involuntary weight loss of greater than 10 percent of baseline, or diarrhea persisting more than one month; and the absence of a concurrent illness or condition other than HIV infection to explain the findings.

   Subgroup B. Neurologic disease. Defined as one or more of the following: dementia, myelopathy, or peripheral neuropathy; and the absence of a concurrent illness or condition other than HIV infection to explain the findings.

Subgroup C. Secondary infectious diseases. Defined as diagnosis of an infectious disease associated with HIV infection or at least moderately indicative of a defect in cell-mediated immunity. Patients in this subgroup are further divided into two categories.

Category C-1. Includes patients with symptomatic or invasive disease due to 1 of 12 specific secondary infectious diseases listed in the surveillance definition (See 5, below.) of AIDS: pneumocystis carinii pneumonia, chronic cryptosporidiosis, toxoplasmosis, extra intestinal strongyloidiasis, isosporiasis, candidiasis (esophageal, bronchial, or pulmonary), cryptococcosis, histoplasmosis, mycobacterial infection with Mycobacterium avium complex or M. kansasii, cytomegalovirus infection, chronic mucocutaneous or disseminated herpes simplex virus infection, or progressive multifocal leukoencephalopathy.

Category C-2. Includes patients with symptomatic or invasive disease due to one of six specified secondary infectious diseases: oral hairy leukoplakia, multidermatomal herpes zoster, recurrent salmonella bacteremia, nocardiosis, tuberculous, or oral candidiasis (thrush).

Subgroup D. Secondary cancers. Defined as the diagnosis of one or more cancers known to be associated with HIV infections as listed in the surveillance definition of AIDS and at least moderately indicative of a defect in cell-mediated immunity: Kaposi's sarcoma, non-Hodgkin's lymphoma (small, noncleaved lymphoma or immunoblastic sarcoma), or primary lymphoma of the brain.

Category C-I and Subgroup D include those patients with one or more of the infectious diseases or specified cancers fulfilling the definition of AIDS as used by the Centers for Disease Control for national reporting.

Subgroup E. Other conditions in HIV infection. Defined as the presence of other clinical findings or diseases, not classified above, that may be attributed to HIV infection or may be indicative of a defect in cell-mediated immunity. Included are patients with chronic lymphoid interstitial pneumonitis. Also included are those patients whose signs or symptoms could be attributed either to HIV infection or to another coexisting disease not classified elsewhere, and patients with other clinical illnesses, the course or management of which may be complicated or altered by HIV infection. Examples include patients with constitutional symptoms not meeting the criteria for subgroup IV-A, patients with infectious diseases not listed in subgroup IV-C, and patients with neoplasms not listed in subgroup IV-D.

4. 1987 Centers for Disease Control Case Definition

I. Without Laboratory Evidence of Infection

If laboratory tests for HIV were not performed or gave inconclusive results and the patient has no other cause of immunodeficiency as listed in Section I.A. below, then any disease listed in Section IB. indicates AIDS if it was diagnosed by a definitive method.

A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection:

1. High-dose or long-term systemic corticosteriod therapy or other immunosuppressive or cytotoxic therapy < 3 months before onset of the indicator disease.

2. Any of the following diseases diagnosed < 3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy.

3. A genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia.

B. Indicator diseases diagnosed definitively:

1. Candidiasis of the esophagus, trachea, bronchi, or lungs.

2. Cryptococcosis, extrapulmonary.

3. Cryptosporidiosis with diarrhea persisting > 1 month.

4. Cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient > 1 month of age.

5. Herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than one month; or bronchitis, pneumonitis, or esphagitis for any duration affecting a patient > 1 month of age.

6. Kaposi's sarcoma affecting a patient < 60 years of age.

7. Lymphoma of the brain (primary) affecting a patient < 60 years of age.

8. Lymphoid interstitial pneumonia or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child younger than 13 years of age.

9. Mycobacterium avium complex or M. kansasii disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes).

10. Pneumocystis carinii pneumonia.

11. Progressive multifocal leukoencephalopathy.

12. Toxoplasmosis of the brain affecting a patient > 1 month of age.

II. With Laboratory Evidence of HIV Infection

Regardless of the presence of other causes of immunodeficiency (Section I.A., above), in the presence of laboratory evidence of HIV infection, any disease listed above (Section I.B.) or below (Sections II.A. or II.B.) indicate a diagnosis of AIDS.

A. Indicator diseases diagnosed definitively:

1. Bacterial infections, multiple or recurrent (any combination of at least two within a two-year period), of the following types affecting a child < 13 years of age: septicemia, pneumonia, meningitis, bone or joint infection, or abscesses of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) caused by haemophilus, streptococcus (including pneumococcus), or other pyogenic bacteria.

2. Coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes).

3. HIV encephalopathy (also called "HIV dementia", "AIDS dementia", or "subacute encephalitis due to HIV").

4. Histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes).

5. Isosporiasis with diarrhea persisting > 1 month.

6. Kaposi's sarcoma at any age.

7. Lymphoma of the brain (primary) at any age.

8. Other non-Hodgkin's lymphoma of B-cell or unknown immunologic phenotype and the following histologic types:

   a. Small noncleaved lymphoma (either Burkitt or non-Burkitt type).

   b. Immunoblastic sarcoma (equivalent to any of the following, although not necessarily all in combination: immunoblastic lymphoma, large-cell lymphoma, diffuse histiocytic lymphoma, diffuse undifferentiated lymphoma, or high-grade lymphoma).

Note: Lymphomas are not included here if they are of T-cell immunologic phenotype or their histologic type is not described, or is described as "lymphocytic", "lymphoblastic", "small cleaved", "plasmacytoid lymphocytic."

9. Any mycobacterial disease caused by mycobacteria other than M. tuberculosis, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes).

10. Disease caused by M. tuberculosis, extrapulmonary (involving at least one site outside of the lungs, regardless of whether there is concurrent pulmonary involvement).

11. Salmonella (nontyphoid) septicemia, recurrent.

12. HIV wasting syndrome (emaciation, "slim disease").

B. Indicator diseases diagnosed presumptively:

NOTE: Given the seriousness of diseases indicative of AIDS, it is generally important to diagnosis them definitively, especially when therapy that would be used may have serious side effects or when definitive diagnosis is needed for eligibility for antiretroviral therapy. Nonetheless, in some situations, a patient's condition will not permit performance of definitive tests. In other situations, accepted clinical practice may be to diagnosis presumptively based on the presence of characteristic clinical and laboratory abnormalities.

1. Candidiasis of the esophagus.

2. Cytomegalovirus retinitis with loss of vision.

3. Kaposi's sarcoma.

4. Lymphoid interstitial pneumonia or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child < 13 years of age.

5. Mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least one site other than or in addition to lungs, skin, or cervical or hilar lymph nodes).

6. Pneumocystis carinii pneumonia.

7. Toxoplasmosis of the brain affecting a patient > 1 month of age.

III. With Laboratory Evidence Against HIV Infection

With laboratory test results negative for HIV infection, a diagnosis of AIDS for surveillance purposes is ruled out unless:

A. All other causes of immunodeficiency listed above in Section I.A. are excluded; AND

B. The patient has either

1. Pneumocystis carinii pneumonia diagnosed by a definitive method; OR

2. a. any of the other diseases indicative of AIDS listed above in Section I.B. diagnosed by a definitive method; AND

   b. a T-helper/inducer (CD4) lymphocyte count < 400/cubic mm.

PRECAUTIONS TO PREVENT TRANSMISSION OF HIV

Universal Precautions

Since medical history and examination cannot reliably identify all persons infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all persons. This approach, "universal precautions" should be used in the care of all persons, especially those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown.

1. All health care workers should routinely use appropriate barrier precautions (i.e., disposable gloves, aprons, gowns) to prevent skin and mucous-membrane exposure when contact is probable with blood or other body fluid, mucous, mucous membranes, or non-intact skin of all patients; for handling items or surfaces soiled with blood or body fluids; and for performing venipuncture and other vascular access procedures.

2. Gloves should be changed after contact with each patient.

3. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes (i.e., bronchoscopy, dentistry, IV insertion).

4. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

5. Hands and other skin surfaces should be washed immediately for at least 15–20 seconds with soap and warm water if contaminated with blood or other body fluids. Hands should also be washed immediately after gloves are removed.

6. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces and/or masks equipped with one-way valves should be available. (Resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.)

7. Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient care equipment until the condition resolves.

8. Pregnant health care workers are not known to be at greater risk of contracting HIV infection than health care workers who are not pregnant; however, if a health care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

9. Implementation of universal blood and body-fluid precautions for all patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended for patients with known or suspected infection with blood-borne pathogens. Respiratory (AFB) Isolation should be used as necessary if associated conditions such as tuberculosis or meningococcal meningitis are diagnosed or suspected. Isolation precautions (i.e., enteric) should be used for infectious diarrhea or associated conditions.

NEEDLES/SYRINGES/SHARPS

All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures.

To prevent needlestick injuries:

1. Except in isolated cases in dentistry, needles shall not be recapped, purposely bent or broken by hand, removed from disposable syringes or otherwise manipulated by hand.

2. After use, disposable syringes and needles, scalpel blades, and other sharp items shall be placed in puncture-resistant containers for disposal.

3. The puncture-resistant containers shall be located as close as practical to the use area.

4. Large bore reusable needles shall be placed in a puncture-resistant container for transport to the reprocessing area.

5. When puncture resistant containers are three-fourths full, they shall be sealed and disposed of as infectious waste. (See Infectious Waste Section)

PRECAUTIONS FOR LABORATORIES

Blood and other body fluids from all patients should be considered infectious. To supplement the universal blood and body-fluid precautions, the following precautions are recommended for health care workers in clinical laboratories.

1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.

2. All persons processing blood and body-fluid specimens (i.e., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.

3. For routine procedures such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.

4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.

5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed. (See Universal Precautions Section, Needles/Syringes/Sharps Section)

6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed. (See Blood/Body Fluid Spills Section)

7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infectious waste.

8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being stored, repaired in the laboratory or transported to the manufacturer. (See Contaminated Equipment and Supplies Section)

9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Implementation of universal blood and body fluid precautions for all patients eliminates the need for warning labels on specimens since blood and other body fluids from all patients should be considered infectious.

PRECAUTIONS FOR DENTISTRY

Blood, saliva, and gingival fluids from all dental patients should be considered infectious. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuations, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.

2. Handpieces should be sterlized after use with each patient since blood, saliva, or gingival fluids of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (i.e., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.

4. Dental equipment and surfaces that are difficult to disinfect (i.e., light handles or X-ray unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

PRECAUTIONS FOR DIALYSIS

Patients with end-stage renal disease who are undergoing maintenance dialysis and who have HIV infection can be dialyzed in hospital-based or free-standing dialysis units using conventional infection-control precautions. Universal blood and body-fluid precautions should be used when dialyzing all patients.

1. Disinfecting the dialysis fluid pathways of the hemodialysis machine is targeted to control bacterial contamination and generally consists of using 500–750 parts per million (ppm) of sodium hypochlorite (household bleach) for 30–40 minutes or 1.5%–2.0% formaldehyde overnight.

2. Several chemical germicides formlated to disinfect dialysis machines are commercially available. None of these protocols or procedures need to be changed for dialyzing patients infected with HIV.

3. Patients infected with HIV can be dialyzed by either hemodialysis or peritoneal dialysis and do not need to be isolated from other patients.

PRECAUTIONS FOR INVASIVE PROCEDURES

An invasive procedure is defined as surgical entry into tissues, cavities, or organs or repairs of major traumatic injuries:

A) in an operating room or delivery room, emergency department or outpatient setting; or

B) a vaginal delivery or other invasive obstetrical procedure during which bleeding may occur; or

C) the manipulation, cutting or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

AT A MINIMUM:

1. All health care workers who participate in invasive procedures must routinely use appropriate barriers (disposable gloves, gown, aprons) to prevent skin and mucous membrane contact with blood and other body fluids of all patients.

2. Gloves and surgical masks must be worn for all invasive procedures.

3. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips.

4. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids.

5. All health care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.

6. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field. (See Employee Health Section).

STERILIZATION AND DISINFECTION

Standard sterilization and disinfection procedures for patient-care equipment currently recommended for use in a variety of health care settings including hospitals, medical and dental clinics, hemodialysis units, and emergency care facilities, are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body fluids from persons infected with blood-borne pathogens including HIV.

1. Instruments or devices that enter sterile tissue or the vascular system of any patient or through which blood flows should be sterilized before reuse.

2. Devices or items that contact intact mucous membranes should be sterilized or receive high-level disinfection.

3. Chemical germicides that are registered with the U.S. Environmental Protection Agency (EPA) as "sterilants" may be used either for sterilization or for high-level disinfection depending on contact time.

EDUCATION

1. All new employees should receive AIDS information during "New Employee Orientation" to assist them in understanding AIDS, how HIV is transmitted, what precautions should be taken to help stem the transmission of the virus, and how to protect themselves from becoming infected.

2. All facilities shall have AIDS educational classes available through In-Service Training.

3. Employees are provided with printed material related to AIDS at the time of hire, upon request, and as new material becomes available.

4. The Office of Health Care Services reviews and disseminates all AIDS education materials which include written material, videos, posters and curriculum prior to institutional utilization.

NOTE: All AIDS material not provided by the Office of Health Care Services must be reviewed and approved by the Office prior to use.