



Western Health
and Social Care Trust

**POLICY ON HIV AND AIDS:
PROTECTION AGAINST BLOOD BORNE VIRUSES IN THE
WORKPLACE**

December 2015

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1.0 INTRODUCTION

This policy gives guidance to healthcare staff on the infection prevention and control management of a patient confirmed with HIV/ AIDS.

1.1 Background

Acquired Immune Deficiency Syndrome (AIDS) was first diagnosed in the United States of America in 1981.

Research has shown that there are a number of viruses responsible for the disease, which is now known as Human Immunodeficiency Virus or HIV.

Human Immunodeficiency Virus type 1 (HIV1) is responsible for the majority of HIV infections and cases of AIDS in the world.

A second virus, HIV2 has been found mainly in West Africa, Sub-Saharan Africa, Europe, India and the United States of America.

The structure, genetic organisation, epidemiology and clinical effects of these viruses are very similar, although there is some evidence that progression of disease in HIV2 infection is slower.

These viruses attack and deplete the human immune system and render the individual particularly susceptible to opportunistic infections and to some types of malignant tumours.

The main targets of HIV are certain types of white blood cells: Helper T Lymphocytes. These are crucial to immune function since they stimulate other immune cells. As the infection advances the Helper T Lymphocyte count drops and the immune system is progressively disabled until the body is left defenceless against infection and the development of certain types of tumours.

Once the HIV has attached to receptors in the human body it becomes incorporated into the host cells' genetic system. In this integrated form, the virus can remain dormant for several years. However, once infected it would appear the cells remain infected permanently.

The opportunistic infections include bacterial, viral, protozoal and fungal infections. The most common tumours are Non-Hodgkin's Lymphoma, Kaposi Sarcoma, and Squamous Cell Carcinoma.

2.0 SCOPE OF THE POLICY

This policy gives advice to healthcare staff on the infection prevention and control management of a patient confirmed with HIV/ AIDS to ensure the patient receives



safe and effective care and prevent avoidable exposure to blood or bodily fluids. It includes details of the procedures, policies and guidelines that need to be followed by all clinical staff in Western Health and Social Services Trust (WHST) when caring for a patient with a confirmed diagnosis of HIV or AIDS

3.0 ROLES AND RESPONSIBILITIES

3.1 Trust Board and Chief Executive

Have responsibility to ensure the necessary management framework is in place to protect patients and the health and safety of staff and provide a safe working environment.

3.2 Senior Managers

Should ensure that staff has access to this policy.

3.3 Ward Managers

Should ensure that:

- When necessary staff have read and understood the policy and are confident nursing a patient with HIV/ AIDS.
- Staff have access to appropriate Personal Protective Equipment (PPE) and are using this appropriately.
- An accurate record is maintained of patient placement within the ward at all times to facilitate accurate retrospective information gathering if required.
- Ensure staff attend Induction/ Mandatory Infection Prevention and Control (IPC) Training as required.

3.4 All Healthcare Employees within the WHST

- Must be familiar with this policy.
- Must apply Standard Precautions for the care of all patients.
- Must attend Induction/ Mandatory IPC Training.

3.5 The Infection Prevention and Control Team (IPCT)

Provide advice when required on assessing the need for isolation of patients and to staff on appropriate transmission based precautions.

3.6 The Consultant Microbiologist

Advise on treatment and IPC issues for individual patients.

3.7 The Occupational Health (OH) Department

- Provide care for staff from 9am-5pm who have been exposed to blood or bodily fluids following a sharps injury at work.
- Will arrange to have the recipient's (healthcare worker who has sustained the exposure to blood or bodily fluids) blood sent for virus triple testing.



- OH will follow up with the recipient when the results of the triple virology test are available.
- A confidential reporting and follow up system is available through OH Department for healthcare workers who feel they may have been exposed to HIV or other blood borne viruses in their personal lives.

3.8 The Emergency Department

- Provide care for staff from 5pm-9am who have been exposed to blood or bodily fluids following a sharps injury at work.
- Refer staff to the OH Department following emergency treatment.

4.0 KEY PRINCIPLES

4.1 Transmission of HIV and AIDS

Available evidence indicates that by far the most important vehicles of infection are blood, semen and genital tract secretions. Thus, worldwide, most infections have been transmitted sexually or by blood (either by transfusion or by use of contaminated needles and syringes).

Infection of babies from infected mothers has been attributed to trans-placental infection, exposure during delivery (risk reduced by planned elective caesarean section) and via breast feeding.

The body fluids of an infected individual, that may be a source of infection to others in the healthcare setting, are:

- Blood
- Cerebrospinal fluid
- Breast milk
- Amniotic fluid
- Vaginal secretions
- Pleural fluid
- Peritoneal fluid
- Pericardial fluid
- Synovial fluid
- Semen
- All unfixed tissues, organs and body parts
- Any other body fluid containing blood

Urine, faeces, saliva, sputum, tears, sweat and vomitus present a minimal risk of blood borne viruses unless contaminated with blood although they may be hazardous for other reasons. Patients who are menstruating pose minimal risk as this is controlled bleeding.

4.2 Routes of Transmission of HIV and AIDS

Blood borne viruses, including HIV, are transmitted by entry of blood or other body fluids containing the virus into the body of another person. This may occur:

- during sexual intercourse
- in sharing injecting equipment
- through skin puncture by blood-contaminated sharp objects, such as needles, instruments or glass
- during childbirth (i.e. the mother infects the child either before or during birth or through breast feeding)
- during blood transfusion.

(Blood transfusion in the United Kingdom carries only a remote risk of infection as all blood donations are screened for blood borne viruses, including HIV).

Less common means of transmission are:

- contamination of open wounds and skin lesions, such as eczema
- splashing the mucous membranes of the eye, nose or mouth
- human bite where blood is drawn.

There is good evidence to date that HIV and other blood borne viruses are not transmitted by everyday social contact, such as shaking hands with an infected individual, or in sharing utensils or by coughs and sneezes.

4.3 The Spectrum of Infection

HIV infection is associated with a spectrum of clinical states or stages:

4.3.1 Acute Infection

Most infected individuals develop antibodies within three months and during the seroconversion period there may be a self-limiting illness resembling glandular fever (infectious mononucleosis).

4.3.2 Asymptomatic State

HIV can have a long and variable incubation period before AIDS develops. However, the patient remains HIV antibody positive throughout this period. It would appear that infectivity increases in the later stages of the disease when HIV related illness has developed.

4.3.3 Symptomatic Stages

Persistent enlargement of lymph glands (Persistent Generalised Lymphadenopathy - PGL) occurs in some otherwise well people with HIV infection.

Some patients may experience persistent constitutional symptoms such as prolonged fever, significant weight loss and protracted diarrhoea. Individuals with these symptoms are sometimes said to have AIDS Related Complex or Condition (ARC).



AIDS is the final stage in the spectrum of the HIV infection. The diagnosis of AIDS is based on the presence of particular infections, malignancies or neurological conditions.

Not all HIV infected individuals will progress through each of the symptomatic stages as above. There has been improvements in relation to screening and treatment, thus resulting in prolonged survival for patients.

4.4 Protection Against HIV in the Healthcare Setting

Standard precautions should be employed with all patients irrespective of their diagnosis.

ALL BLOOD, BODY FLUIDS, SECRETION AND EXCRETIONS OF ALL PATIENTS SHOULD BE TREATED AS POTENTIALLY INFECTIOUS.

4.5 Admission of a Known or Suspected Case

The inside cover of the patient's medical notes should be labelled with a Hazard Group 3 sticker. An alert can be placed on Patient Centre and also on the Theatre Management System.

A patient who is known/ suspected to be HIV positive can be admitted to and cared for in an open ward/ bay. Isolation is required if there is a risk of bleeding with significant environmental contamination. Staff should adhere to standard precautions at all times.

4.5.1 Case Reported After Admission

A patient who has been diagnosed after admission does not require to be isolated unless there is a risk of bleeding with significant environmental contamination. Staff should adhere to standard precautions at all times.

4.6 Informing the Patient of a Positive Result

Pre-test discussion must take place to gain informed consent for HIV testing and this should be documented in the patient case record. The clinician responsible for the care of the patient should inform the patient of positive test results in person, in a confidential environment, and in a clear and direct manner. A clear pathway for onward referral must be established.

Patients should be told not to donate blood, semen or organs and given advice on prevention of other routes of transmission. Advice on prevention of sexual transmission should be discussed.

The patient should be advised to share their diagnosis with their dentist and other healthcare professionals following discharge from hospital.

4.7 Isolation

Patients who require isolation have equal rights to treatment without prejudice because they have a diagnosis of HIV/ AIDS.

Staff who care for the patient must explain the reason for additional transmission based precautions.

Excretion/ Secretion/ Blood Isolation is required if the patient is actively bleeding or has diarrhoea which cannot be contained.

Protective Isolation is required if the patient's CD4+ count is less than 200. Refer to Isolation Guidelines for further details.

If the patient requires isolation due to the risk of bleeding or has diarrhoea the following precautions are required:

- Patients should not leave the ward to attend other departments without informing the receiving ward/ department.
- Contact isolation sign must be placed on the door of the isolation room.
- The door of the isolation room should be kept closed at all times.
- PPE must be worn (apron and gloves) if it is anticipated that there may be contact with blood or body fluids. A fluid shield mask/ goggles must be worn if there is a risk of spraying or splashing of blood. PPE must be removed and hands washed with soap and water before leaving the isolation room.
- Sharps must be used and handled appropriately in accordance with the WHSCT's [Guidelines for the Safe Handling and Disposal of Sharps](#).
- Sharps/ needlestick injuries must be dealt with in accordance with the WHSCT's [Guidelines for the Safe Handling and Disposal of Sharps](#).

4.8 Specimens to the Laboratory

All blood and body fluid specimens must be labelled and transported as Hazard Group 3. The Lab must be informed prior to dispatch of the first of a set of samples. Do not use the vacuum transfer system.

4.9 Disposal of Contaminated Waste

Contaminated waste should be disposed of in clinical waste bag/ container in accordance with the WHSCT's [Waste Manual](#).

4.10 Decontamination and Cleaning

Spillages of blood must be cleaned **immediately** using Actichlor Plus 10,000 p.p.m./ Difficil-S. in accordance with WHSCT's Disinfection and Decontamination Policy. DO NOT bleep the domestic supervisor and allow the spill to remain.

After discharge of the patient the room should have a terminal cleaned using Actichlor Plus (1,000 p.p.m.)/ Difficil-S.

For decontamination of pieces of equipment refer to the WHCST's Disinfection and Decontamination Policy.

4.11 In-Hospital Transfer

4.11.1 Ward Transfers

Transfer to other wards within the hospital should be kept to a minimum. If transfers need to take place the receiving ward must be made aware of the patient's status. Confidentiality is essential.

4.11.2 Transfers to Other Departments, e.g. X-Ray

Staff in the receiving department do not need to know about the patient's HIV status. In cases where transmission is a risk because of likely exposure to blood and or body fluids staff must be informed the patient has a Hazard Group 3 pathogen.

4.12 Discharge of a Known or Suspected HIV Patient

4.12.1 To Another Hospital/ Healthcare Setting

It is the responsibility of the transferring ward/ department to inform the receiving hospital/ ward of the current status of the patient.

4.12.2 Transport

Those involved in patient transfers do not need to know about the patient's HIV status. In cases where transmission is a risk because of likely exposure to blood and/ or body fluids, staff must be informed the patient has a 'Hazard Group 3 pathogen.

PPE does not need to be worn unless there is a risk of blood/ body fluid contamination.

4.12.3 Discharge of a Patient to Primary Care

The GP should be informed of the patient's HIV status on discharge. Confidentiality is as important for HIV patients as it is for all other patients. Information regarding the patient's HIV status should only be shared with healthcare professionals who are involved in invasive procedures.

Employers must complete a risk assessment to ensure a safe system of working is provided for their employees to reduce the risk of exposure to blood and/ or body fluids. Employees must attend IPC training.

4.13 Confidentiality, Privacy and Dignity

People who are HIV positive and require inpatient admission should experience high standards of confidentiality, privacy and dignity in line with the law, GMC guidance and national standards. People with HIV infection have the right to expect that their care is provided in a safe environment and that everyone is treated with dignity and respect regardless of race, sex or sexuality.

<http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf>

4.14 Deceased Patients/ Management of an Infected Body

Standard infection control precautions should be used in the care of all deceased patients, as not all cases of infection will have been identified

before death (see section 4.15). It is important to risk assess each case as additional precautions will be required for some infectious diseases, confirmed or suspected.

If a person dies with a known or suspected infection it is a legal requirement that all persons who may be involved in handling the body are informed of the potential risk of infection. The mortuary staff and funeral directors should be informed of the risk, but not the diagnosis, as this remains confidential even after death.

The portering staff must be informed they are transporting an infected body. They must put on gloves and after removal to the mortuary is complete, gloves must be removed and disposed of in clinical waste and hands washed using the 7-step technique.

The bereaved relatives must be advised by the certifying doctor on precautions to take to avoid the risk of infection.

HIV is a Hazard Group 3 pathogen; embalming is not permitted. The cadaver should be placed in a body bag ensuring that the zip closure is at the head. A body bag is adjunct to safe practice to avoid leakage of body fluids which are potentially infectious. Once placed in a bag the body must not be removed. The face may be revealed once the body has been placed in a coffin.

Please refer to the Health and Safety Executive (2005) *Controlling the risks of infection at work from human remains: A guide for those involved in funeral services (including embalmers) and those involved in exhumation*. Available for download at: <http://www.hse.gov.uk/pubns/web01.pdf>

4.15 Action to be Taken Following a Sharps Injury with HIV Contaminated Equipment

- Wash the affected area with running water/ saline; do not scrub or cause further tissue damage whilst carrying out first aid.
- **Immediately** contact Occupational Health (Monday-Friday, 9am-5pm)
 - Northern Sector – (028) 71345171 Ext 214420/ 214421/ 214422
 - Southern Sector – (028) 66382000 Ext 253613/ 253607/ 253603 or Emergency Department (out of hours)
 - Altnagelvin – (028) 71345171 Ext 213629/ 213631
 - SWAH – (028) 66382000 Ext 257603/ 257604
- If treatment is necessary it should ideally be commenced within one hour (refer to Policy on Exposure to Body Fluids and HIV Post Exposure Prophylaxis).
- Report the incident immediately to your line manager or person in charge who will arrange for a risk assessment and source testing to be carried out.
- Complete an adverse incident report as soon as possible after receiving treatment.

4.16 **Standard Precautions to Prevent Occupational Transmission of Blood Borne Viruses**

To minimise the risk of transmission of blood borne viruses from infected patients to healthcare workers and from infected healthcare workers to patients:

1. Apply hand hygiene before and after contact using 7-step technique and as per the 5 moments for hand hygiene with each patient and before putting on and after removing gloves. Change PPE between patients.
2. For all clinical procedures cover existing wounds, skin lesions and all breaks in exposed skin with waterproof dressings, or with gloves if your hands are affected.
3. Healthcare workers with chronic skin disease, such as eczema, should avoid invasive procedures which involve sharp instruments or needles when their skin lesions are active or if there are breaks in the skin surface. A non-intact skin surface provides a potential route for blood borne virus transmission and blood-skin contact is common through glove puncture, which may go unnoticed. Clinical staff with extensive skin rashes must avoid patient contact until the rash is resolved. Staff whose rashes persist beyond two weeks must be referred to Occupational Health for assessment.
4. Use protective clothing as appropriate, including protection of mucous membrane of eyes, mouth and nose from blood and body fluid splashes. Avoid wearing open footwear in situations where blood may be spilt, or where sharp instruments or needles are handled as per the Trust [Dress Code Policy](#).
5. Avoid puncture wounds and cover all cuts and abrasions with waterproof dressings if present. Use safety needles and needle free access devices.
6. Avoid sharps usage wherever possible and consider the use of alternative instruments, cutting diathermy and laser.
7. Where sharps usage is essential, exercise particular care in handling and disposal, following approved procedures and using approved sharps disposal containers.
8. Clear up spillages of blood and other body fluids promptly and disinfect surfaces as per Trust Disinfection and Decontamination Policy.
9. Follow approved procedures for cleaning, disinfection and sterilisation of instruments and equipment.
10. Follow approved procedures for safe disposal of contaminated waste (Trust [Waste Manual](#)).



4.17 HIV Positive Healthcare Workers

Exposure prone procedures (EPP) are those where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharps instruments, needle tips, inside a body cavity, wound or confined space where the hands or finger tips may not be visible at all times.

Practising healthcare workers who perform EPP are under professional duty to seek medical advice, on the need to be tested, as soon as they are aware they may have been exposed to HIV infection occupationally or otherwise. If found to be positive, they must obtain and follow appropriate clinical and Occupational Health advice.

The circumstances in which HIV could be transmitted from a healthcare worker to a patient are limited to EPP in which injury to the healthcare worker could result in the worker's blood contaminating the patient's open tissues ("bleed-back").

4.18 Reporting HIV Exposure

A voluntary confidential reporting system for significant occupational exposure incidents involving HIV exists in the United Kingdom.

A confidential reporting and follow up system is also in place through the Occupational Health Department for healthcare workers who feel they may have been exposed to HIV or other blood borne viruses in their personal life.

The telephone numbers for the Occupational Health Consultants are:

Altnagelvin Hospital – (028) 7134 5171 Ext 214420/ 214421/ 214422

South West Acute Hospital – (028) 66382000 Ext 253613/ 253607/ 253603

5.0 IMPLEMENTATION

5.1 Dissemination

This is an updated policy and continues to be relevant for application by healthcare staff working with patients, including OH staff.

This policy shall be available for staff to access on the Trust intranet.

Staff shall be alerted via Trust Communication in relation to the availability of the policy on the Trust intranet.

5.2 Exceptions

There are no exceptions.



6.0 MONITORING

Compliance with this policy shall be monitored by the Infection Prevention and Control Team on a case by case basis.

7.0 REFERENCES

Guidance for Clinical Health Care Workers: Protection Against Infection with Blood-Borne Viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. Produced by the Department of Health, March 1998.

The Management of HIV infected Healthcare workers who perform Exposure Prone Procedures: updated guidance January 2014 Public Health England.

U K National Guidance for HIV Testing 2008

British HIV Association (BHIVA)

<http://www.bhiva.org/documents/guidelines/testing/glineshivtest08.pdf>

Health and Safety Executive. (2005). Controlling the risks of infection at work from human remains: A guide for those involved in funeral services (including embalmers) and those involved in exhumation.

Guidelines for the Management of HIV Positive Pregnant Women in Northern Ireland (NI). Revised and reviewed 2013 Public Health Agency (PHA)

http://www.publichealth.hscni.net/sites/default/files/2013%20Guidelines%20for%20the%20management%20of%20HIV%20positive%20pregnant%20women%20in%20NI1_0.pdf

Guidelines for the Management of the HIV-Exposed Infant.

<http://www.dhsspsni.gov.uk/hivpregnancyguidelines.pdf>

8.0 CONSULTATION PROCESS

Infection Prevention and Control Team

Acute Services Senior Management Team

Consultant Microbiologists

Occupational Health Service

Medical Director

IP&C Policies & Guidelines Working Group

Chief Executive HCAI Accountability Forum

Trust Board

9.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1988), Targeting Social Need Initiative, Disability Discrimination and

the Human Rights Act 1998, an initial screening exercise to ascertain if this guidance should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this guidance is: **Pending**

Major Impact

Minor Impact

No Impact

10.0 SIGNATORIES

Signed for and on behalf of the Western Health & Social Care Trust:

Shireen McGlone
Infection Prevention & Control Nurse

Date

Fiona Hughes
Head of Infection Prevention & Control

Date