THE · UNITED · STATES · CONFERENCE · OF · MAYORS

LOCAL AIDS POLICIES

UNITEDSTATES
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OF MAYORS

SALT LAKE CITY
JUNE 10-15
1988

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AIDS is a national problem, affecting millions of people throughout the country: those who are actually diagnosed, their friends, parents, children and families, employers, as well as the health care system of the nation. AIDS is a disease that affects us all.

When first identified in 1981, the incidence of AIDS was limited to a small number of gay men in our larger, coastal cities—San Francisco, New York, and Los Angeles. Since that time, more and more cases and deaths have been reported, primarily from within our major urban centers.

The United States Conference of Mayors Task Force on AIDS was formed in the Spring of 1983 to enable mayors to work together and with the federal government in fighting this growing epidemic. In 1987, the Conference established the Committee on Health, in part to further address the issues surrounding AIDS. Lacking a cure or vaccine, the only means of preventing the further transmission of AIDS is through education. Yet, education is not an easy task. Confronting the rampant myths and rumors surrounding the disease has been a monumental undertaking.

Since 1984, the Conference of Mayors has been working with the Centers for Disease Control in providing AIDS education and information to local officials. In addition, the Conference has provided grants for community-based organizations to conduct AIDS education and risk reduction programs. In five grant rounds, the Conference has provided over $1 million to educate persons who are at higher risk of infection.

To deal with the continuing AIDS crisis, local government needs to develop policies which reasonably address the various issues and areas which will arise in all cities. This volume, *Local AIDS Policies*, serves to assist local government officials in the development of appropriate responses by providing working examples of locally-developed policies covering first responders (i.e., police, fire safety, emergency medical services), health care workers, AIDS-related discrimination, and correctional facility management.

To fight this disease, we as mayors need to learn from the experiences of each other, to accept that AIDS will touch all of our cities, and to avoid management by crisis by adopting policies before situations arise.

Richard L. Berkley
Mayor of Kansas City, MO
President

Donald Fraser
Mayor of Minneapolis
Chair, Committee on Health

W. Wilson Goode
Mayor of Philadelphia
Chair, Task Force on AIDS

The United States Conference of Mayors

The United States Conference of Mayors is the official nonpartisan organization of cities with populations of 30,000 or more. There are well over 800 such cities in the country today, each represented in the Conference by its chief elected official, the Mayor. The U.S. Conference of Mayors is in its second half-century of service to the Mayors and the citizens of America's principal cities. Throughout its history, the Conference of Mayors has taken the lead in calling national attention to the problems and the potential or urban America. Since its founding it has carried the message of cities to every President, every Congress. This is the heritage of the Conference of Mayors. It is the heritage of every Mayor who serves today.

This publication was prepared by the Conference of Mayors AIDS Program. Conference staff include Richard D. Johnson, Assistant Executive Director; Alan E. Gambrell, Principal Associate, who was responsible for the development of this document; Matthew Murguia, Senior Staff Associate; and Phyllis Dickerson, Administrative Assistant II. The following individuals assisted in the preparation of this document: George Ekdahl, Miriam Feldbaum, Jeanne Glaittli, and Jason Pedersen.

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OVERVIEW

OVERVIEW

Since its earliest years the AIDS crisis has been associated with America's largest urban areas—particularly New York City, San Francisco, and Los Angeles—where 40 percent of the over 62,000 cases occurred (as of June 1988). The future, however, is of a disease that will increasingly affect areas outside of these cities: by 1990, 80 percent of new cases will be in urban areas outside of New York City and San Francisco.

Consequently, there is a critical need for local government officials, from smaller as well as larger communities, to address and formulate policy responses to AIDS-related issues before crisis situations arise. A number of communities throughout the country have unfortunately been caught unprepared in dealing with the hysteria and fear that accompany AIDS. If at all possible, communities must take steps to avoid developing AIDS-related policies during a crisis period. Local governments will need policies in place to deal with the varioius situations that may arise. A question remains whether those policies will be rationally-developed, in a period of calm, or hastily fashioned in the heat of crisis management.

Local AIDS Policies is designed to provide local officials with guidance in developing appropriate AIDS-related policy positions vis-a-vis concerns regarding employee health and safety; protection of citizens against unwarranted discrimination; protection of the municipality against liability claims; and maintenance of public confidence in the operations of the local government. Included in this document are brief outlines of major policy issues along with sample AIDS-related policies in the following areas: discrimination, police, emergency medical services (EMS) personnel, fire safety workers, correctional facilities, and health care workers.

A major goal of the U.S. Conference of Mayors AIDS Program is to assist local communities in developing effective responses to AIDS through a process of information sharing among local governments. This publication is the second major AIDS policy development guidance document prepared by USCM; the first, published in July 1986 (*Local Responses to AIDS, ARC, and HTLV-III Infection*), was a compilation of various AIDS policies developed at the local level.

WHY DEVELOP LOCAL AIDS RELATED POLICIES?

A major tenet of management is to treat problems before they actually arise. This is especially true with AIDS, where unwarranted fear of infection can cause *ad hoc* policies which are detrimental to the work environment, the people involved, and the work which must be accomplished.

- Local government can anticipate and thus be prepared to deal with AIDS-related crises (e.g., employee with AIDS and unwarranted co-worker fear, emergency worker fears and uncertainties about contracting AIDS during trauma situation).
- The locality will have a written policy protocol and will thus be better prepared to deal with any liability claims that may arise.
- Development and implementation of a policy provides a channel for educating the public about AIDS and HIV infection and adds to public confidence in local government operations.
- Employee fears can be resolved or dealt with through education and formulation of policy positions.
- Process of policy development provides opportunity for locality to assess adequacy of current operating procedures (e.g., health and safety of workers, emergency response protocol) and their associated cost impact.

WHAT ARE THE TYPES OF AIDS RELATED POLICIES?

- Police, fire safety, EMS (i.e., first responders)
- health care workers
- correctional facilities
- anti-discrimination (employment, housing, public accommodations)
- foster care, day care, school attendance
- waste management

HOW ARE POLICIES DEVELOPED?

Different communities have developed policies on AIDS through different processes, depending on the structure of local government, the political climate, and local traditions. In each case the Mayor can act as a unifying leader in the community-determining a potential problem area, educating staff and the public to the issues, and establishing a process to have policy in place before an emergency arises.

The following points have a proven record as elements of a successful policy development procedure:

- Establish an interdepartmental committee, where cooperation and input can be solicited from throughout the government.
- Establish lead agency/individual responsible for development of policy.
- Establish time frame for policy development process (6-8 months is standard time that most localities indicate is necessary).
- Local health department input is a useful resource for providing medical and technical assistance in the development of policies.
- Include line employees as well as supervisory personnel in the policy development process, thus providing for more confidence in the policy eventually developed. It is important to address the concerns of all employees.
- Establish budget necessary to implement policy.

WHAT SHOULD POLICIES INCLUDE?

- General information on AIDS, its cause, how AIDS is spread, how AIDS is not spread, and how to avoid contracting the disease.
- Explanation of on-the-job situations in which protective measures need to be taken.
- What an employee should do if an on-the-job exposure is suspected, including: reporting the incident to supervisory personnel, follow-up testing, and precautions to take to avoid potential further spread.
- Resources to contact for further information.

DISCRIMINATION

Allentown, Pennsylvania
San Francisco, California
Minneapolis, Minnesota

DISCRIMINATION

AIDS anti-discrimination statutes:

- address issues of unfair employment, housing, and business practices;
- serve as a means of educating the public and resolving unwarranted fears that AIDS can be transmitted casually;
- codify the local government's policy, providing a legal basis for local operations.

A number of localities of both high and low AIDS incidence have adopted discrimination statutes (e.g., Alexandria, Allentown, Austin, Boston, Hennepin County (Minneapolis), Indianapolis, Madison, Minneapolis, New York City, Philadelphia, St. Paul, Sacramento, San Francisco, San Mateo County, Washington, DC). Below are reprints of discrimination policies adopted in Allentown, San Francisco, and Minneapolis . Allentown's Policy Statement on AIDS extends the City's previous ordinance on discrimination to persons with AIDS and persons perceived to have AIDS. Minneapolis' ordinance, adopted in 1986, prohibits discrimination in city employment and operations.

San Francisco's ordinance, passed in 1985, provides specific language prohibiting discrimination in employment, housing, business establishments, public accommodations, educational institutions, and city facilities/ services. The San Francisco ordinance has served as the basis for ordinances adopted in other cities (e.g., Austin, Sacramento).

Allentown Human Relations Commission
Policy Statement on AIDS

The Allentown Human Relations Commission affirms the protection from discrimination based on Handicap in Employment, Housing and Public Accommodation as stated under Articles 181.02, .03 and .04 of the Codified Ordinances of the City of Allentown.

The Handicap protection offered by the Commission's Ordinance follows state law which in turn is based upon "relevant Federal and State Laws," most notably the Vocational Rehabilitation Act of 1973.

The definition of Handicap, under Federal and State law includes any person who:

a) Has a record of physical or mental impairment that substantially limits one or more major life activities; or

b) Has record of such impairment; or

c) Is regarded as having such an impairment.

The Commission affirms that persons with disabling diseases such as tuberculosis, cancer and AIDS, as well as persons perceived to have such a disease, are under the protection of the City's Handicap ordinances. The commission directs staff to accept such complaints and investigate on a case by case basis consistent with Federal and State guidelines and case law.

June 26, 1987

Testimony by Mayor William H. Hudnut, III before the Presidential Commission on the Human Immunodeficiency Virus Epidemic Public Hearing on AIDS in the Workplace

Tuesday, May 10, 1988

I would like to thank the Presidential Commission on the Human Immunodeficiency Virus Epidemic for allowing me this opportunity to share my thoughts as a public employer about the AIDS epidemic in America and Indianapolis in particular. To date, there have been 120 cases of AIDS reported in Marion County, with 59 deaths. It is estimated that 50 to 100 times that number of reported cases exist but have not been identified. The State of Indiana ranks 13th in the nation in the number of reported AIDS cases. By the end of 1989, statistics predict there will be 270,000 AIDS cases in America, with 179,000 deaths. All of our lives will be touched in some way by the AIDS virus, whether it be as an employer, co-worker, relative, or friend. We must marshal a compassionate and professional approach to AIDS.

The City of Indianapolis is the ninth largest employer in Marion County with 4,763 employees. As the Mayor of this City, it is my responsibility to protect the rights of all of our citizens and all of our City and County employees. The AIDS epidemic represents a challenge in respecting individual rights while at the same time safeguarding public health.

The federal and state government have worked hard toward developing policies and programs on AIDS. The recently announced federal government guidelines for employees and recently passed legislation by the Indiana General Assembly, with the leadership of Senator Patricia Miller from Indianapolis, places an emphasis on creating an awareness and understanding of AIDS-related issues and employee conduct toward AIDS-infected co-workers. I applaud this decision and the efforts of Health and Human Services Secretary Otis R. Bowen and Surgeon General C. Everett Koop in their recently announced campaign to mail an AIDS informational brochure to every household in the nation. It is our responsibility as employers and elected representatives of the poeple of this country to educate the public about AIDS—how it is transmitted and how transmission can be prevented.

We take this responsibility seriously in Indianapolis. This afternoon I signed an Executive Order stating the City's policy on AIDS and our employees....

AIDS DISCRIMINATION

SAN FRANCISCO

Ordinance 499-85 File No. 97-85-36

Prohibiting Discrimination on the Basis of AIDS and Associated Conditions

Sec. 3801. POLICY. It is the policy of the City and County of San Francisco to eliminate discrimination based on the fact that a person has AIDS or any medical signs or symptoms related thereto. In adopting this ordinance, the Board of Supervisors does not intend to proscribe any activity the proscription of which would constitute an infringement of the free exercise of religion as guranteed by the United States and California constitutions.

Sec. 3802. FINDINGS. After public hearings and consideration of testimony and documentary evidence, the Board of Supervisors finds and declares that the medical condition described as acquired immune deficiency syndrome, and commonly known as AIDS, is deadly disease which has the potential to affect every segment of the City's population. AIDS was first recognized in 1981. It is now seen as the top priority of the United States Public Health Service.

AIDS is the most severe manifestation of a spectrum of clinical disease caused by a virus, variously known as human T-lymphotropic virus type III, lymphadenopathy-associated virus, or AIDS-associated retro-virus, which attacks and cripples the body's immune system by killing T-helper lymphocytes, thereby leaving the body vulnerable to opportunistic infections and malignances. A person afflicted with AIDS can suffer a variety or viral, bacterial, fungal, and protozoal infections and malignancies which eventually lead to death, usually within one year after diagnosis.

The spread of the virus has occurred only through the exchange of body fluids, that is blood, blood products, or semen, between individuals. No evidence exists to indicate that the virus can be spread by casual person-to-person contact. Medical studies of families in which one or more members have been infected with HTLV-III/LAV/ARV show no spread of the virus other than through sexual intercourse or from mother to fetus in utero. Medical studies of hospital personnel caring for AIDS patients show no spread of the virus other than through needle sticks. The public halth danger presented by the virus and its subsequent manifestations of AIDS-related complex and AIDS is caused by lengthy asymptomatic period of infection during which an apparently healthy individual may unknowingly spread the disease to other persons through the exchange of blood, blood products, or semen. AIDS is concentrated primarily in urban areas, with the City and County of San Francisco having the largest incidence of the disease in the country. In the opinion of the scientific, medical, and public health communities, AIDS will continue to increase at a high rate within our City for the foreseeable future.

AIDS and AIDS-related complex by their nature have created a minority of our citizens who are afflicted with a seriously disabling condition whose ultimate outcome is fatal. Individuals infected with the virus represent a significant segment of our population particularly victimized due to the nature of their infection and to the present climate of misinformation, ignorance, and fear inthe general population. Discrimination against victims of AIDS and AIDS-related conditions exists in the City and County of San Francisco. Persons with AIDS or AIDS-related conditions are faced with discrimination in employment, housing, business establishments, city facilities, city services, and other public accommodations. This discrimination cuts across all racial, ethnic, and economic lines. Such discrimination poses a substantial threat to the health, safety, and welfare of the community. Existing state and federal restraints on such arbitrary discrimination are inadequate to meet the particular problems of this city and county.

Sec. 3803. EMPLOYMENT.

(a) Prohibited Activity. It shall be unlawful for any person to do any of the following acts as a result of the fact, in whole or in part, that a person has AIDS or any of the associated conditions covered by this Article:

(1) By an employer: To fail or refuse to hire, or to discharge any individual; to discriminate against any individual with respect to compensation, terms, conditions or privileges of employment, incluidng promotion; or to limit, segregate or classify employees in any way which would deprive or tend to deprive any individual of employment opportunities, or otherwise adversely affect his/her status as an employee;

(2) By an employment agency: To fail or refuse to refer for employment any individual; or otherwise to discriminate against any individual;

(3) By a labor organization: To exclude or expel from its membership or to otherwise discriminate against any individual; or to limit, segregate or classify its membership; or to classify or fail or refuse to refer for employment any individual in any way which would deprive or tend to deprive such individual of employment opportunities, or would limit such employment opportunities, or otherwise adversely affect his/her status as an employee or as an applicant for employment;

(4) By an employer, emploment agency or labor organization:

(i) to discriminate against any individual in admission to, or employment in, any program established to provide apprenticeship or other training or retraining, including any on-the-job training program;

(ii) to print, publish, advertise or disseminate in any way, or cause to be printed, published, advertised or disseminated in any way, any notice or advertisement with respect to employment, membership in, or any classification or referral for employment or trairing by any such organization, which indicates an unlawful discriminatory act or preference.

(b) Bona Fide Occupational Qualification Not Prohibited; Burden of Proof.

(1) Nothing contained in this section shall be deemed to prohibit selection or rejection based upon a bona fide occupational qualification.

(2) In any action brought under Section 3811 of this Article (Enforcement), if a party asserts that an otherwise unlawful discriminatory practice is justified as a bona fide occupational qualification, that party shall have the burden of proving:

(i) that the discrimination is in fact a necessary result of a bona fide occupational qualification; and

(ii) that there exists no less discriminatory means of satisfying the occupational qualification.

(3) The capacity of an individual to perform his or her duties without endangering his or her health or safety, or the health or safety of others is a bona fide occupational qualification.

(c) Exceptions. Nothing in this section shall be construed to prohibit any act specifically authorized by the laws of the State of California or any actions taken by or under the direction of the San Francisco Department of Public Health in order to protect the public health.

SEC. 3804. HOUSING.

(a) Prohibited Activity. It shall be unlawful for any person to do any of the following acts as a result of the fact, in whole or in part, that a person has AIDs or any of the associated conditions covered by this Article:

(1) To interrupt, terminate, or fail or refuse to initiate or conduct any transaction in real property, including but not limited to the rental thereof; to require different terms for such transaction; or falsely to represent that an interest in real property is not available for transaction;

(2) To include in the terms or conditions of a transaction in real property any clause, condition or restriction;

(3) To refuse to lend money, guarantee the loan of money, accept a deed of trust or mortgage, or otherwise refuse to make available funds for the purchase, acquisition, construction, alteration, rehabilitation, repair or maintenance of real property; or impose different conditions on such financing; or refuse to provide title or other insurance relating to the ownership or use of any interst in real property;

(4) To refuse or restrict facilities, services, repairs or improvements for any tenant or leasee;

(5) To make, print, publish, advertise or disseminate in any way, or cause to be made, printed or published, advertised or disseminated in any way, any notice, statement or advertisement with respect to a transaction or proposed transaction in real property, or with respect to financing related to

any such tranaction, which unlawfully indicates perference, limitation or discrimination based on AIDS.

(b) Exceptions.

(1) Nothing in this Article shall be deemed to permit any rental or occupancy of any dwelling unit or commercial space otherwise prohibited by law.

(2) Nothing in this section shall be construed to prohibit any act specifically authorized by the laws of the State of California or any actions taken by or under the direction of the San Francisco Department of Public Health in order to protect the public health.

SEC. 3805. BUSINESS ESTABLISHMENTS AND PUBLIC ACCOMMODATIONS.

(a) Prohibited Activity. It shall be an unlawful practice for any person to deny any individual the full and equal enjoyment of the goods, services, facilities, privileges, advantages and accommodations of any business establishment or public accommodation as a result of the fact, in whole or in part, that a person has AIDS or any of the associated conditions covered by this Article.

(b) Advertising. No person shall make, print, publish, advertise or disseminate in any way any notice, statement or advertisement with respect to any business establishment or public accommodation which indicates that a person is doing or will do anything which this section prohibits.

(c) Exceptions. Nothing in this section shall be construed to prohibit any act specifically authorized by the laws of the State of California of any actions taken by or under the direction of the San Francisco Department of Public Health in order to protect the public health.

SECTION 3806. EDUCATIONAL INSTITUTIONS.

(a) Prohibited Activity. It shall be an unlawful educational practice for any person to do any of the following:

(1) To deny admission, or to impose different terms or conditions on admission, as a result of the fact, in whole or in part, that a person has AIDS or any of the associated conditions covered by this Article.

(2) To deny any individual the full and equal enjoyment of, or to impose different terms or conditions upon the availability of, any facility owned or operated by or any service or program offered by an educational institution as a result of the fact, in whole or in part, that a person has AIDS or any of the associated conditoins covered by this Article.

(b) Exceptions.

(1) It shall not be an unlawful discriminatory practice for a religious or denominational institution to limit admission, or give other preference to applicants of the same religion.

(2) Nothing in this section shall be construed to prohibit any act specifically authorized by the laws of the State of California or any actions taken by or under the direction of the San Francisco Department of Public Health in order to protect the public health.

SEC. 3807. CITY FACILITIES AND SERVICES.

(a) Prohibited Activity. It shall be an unlawful practice for any person to deny any person the full and equal enjoyment, or to impose different terms and conditions on the availability, of any of the following:

(1) Use of any City facility or City service as a result of the fact, in whole or in part, that a person has AIDS or any of the associated conditions covered by this Article.

(2) Any service, program or facility wholly or partially funded or otherwise supported by the City and County of San Francisco, as a result of the fact, in whole or in part, that a person has AIDs or any of the associated conditions covered by this Article.

(b) Exceptions. Nothing in this section shall be construed to prohibit any act which is specfically authorized by the laws of the State of Califorina or any actions taken by or under the direction of the San Francisco Department of Public Health in order to protect the public health.

SEC. 3808. ASSOCIATION AND RETALIATION.

(a) Association. It shall be unlawful for any person to do any of the acts described in Sections 3803(a), 3804(a), 3805(a), 3806(a) or 3807(a) as a result of the fact that a person associates with anyone who has AIDS or any of the associated conditions covered by this Article.

(b) Retaliation. It shall be unlawful for any person to do any of the acts described in Sections 3803(a), 3804(a), 3805(a), 3806(a) or 3807(a) or to retaliate against a person because a person:

(i) has opposed any act or practice made unlawful by this Article;

(ii) Has supported this Article and its enforcement;
(iii) has filed a complaint under this Article with the San Francisco Human Rights Commission or any court;
(iv) has testified, assisted or participated in any way in any investigation, proceeding, or litigation under this Article.

SEC. 3809. TESTING.
(a) No person shall require another to take any test or undergo any medical procedure designed to show or help show that a person has AIDS or any of the associated conditions covered by this Article.
(b) Subsection (a) does not apply to an employer who can show that the absence of AIDS is a bona fide occupational qualification.
(c) Nothing in this section shall be construed to prohibit any act specifically authorized by the laws of the State of California or any actions taken by or under the direction of the San Francisco Department of Public Health in order to protect the public health.

SEC. 3810. LIABILITY.
Any person who violates any of the provisions of this Article or who aids in the violation of any provisions of this Article is liable for each and every such offense for the actual damages, , and such amount as may be determied by a jury, or a court sitting without a jury, up to a maximum of three times the amount of actual damage but in no case less than one thousand dollars ($1,000), and such costs and attorney's fees as may be determined by the court. In addition, punitive damages may be awarded in a proper case.

SEC. 3811. ENFORCEMENT.
(a) Human Rights Commission. Any person who believes that he or she has been discriminated against in violation of the provisions of this Article may file with the Human Rights Commission a request to have the Commission investigate and mediate his or her complaint under the provisions of the Administrative code of the City and County of San Francisco.
(b) Civil Action. Any aggrieved person may enforce the provisions of this Article in a civil action.
(c) Equitable Relief.
(1) Any person who commits, or proposes to commit, an act in violatio of this Article may be enjoined therefrom by any court of competent jurisdiction.
(2) An action for equitable relief under this subsecion may be brought by any aggrieved person, by the District Attorney, by the City Attorny, or by any other person.
(d) Bar. A complaint to the Human Rights Commission is not a prerequisite to the filing of a civil action under this section. The pendency of a complaint before the Human Rights Commission shall not bar any civil action under this section, but a final judgment in any civil action shall bear any further proceedings by the Human Rights Commission.

SEC. 3812. LIMITATION ON ACTIONS. Judicial actions or requests to the Human Rights Commission under this Article must be filed within two years of the alleged discriminatory acts.

SEC. 3813. DEFINITIONS. As used in this Article, the following words or phrases shall have the meanings indicated:
(a) The word "AIDS" shall mean the condition which occurs when an individual is infected with the virus known as lymphadenopathy-associated virus or human T-lymphotropic virus type III or AIDS-associated retrovirus including, but not limited to, acquired immunodeficiency syndrome (AIDS), AIDS-related complex, progressive generalized lymphadenopathy, lymphadenopathy syndrome, and asymptomatic infection. It also includes anyone who has any medical condition as a result of having any of the above. It also includes any perception, whether real or imaginary, that a person is suffering from AIDS, any of the conditions described above, or the perception, real or imaginary, that a person is at risk for any of the conditions described above.
(b) The phrase "business establishment" shall mean any entity, however, organized, which furnishes goods or services to the general public. An otherwise qualifying establishment which has membership requirements is considered to furnish services to the general public if its membership re-

quirements consist only of payment of fees or consist of requirements under which a substantial portion of the residents of this City could quality.

(c) The word "person" as used in this Article shall mean any individual, person, firm, corporation, or other organization or group of persons however organized.

SEC. 3814. SEVERABILITY.

If any part or provision of this Article, or the appplication thereof to any person or circumstances is held invalid, the remainder of the Article, including the application of such part or provision to other persons or cirumstances, shall not be affected thereby and shall continue in full force and effect. To this end, provisions of this Article are severable.

SEC. 3815. NON-WAVERABILITY. Any written or oral agreement which purports to waive any provision of this Article is against public policy and void.

SEC. 3816. APPLICATION TO THE CITY AND COUNTY OF SAN FRANCISCO. All the provisions of this Article apply to the Citye and County of San Francisco.

November 20, 1985

CITY OF MINNEAPOLIS POLICY REGARDING AIDS AND CITY EMPLOYMENT AND OPERATIONS

GENERAL POLICY

It is the policy of the City of Minneapolis that no employee, applicant or client shall be subjected to testing, removed from normal and customary employment status, or deprived of any rights, privileges or freedoms because of AIDS or conditions associated with the HIV Virus (AIDS virus) except for clearly stated, specific, and compelling medical and/or public health reasons.

For the purpose of this policy, and individual with AIDS or conditions associated with HIV Virus (AIDS virus) shall be defined as follows:

- Any person diagnosed as having the medical condition known as "Acquired Immune Deficiency Syndrome" (AIDS), in accordance with the Center for Disease Control case definition.
- Any person diagnosed as having the medical condition known as "AIDS Related Complex" (ARC) in accordance with commonly accepted clinical criteria.
- Any person who is antibody or culture positive for the HIV virus, referred to as the AIDS virus.

SPECIFIC POLICIES

1. Any employee known to have AIDS or conditions associated with HIV Virus (AIDS virus) who is able to continue safe and effective work performance shall be entitled to remain in the same job classification and work location unless the employee's physician or the City's designated employee physician

makes a finding that this would significantly threaten the health of the public, the employee, or his/her co-workers. If such a finding is made, an effort will be made to modify the employee's duties based on medical recommendations by the employee's physician and the City's employee physician. The Health Department's Medical Consultant will be consulted, as needed, to make a determination about public health reasons for any change in work status.

Requests by an employee to not work with other employees or clients who have AIDS or conditions associated with HIV Virus will be discouraged but will be considered on a case-by-case basis by the employee's supervisor in consultation with the City's employee physician and, if necessary, the Health Department's Medical Consultant.

2. No employee shall be required to submit to an AIDS virus test as a condition of beginning or maintaining employment with the City of Minneapolis. Employees who have had a significant AIDS-related work incident exposure, as defined below, shall be strongly encouraged to have an AIDS virus test.

   A significant exposure occurs when infectious body fluids or tissues come in contact with a person's blood or mucous membranes. The body fluids/tissues containing the virus in infected persons are blood, semen, and deep organs. These infectious secretions must come in contact with a person's mucous membranes or directly into the person's vascular (blood) system to be defined as a significant exposure. Employees who have experienced a significant AIDS- related work incident exposure as defined here shall report the incident to their supervisor and contact the City's employee physician who will then make a decision regarding the necessity of an AIDS virus test.

3. If an employee misses work because of an AIDS-related illness and must report to his/her supervisor or personnel officer the reason for absence, the same strict confidentiality requirements that apply to any medical disclosure shall be followed.

4. The City shall encourage employees to attend free City-sponsored educational presentations about AIDS and AIDS virus in order to limit the spread of AIDS and to offer employees current and accurate information about this important public health concern. The City's Health Department will be responsible for planning and conducting such presentations as needed.

5. The City of Minneapolis will continue to negotiate health insurance contracts which include open enrollment with no evidence of insurability. The City will continue to provide basic life insurance coverage. No person will be required to supply information of a nature not required of all persons in City negotiated insurance packages. No modifications will be made to current disability or sick leave policies based solely on AIDS.

6. The Health Department shall review this policy at least on an annual basis and made recommendations to the City Council as needed to ensure that this policy complies with the most current epidemiologically-accepted facts about AIDs and AIDS-related conditions.

FIRST RESPONDERS

Emergency Medical Services

Hennepin County, Minnesota
Philadelphia, Pennsylvania

Fire

Philadelphia, Pennsylvania

Police

Washington, DC

FIRST RESPONDERS

POLICE, FIRE SAFETY, EMERGENCY MEDICAL SERVICES (EMS)

Police, fire safety personnel, paramedics, and emergency medical service workers (EMS) are commonly referred to as "first responders" to emergency situations in which the possibility exists of exposure to blood. Situations may include: need to perform CPR, handling bloody materials, collection of bloody evidence, restraint of uncooperative suspects, search of suspects.

Policies covering this classification of workers should cover the following:

- protective measures to follow to avoid exposure;
- protocol to follow in the event of a possible on-the-job exposure; and
- education of personnel about AIDS, including training of key personnel who will, in turn, educate line employees.

This section contains sample policies for EMS workers (Hennepin County; Philadelphia); Fire Safety (Philadelphia); and Police (Washington, DC). The major issues within these areas are outlined below.

Protective Measures - Body Fluid Precautions

Policies should call for adherence to universal body fluid precautions (i.e., treating all situations of exposure to blood or body fluids as potentially infectious). First responders should use protective equipment and follow standard precautionary procedures in all emergency situations involving presence of blood and body fluids. Universal precautions are preferable for a number of reasons:

- First responders become accustomed to being prepared for all situations and are thus more likely to avoid possible on-the-job exposure.
- Relying upon currently-available information in dealing with clients (e.g., only taking precautions in situations where the client appears to be sick; relying upon screening protocols of 911 operators) does not account for situations in which client may be HIV positive but without symptoms. Furthermore, adjusting response techniques according to perceived risk does not account for situations where a client may not have full knowledge of his/her HIV status, may be unprepared to provide accurate information, or may be unwilling—out of fear of discrimination—to reveal his HIV status, sexual preference, or personal history.

Protocol to Follow in the Event of a Suspected Exposure

- Immediate Cleansing of the Skin, Puncture Wound
- Documentation of Incident
- Filing of Appropriate Report With Supervisor
- HIV Test (Initial and Follow-up) (e.g., 3 months, 6 months) to Determine if Infection Occurred
- Follow-up with Employee - Education Regarding Likelihood of Being Exposed, Reassurance on Emotional Concerns, Counseling on Safer Sex Until Determination is Made if Exposure Occurred

Testing/Counseling Issues

Testing of first responder who suspects exposure occurred.

- Taking an initial test of the first responder after a potential exposure provides a baseline measure for possible later determination of on-the-job exposure.
- Follow-up tests are necessary in order to account for lag-time in potential seroconversion (i.e., 3 months, 6 months, and 1 year after exposure).
- Pre- and post-test counseling are essential and should include information about risk reduction strategies to follow (e.g., safer sex so as to avoid transmitting the virus if the first responder, in fact, has contracted the virus).

Testing of clients when an exposure to blood or body fluids occurs.

- Legality of requiring a client to submit to HIV antibody testing is unclear.
- Purpose of testing a client is unclear since proper protocols should exist concerning universal body fluid precautions which protect the first responder from possible infection.

Confidentiality of Medical Records

- Confidentiality of HIV antibody test results is important in order to maintain confidence in the health care system and to protect against potential discrimination. Other than the individual being tested and the health care provider, there is no clear rationale for disclosing information to other parties, unless required by state law.
- Localities should be prepared to deal with situations in which test results are subpoenaed by the court.

Educating Personnel

AIDS education for first responders must address a wide spectrum, with initial information being presented on the general facts about AIDS (e.g., epidemiological explanation of the disease) and how it is transmitted (i.e., injury with contaminated needles, unprotected sexual intercourse with infected persons, exposure to blood of infected person that results in blood entering bloodstream of individual). Information also must be presented on: protective measures to take, including use of protective gear and techniques to follow in searches; handling of evidence/bloody items; restraint techniques; clean-up procedures; and procedures to follow in the event of a significant on-the-job exposure in which the employee suspects that contamination may have occurred.

Considerations in Conducting Education Programs
Recommendations of San Francisco Department of Public Health

If employees within the department will be responsible for conducting education/training sessions, it is often useful to have trainers who are in the same job circumstances as their audience.

One time education/training may not suffice. Ongoing sessions may be necessary in order to ensure that information is retained and protocols are followed.

Focus of training should be upon high risk situations, not high risk people.

Focus of training should be upon operating during unique situations; ranking risk factors alone will not be an effective means of training.

Training should address on-the-job concerns as well as personal risks (to family and friends).

Standards Operating Procedures Regarding Exposure to Blood and Body Fluids

West Metro EMS Council

Developed on Cooperative Basis by EMS Providers in Hennepin, Scott, Carver, Anoka Counties (Minneapolis Area), Minnesota

1. Exposure to blood should be minimzied. When the possibility of exposure to blood or other body fluid exists, gloves are recommended. During extrication, or when broken glass is present, leather gloves or firefighter gloves should be used. If hands accidentally become contaminated with blood, they should be washed thoroughly as soon as possible. When there is risk of eye or mouth contamination (for example, the patient is vomiting bloody material or there is arterial bleeding), protective eyewear and masks are recommended.

2. Needles and other sharp objects should be considered as potentially infective and be handled with extraordinary care.

   Needles should not be recapped. If it is absolutely necessary to recap a needle, use the appropriate technique prescribed by the emergency medical service (see Appendix I.C.2). Needles, syringes and broken glass vials should be immediately placed in puncture-proof containers after use.

3. Pocket masks with one-way valves if possible or positive pressure ventilators should be used fo artificial respiration whenever possible.

4. Equipment should be thoroughly cleaned per protocol after each use (see Appendix I). Disposable equipment should be considered for use whenever appropriate.

5. In the event of significant exposure to blood or body fluids, supervisory personnel should be promptly informed.

6. Significant exposure is defined as follows:

   a. Any puncture of the skin by a needle or other sharp object that has had contact with the patient's blood or body fluids or with fluids infused into the patient.
   b. Blood spattered onto mucous membranes (e.g., mouth) or eyes.
   c. Contamination of open skin (cuts, abrasions, blisters, open dermatitis) with blood, vomitus, saliva, amniotic fluid or urine. Bite wound to providers would be included in this category.

7. Your policies should define a plan of action in the event of a significant exposure of an emergency responder to blood or body fluids (See Appendix II).

The following is a suggested procedure: If an employee is concerned about a significant exposure, he or will fill out the form provided (see Appendix III) and take it to his/her supervisor.

If the supervisor believes the exposure was significant, the employee will be referred to an appropriate local agency for counseling and collection of HIV and/or hepatitis serology per protocol (see Appendix IV). Your agency should arrange for a source of both expert opinion counseling and serological testing. Begin by contacting the local hospital's infection control nurse. If there is no such position, ask your local EMS medical advisor for guidance.

The ambulance or rescue agency will bear the expense of testing the employee's blood while the hospital to which the patient was transported will bear the cost of the blood drawing and tests for the patient. When the victim is dead at the scene or arrives dead on admission, testing will be done by the medical

examiner's office or the county coroner's office, if appropriate.

Blood from the patient will, with the patient's consent (Appendix V), be drawn and tested for hepatitis B surface antigen or HIV antibody as appropriate. These results will be made available only to the local medical agency (hospital or physician's office or clinic) for use in counseling the exposed employee. The employee must understand and honor the confidentiality of this information. A breach of this confidentiality may be considered an invasion of privacy in a court of law.

Results of the employee's blood testing will be kept confidential and only made available to a physician or other designated individuals from the local medical agency.

Appendix 1

Infection Control Protocol for First Responders

II. Personal Protection - to prevent the acquisition of an occupationally related disease.

A. Know your immunization history. Consider vaccinations if not immune to tetanus, diphtheria, rubella, measles, mumps, polio. Hepatitis B vaccines may also be very useful in communities where there is evidence of this disease. Influenza vaccine should be considered annually.

B. Consider all blood and body fluid a source of contamination.

1. Wear gloves whenever possible to avoid exposure. Leather or fire fighter gloves should be used during extrication or when broken glass is present.
   a. for exposure to the following body fluids: saliva (e.g., sputum, human bites), emesis, blood, stool, urine, amniotic fluid, genital secretions
   b. for all needle insertions
   c. for obvious infective wounds (pus drainage)
   d. for any other generally unclean surroundings
   e. for protection of workers who have open and/or exudative lesions as well as for protection of the patient.
2. Wash hands at the earliest opportunity after contact with blood and body fluids (e.g., consider available sources of water such as clean towels wet with irrigating solution, fire rigs, hospitals, etc.)
3. Use protective eye wear and mask when there is a risk of eye or mouth contamination (e.g., vomiting blood or arterial bleeding)
4. Use pocket mask and O2 equipment instead of mouth-to-mouth resuscitation. One-way filters valves ar available to attach to pocket masks or EOA's to pervent physical contact with vomit or saliva between the patient and your mouth.
5. Shower after heavy contamination at the earliest opportunity.

C. Dispose of needles safely

1. Place used needles, syringes, scapel blades and other disposable sharp items in a puncture proof container as soon after use as possible. Put syringes and needles in the container without recapping unless the distance to the container is so great that others might be accidentally punctured in transit. If that is the case, lay the needle cap on a flat surface and slide the needle in horizontally without holding on to the cap until the needle is engaged far enough to tighten.
2. DO NOT place contaminated needles in cushions, blankets or clothing, waste baskets, or paramedic bags on the floor.

D. Wash your uniform as usual for normal daily soil. For items soaked with blood and body fluids, wash separately with hot water and detergent using a full load of water.

E. Report all exposures to blood and body fluids to your supervisor and report for medical evaluation within the first 24 hours.

1. Define significant exposures as follows:
   a. Any puncture of the skin by a needle or other sharp object that has had contact with the patient's blood or body fluids or with fluids infused into the patient.
   b. Blood spattered onto mucous membranes (e.g., mouth or eyes).
   c. Contamination of open skin (cuts, abrasions, blisters) with blood, vomitus, saliva, amniotic fluids or urine. Bite wounds to providers would be included in this category.
2. Report exposures in this agency to _____.
3. It is expected that infection control practitioners (ICPS) will notify first responders of exposures to communicable diseases of significance (e.g., tuberculosis, chicken pox, memingococcal memingitis, measles, mumps, rubella) spread by the airborne route after the diagnosis has been made.

II. Cleaning and Disinfection of Reusable Patient Care Equipment

A. Prevent infections in the patient.

1. Use sterile technique with all intravenous solution set-ups. A 24 hour limitation for sterility on al IV solutions set-up, but not unused.
2. Disinfect skin with alcohol before all invasive needle techniques. (Using circular motion, starting from site rotating outward to cleanse.)
3. Disinfect portal of IV tubing with alcohol before infusing a drug.
4. Use disposable clean gloves when suctioning patient or dressing wounds.

B. Prevent the spread of viruses or bacteria to another patient by thorough cleaning and in some cases disinfection of items used in direct patient care. (Use gloves when handling all soiled equipment for protection against microbes and chemicals.)

1. Reprocess airways, resusable masks, positive pressure devices and other nondisposable instruments that touch intaact mucous membranes by cleaning an disinfecting as described below or by sending to the local hospital for central sterile reprocessing.
   a. Wash interior and exterior of surfaces with detergent and water.
   b. Rinse with tap water and drain to remove excess water.
   c. Soak items for 10-15 minutes in a plastic pan or pail containing a solution of 1 1/2 cup of household bleach to 1 gallon of water. This solution should be prepared daily.
   d. Rinse items in tap water, allow to dry thoroughly to prevent growth of organisms from the environment. Dry on a clean laundered towel and then store in a new zip lock bag to prevent recontamination until ready to use.
2. Reprocess equipment such as blood pressure cuffs (cuff only), chin straps, etc. that does not touch a mucous membrane in the same way as #1 only when visibly contaminated with body fluids.
3. Wipe items like head blocks, stethoscopes, back boards with household detergent and water followed by a solution of 1/4 cup bleach to 1 gallon of water.
4. Discard cervical collars that are contaminated with any body fluids.
5. Launder mast trousers that are visibly contaminated with body fluids.
   a. Set machine on Perma Press with water level on "high." Use warm (not hot) water temperature.
   b. While machine is filling, add 1 cup of household bleach and detergent (slightly less than manufacturers directions).
   c. Open G-suit on a flat surface and inspect for damage. With valves open, roll the bladders toward the open valve to expel air. Close valves when

bladders are deflated, and close velcro fasteners.

d. Place G-suit in machine in a uniform manner to start wash cycle-allow trousers to soak for 20-30 minutes. The time an item is in contact with a disinfectant is critical for the appropriate disinfection.

e. Resume wash cycle after soaking period and allow cycle to complete.

f. Inflate and inspect for fabric damage and leaks by using a rapid inflation device.

g. Hang to dry and then place in storage.

6. Launder the following items:
   a. All sheets, towels, blankets after every patient use.
   b. Wool mummy bags, when soiled and on a regular schedule.
   c. All uniforms or clothing grossly contaminated from patient services.
7. Reprocess suction equipment with household detergent and water. The large tubing from the suction apparatus to the catheter connection is replaced daily. All suction catheters are a one time use per patient.
8. Discard securely wrapped soiled or paper wastes that cannot be flushed down a toilet in a sturdy plastic bag.

III. Ambulance Cleaning

A. Ambulance service should have protocols for regular cleaning of rigs.

1. Clean and disinfect all surfaces contaminated with body fluids during a patient transport before another patient is transported. The disinfectant may be bleach and detergent or any hospital grade disinfectant diluted according to manufacturer's instructions.
2. Clean entire inside of rig with a detergent on a regular basis as a part of regular rig maintenance depending on the frequency of use. (Active departments will do this weekly.) This procedure should include thorough wiping of seldom used items and vacuuming of hard to reach corners. It includes visual inspection and repair of all equipment. Documentation of routine cleaning should be done.

Appendix II

Guidelines for EMS Association Supervisors Regarding Exposure of Employees to Blood or Body Fluids

1. Exposure of any individual to blood or body lfuids of a patient carries a risk of exposure to bloodborne disease such as human immunodeficiency virus (HIV) infection (the AIDS virus) or the hepatitis B virus. Acquiring either of these infections through blood or body fluids is relatively infrequent. Individuals who are stuck by a needle containing blood from a patient who is a carrier of hepatitis B have a 6-30 percent chance of developing this infection if they are not appropriately treated. The likelihood of transmitting HIV infection appears to be much, much less; indeed, there are fewer than half a dozen well-documented cases of transmission of this organism to a health care worker throughout the world (as of mid-1987).

2. There is a need to evaluate all exposures to blood and body fluids. Such an exposure may suggest standard procedures were not followed and it may be appropriate to review these procedures with the employee.

3. A significant exposure is defined as follows:

   a. Any puncture of the skin by a needle or other sharp object that has had contact with the patient's blood or body fluids or with fluids infused into the patient.

   b. Blood spattered onto mucous membranes (e.g., mouth) or eyes.

   c. Contamination of open skin (cuts, abrasions, blisters, with blood, vomitus, saliva, amni-

otic fluid or urine). Bite wounds to providers would be included in this category.

If the employee's contact with the patient meets any of these criteria or if you are concerned that another type of contact may represent signifacnt risk to the employee, complete the form provided with the employee and refer it to the individual in your local hospital or public health agency for appropriate evaluation and follow-up.

Appendix III

Communicable Disease Exposure Report

Employee Information (completed by employee at the time of the incident)

SECTION 1

NAME _____ JOB TITLE _____
ADDRESS _____ PHONE _____

Date of Incident _____ Run # _____ Location _____

_____ Signature of First Responder

Exposure Description:

A. Blood or Body Fluids
1. _____ Needlestick with contaminated needle
2. _____ Blood or body fluids into natural body openings (nose, mount, etc.)
3. _____ Blood or body fluids into cut or wound less than 24 hours old
4. _____ Blood or body fluids on intact skin
5. _____ Other (describe) _____

B. Respiratory
1. _____ Mouth to mouth resuscitation
2. _____ Resuscitation using airway
3. _____ Present at scene, but no resuscitation effort that involved breathing
4. _____ Other (describe) _____

Type of Fluid to which you were exposed:
1. ____ Blood 2. ____ Emesis 3. ____ Saliva 4. ____ Amniotic
5. ____ Other (describe)

How could this Incident have been prevented:

_____

_____

Source of Contamination:
Patient name _____ D.O.B. _____ SS# _____
Male _____ Female _____ Address _____
Phone _____
Name of hospital receiving patient _____

_____

Signature of Supervisor _____

SECTION II EXPOSURE INFORMATION **Be Completed by Hospital Staff**

Patient Diagnosis: _____

Does the patient have a communicable disease which would put the employee at tisk of occupational exposure? Yes _____ No _____

Exposure Evaluation:
Exposure significant Yes _____ No _____
Further Follow-up needed Yes _____ No _____
Comments

Hepatitis B Surface Antigen (patient) _____ Positive _____ Negative _____ Not Done
HIV Antibody (patient) _____ Positive _____ Negative _____ Not Done
Date patient's physician notified of test results _____

SECTION III EXPOSURE INFORMATION

Employee Hepatitis B History:
Treated for exposure to Hepatitis B with the past 6 months.
Yes _____ No _____
Is employee immune to Hepatitis B? Yes _____ No _____
If Yes, Had vaccine _____ Had disease _____

Hepatitis B Surface Antibody (Employee) _____ Reactive _____ NonReactive _____ Not Done
Hepatitis B Surface Antigen (Employee) _____ Reactive _____ NonReactive _____ Not Done
HIV Antibody (Employee) _____ Reactive _____ NonReactive _____ Not Done

SECTION IV ACTION PLAN

_____ No further follow-up necessary

Employee Rx _____ Td/T _____ HBIG _____ ISG _____ Hep B VACCINE
_____ Date 1st dose
_____ Date 2nd dose
_____ Date 3rd dose

_____ HIV Surveillance Started (0, 3, 6, months)
_____ Date Results _____
_____ Date Results _____
_____ Date Results _____

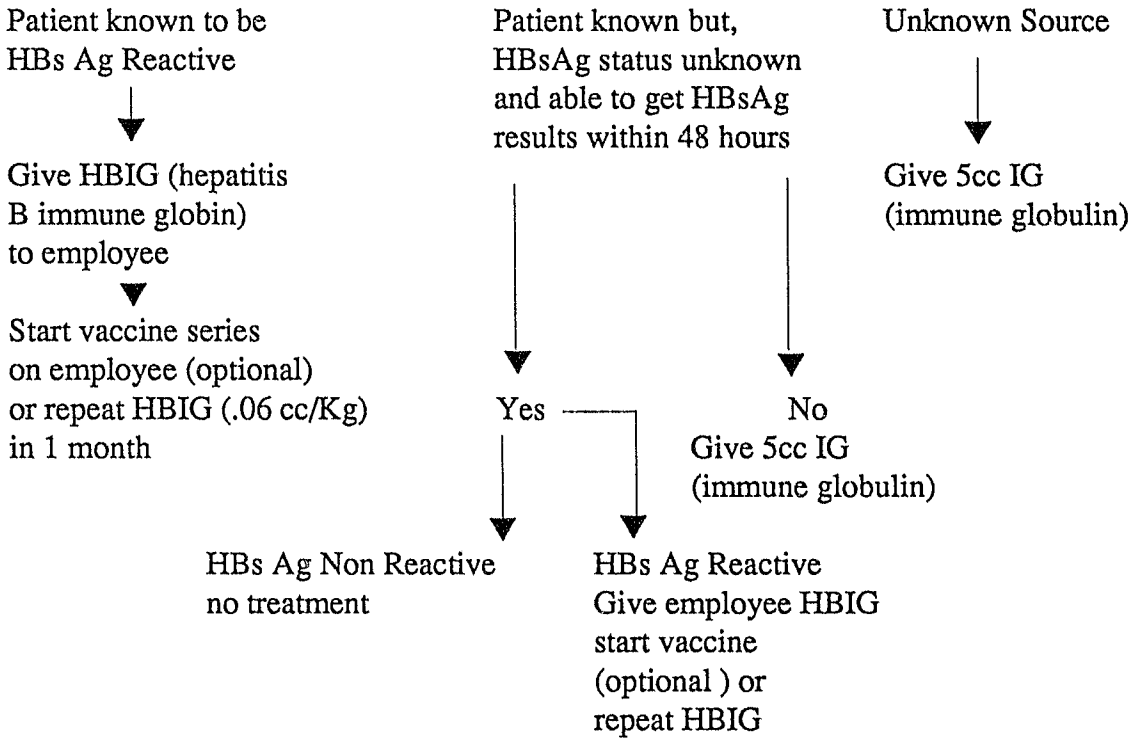
_____
Signature of Hospital Employee
Treating First Responder

4/16/87

Appendix IV

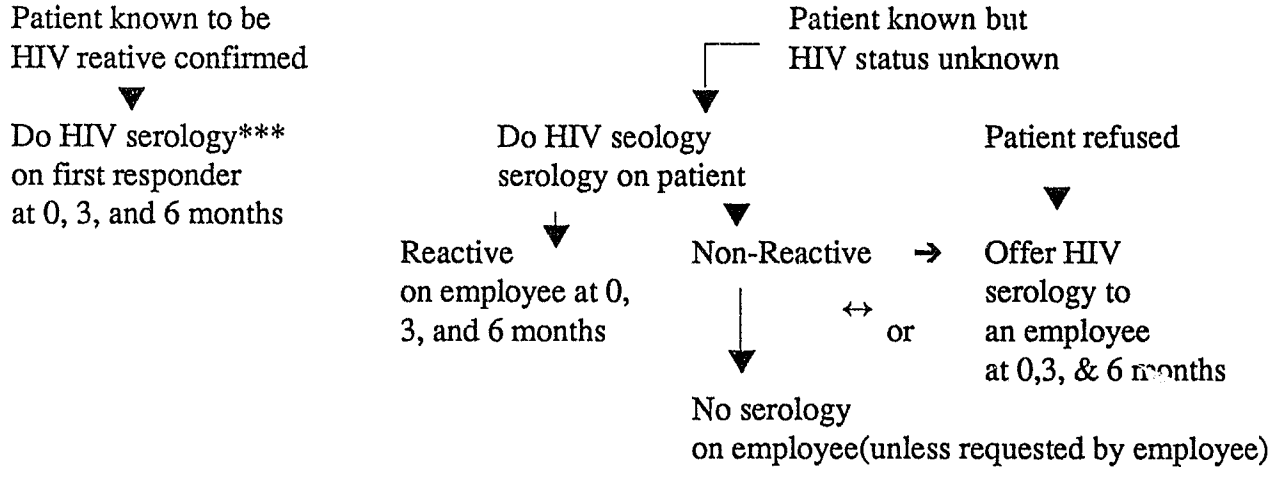
*Employee Documented Exposure to Blood and Body Fluids

*(Algorithm for Hepatitis B virus (HBV) exposure to unvaccinated **employee)*



Alorithm for human immunodeficiency virus (HIV) exposure

Documented Exposure



* Employee includes volunteer and paid first responders

** No specific treatment is necessary for Hepatitis B virus exposures to employees who have completed a series of 3 vaccinations and are known to be immune. (Anti HBs ratio units greater than 10)

*** HIV serology presently refers to antibodies to the HIV virus.

4/16/87

Appendix V

Information for Patients and Families on Special Testing

In the health care setting, accidental exposure to patient's blood or body secretions can rsult in an infectious risk to a health care worker including nurses, technicians, and emergency service personnel. Blood testing can identify specific infectious risks and dtermine recommended treatments.

By signing this consent, you are giving your permission for testings a sample of your blood in the event a health car worker has accidentally become exposed to your blood or body secretions.

There will be no charge to you or your insurance carrier. The test is confidential and will not be indicated on your hospital bill. If the test results indicate the presence of some infectious disease, the results will be first communicated with your physician, who will then discuss the significance of the results with you.

Please contact the Nurse Epidemiologist at (_____) _____, Monday through Friday, _____. Please contact nursing supervisor at other times.

In the event a health care worker sustaains exposure to my blood or body fluids, I give permission for a sample of my blood to be drawn and tested for the presence of infectious diseases.

_____ _____

Patient's Signature Witness

_____ _____

Date Date

AIDS AVOIDANCE MEASURES FOR EMERGENCY MEDICAL SERVICES PERSONNEL ON DUTY

PHILADELPHIA

I. USE OF PROTECTIVE EQUIPMENT

Gloves or protective equipment are not needed for the performance of routine EMS duties which do not require direct contact with blood/body fluids.

In the following special circumstances OBSERVE THESE PRECAUTIONS:

1. **Cardiopulmonary resuscitation (CPR).**
   Use the Loerdal face mask.
   No one has ever become infected with the AIDS virus by performing CPR. Therefore, you should not hesitate to perform CPR when indicated.
2. **Contact with blood or body fluids.**
   Wear disposable latex gloves. Wash hands with soap and water before and after removing gloves.
3. **Never recap needles or catheters.**
   Dispose of used needles or catheters by placing them in the puncture proof containers provided specifically for this purpose. These containers, when full, must be autoclaved and then incinerated.

II. IF CONTACT WITH BLOOD/BODY FLUIDS OCCURS

OBSERVE THESE PRECAUTIONS:

1. Contact of Blood/Body Fluids with Your Unbroken Skin
   Immediately use 70% alcohol pads or rubbing alcohol to remove blood/body fluid.
   As soon as possible, thoroughly wash the exposed area with soap and water.

2. Contact of Blood/Body Fluids with Your Broken Skin (Cut, Puncture Wood or Rash)
   Immediately use 70% alcohol pads or flush with rubbing alcohol to remove blood/body fluid.

   As soon as possible, thoroughly wash the exposed area with soap and water.
   Report to the Compensation Clinic, 216 North Broad Street, during regular business hours (8:00 a.m. to 5:30 p.m.). You will be seen without an appointment. At the Compensation Clinic, medical personnel will conduct appropriate evaluations, including testing for the AIDS virus and the hpatitis B virus, and will provide you with all necessary information and follow-up.

3. Contact of Blood/Body Fluids with Your Mouth or Eye
   Flush eye with water.
   Wash mouth out with water. Rinse mouth with mouthwash.

4. Blood/Body Fluid on Clothing
   Clothing contacted by blood or body fluids should be commerically dry cleaned or machine-laundered in hot water and machine-dried at high temperatures.

5. Vehicle Soiled with Blood/Body Fluids
   Any vehicle soiled with blood/body fluids should be cleaned as soon as possible with a solution of 1 part household bleach (such as Clorox) with 9 parts of water.

AIDS AVOIDANCE MEASURES FOR EMERGENCY MEDICAL SERVICES PERSONNEL

FIREFIGHTERS

PHILADELPHIA

I. USE OF PROTECTIVE EQUIPMENT

The standard firefighter uniform is adequate for the performance of routine duties.

In the following special circumstances **OBSERVE THESE PRECAUTIONS:**

1. **Cardiopulmonary resuscitation (CPR).**
   Use the Loerdal face mask.
2. **Contact with blood or body fluids.**
   If the hands are no otherwise covered, wear disposable latex gloves. Wash hands with soap and water after removing gloves.
3. **Avoid exposure to contaminated needles or other sharp objects.**
   Wear tear-resistant gloves to protect against piercing of your skin.
   If your skin is pierced by a needle or sharp object, follow the instructions below.

II. IF CONTACT WITH BLOOD/BODY FLUIDS OCCURS

OBSERVE THESE PRECAUTIONS:

1. Contact of Blood/Body Fluids with Your Unbroken Skin
   Immediately use 70% alcohol pads or rubbing alcohol to remove blood/body fluid.
   As soon as possible, thoroughly wash the exposed area with soap and water.

2. Contact of Blood/Body Fluids with Broken Skin (Cut, Puncture Wound or Rash)
   Immediately use 70% alcohol pads or flush with rubbing alcohol to remove blood/body fluid. As soon as possible, thoroughly wash the exposed area with soap and water.

   Report to the Compensation Clinic, 216 North Broad Street, during regular business hours (8:00 to 5:30 p.m.). You will be seen without an appointment. At the Compensation Clinic, medical personnel will conduct appropriate evaluations including testing for the AIDS virus and the hepatitis B virus, and will provide you with all necessary information and follow-up.

3. Contact of Blood/Body Fluids with Your Mouth or Eye
   Flush eye with water.
   Wash mouth out with water. Rinse mouth with mouthwash.

4. Blood/Body Fluid on Clothing
   Clothing contacted by blood or body fluids should be commercially dry cleaned machine-laundered in hot water and machine-dried at high temperatures.

5. Vehicle Soiled with Blood/Body Fluids
   Any vehicle soiled with blood/body fluids should be cleaned as soon as possible with solution of 1 part household bleach (such as Clorox) with 9 parts of water.

Metropolitan Police Department

WASHINGTON, DC

AIDS RESPONSE PLAN

A Plan To Address Problems and Issues Concerning AIDS and How Police Officers Should Handle Them

May 1988

GOAL # 1

To disseminate information promptly to ensure that members have accurate and current information available to them as soon as possible.

Objective #1

To create an AIDS Information Bulletin

Purpose: To provide significant or pertinent information on the subject of AIDS, to serve as a transmittal for department or outside agency publications, or to announce the availability of publications on the subject.

Objective #2

To disseminate the "Surgeon General's Report on Acquired Immune Deficiency Syndrome."

Purpose: To provide members with an easy-to-read but comprehensive treatment of AIDS.

Objective #3

To disseminate the film "AIDS and Your Job."

Purpose: To provide members with information and recommendations for emergency service workers. The film is produced by the Centers for Disease Control and is 13 minutes long. It will be shown at roll calls.

Objective #4

To edit are re-release the MPD film "AIDS: The Known Facts."

Purpose: To provide members with information and recommendations pertinent to law enforcement.

Objective #5

To implement the Commission of Public Health to designated MPD personnel so that these trained members can in turn provide continuous educational services to members of their organizational elements.

*****

GOAL #2

To issue policies and procedures that reflect due consideration of the safety of our members, the best medical evidence, and the concerns of the community.

Objective #1

To publish a Special Order on "Protective Equipment".

Purpose: To better ensure the safety and welfare of members, to ensure consistency in the use of protective equipment, and to instill in members a sensitivity to legitimate concerns raised when protective equipment is used.

Objective #2

To study the feasibility of storage containers for syringes and needles.

Purpose: To reduce the occurrence of needle sticks by providing a safe container for syringes and needles that must be stored for evidence or for disposal.

Objective #3

To study the feasibility of storage containers for syringes and needles.

Purpose: To reduce the occurrence of needle sticks by providing a safe container for syringes and needles that must be stored for evidence or for disposal.

Objective #4

To explore alternative field searching techniques.

Purpose: To reduce the likelihood of needle sticks which most often occur during the searching of prisoners.

Objective #5

To develop collection, handling, and storage procedures for possibly contaminated evidence.

Purpose: To ensure that Mobile Crime and Crime Scene Search personnel have adequate safeguards while handling evidence that is possibly contaminated.

*****

GOAL #3

To keep abreast of protective equipment that is on the market to ensure that department issued equipment is sufficiently protective, efficient, and cost effective.

Objective #1

For the Uniform and Equipment Board to designate a sworn member to monitor and report on developments in the area of protective equipment.

Purpose: To ensure that the department, through the Uniform and Equipment Board, has a systematic method of keeping abreast of developments in the area proposals for and acquisition of new equipment.

*****

GOAL #4

To provide mechanisms to respond immediately to the needs and concerns of members to ensure that they are served promptly and satisfactorily.

Objective #1

To establish an AIDS Medical Desk.

Purpose: To provide members with a mechanism, on a 24-hour, seven-day-a week basis, by which they can contact a member of the Board of Police and Fire Surgeons for medical advice and counselling with respect to AIDS- related problems or situations.

Objective #2

To implement procedures for handling occupational exposures.

Purpose: To provide members with a means for being tested and, if necessary, tested as a result of occupational exposures to blood or other body fluids; and to provide a means for the examination and testing of individuals from whom the member received the exposure.

*****

GOAL #5

To disseminate AIDS Information to prisoners who are considered to be sick.

Purpose: To assist the Commission of Public Health in its effort to educate the public. Since the Morals Division processes many drug and prostitution arrests, members of that organizational element will distribute publications furnished by the Commission of Public Health to prisoners who have been arrested for their involvement in drug abuse or prostitution.

*****

GOAL #6

To designate knowledgeable and involved personnel to serve as a resource and consultative body to enable the department to meet the goals of the plan, the interests of our members, and the interests of the community.

Objective #1

To establish an AIDS Resource Group.

Purpose: To ensure that the best information is being disseminated and to assist with the implementation of the AIDS Response Plan. The group, which will be chaired during meetings by the Chairman of the Board of Police and Fire Surgeons, will be a network of civilian and sworn members with expertise in public health, medicine, technical areas such as protective equipment, education, planning, and public relations. It will also consist of officers familiar with street operations and a representative from the community.

Protective Equipment

PURPOSE:

The purpose of this order is to establish policy and procedures for the wearing of protective equipment in certain circumstances in order to:

- better ensure the safety and welfare of members by further reducing the low risk of contracting communicable diseases; and promoting hygienic practices;
- ensure consistency in the use of protective equipment; and
- instill in members a sensitivity to legitimate concerns raised when protective equipment is used as a barrier to direct contact between police officers and citizens.

POLICY

A. Standards for Wearing Protective Equipment.

1. Mandatory Wearing of Protective Equipment.

Members shall wear appropriate protective equipment:

a. While processing crime scenes or handling situations, such as a traffic accident, where there is a presence of body fluids, especially blood, and/or contaminated materials; and

b. When they encounter individuals, as well as evidence and personal property associated with them, who:

(1) Are bleeding or excreting other body fluids.

(2) Have open sores;

(3) Have body fluids on their clothing; or

(4) Appear to be infected with parasites, such as lice.

2. Optional Wearing of Certain Protective Equipment.

a. By the nature of police work, members regularly encounter unsanitary, hazardous, and possibly infectious conditions where body fluids may not be readily apparent or even present. for hygienic and safety reasons and to reduce the potential of exposure to blood or other body fluids, members may wear appropriate protective equipment in the following circumstances:

(1) To search and process prisoners;

(2) To handle individuals who are outwardly unsanitary;

(3) When coming into physical contact with individuals, as well as evidence and personal property associated with them, who claim, are reasonably believed, or are known to have a communicable disease, and there is any risk of coming into contact with blood or other body fluids;

(4) To process, or assist in the processing of, crime scenes and evidence, and

to conduct searches of areas that are hazardous or hidden from view; and

(5) To handle a violent altercation or a situation where, by the nature of the assignment or the belligerent behavior of individuals on the scene, the member expects that the event will escalate into an altercation where bleeding may occur.

b. The wearing of protective equipment in the foregoing circumstances shall be a consistent, non-discriminatory practice. Members shall not base a decision to wear protective equipment on the personal characteristics of an individual, unless the person exhibits violent tendencies.

c. In the case of a planned police operation, however, the above provisions will be superseded by the decision of the official in charge as to what protective equipment may be worn by members under his/her supervision. (See Section C under "Applicability")

3. Restrictions on Wearing of Protective Equipment.

a. The term "appropriate protective equipment" means only those items of equipment that are necessary to protect the particular areas of the body that will likely come into contact with body fluids or with unsanitary, hazardous, or infectious conditions.

b. The use of particular items of protective equipment must address the risk involved for members according to their functions at a scene or during an operation.

c. Other than those circumstances described above and unpredictable situations where the use of protective equipment is appropriate and reasonable as a precaution against exposure to body fluids and unsanitary, hazardous, or infectious conditions, members shall not wear protective equipment.

B. Hygiene and Cleaning.

Good personal hygiene, prompt, sanitary cleaning practices, and the proper medical care for and attention to cuts, sores, and skin conditions on one's own body, particularly the hands,. are the most important preventive measure for reducing the possibility of contracting a communicable disease through contact with body fluids. The Department therefore advocates that members:

1. Wash their hands or other affected skin thoroughly with soap and water after contact with body fluids. Careful hand washing is probably the most effective method of preventing the spread of infection, and alcohol preps are provided in each department vehicle as an interim preventive cleaning procedure.

2. Properly treat and cover cuts, sores, and skin conditions in order to avoid direct contact with body fluids. Such members shall be particularly careful in evaluating their personal need for protective equipment.

3. Use water to flush the eyes thoroughly or to rise the mouth amply if blood or other body fluids have splashed into the eyes or mouth.

4. Refer to the attached publication by the D.C. commission of Public Health, entitled "Guidelines for Handling Body Fluids," when questions arise as to cleaning procedures when members come into contact with body fluids (Attachment A).

C. Education.

1. Since members regularly come into contact with unsanitary, infectious, and other hazardous situations, it is imperative that they know the dangers they face and how to reduce the risks involved in these hazards.

2. In that light, the Department espouses the concept that the education of its personnel is the most effective means of dispelling misconceptions and fears, and commits itself to providing information that will enable members to carry out their responsibilities confidently, safely, and effectively.

3. The Department will therefore pursue a course of education and information dissemination on communicable diseases in cooperation with the Commission of Public Health and through the periodic issuance of publications to the force.

APPLICABILITY

A. To Members Who Process Crime Scenes.

With regard to processing crime scenes, the policy shall specifically apply to members assigned to:

1. The Crime Scene Examination Section, Identification and Records Division;

2. The Police Districts' Crime Scene Search Sections;

3. Homicide Branch, Criminal Investigations Division (CID)

4. Sex Offense Branch, CID; and

5. Any other unit that has occasion to be involved in the processing of scenes or handling situations where body fluids and/or contaminated materials are present.

B. To Situations and Persons.

1. Members should balance precaution with reasonableness when handling situations where body fluids are present and when exercising their option to wear protective equipment.

a. I am primarily concerned that our members are properly and reasonably protected from infections brought on by communicable diseases and unsanitary conditions. To this end, protection have been provided, and I believe they meet the needs of our members. I am also concerned, however, that we meet our responsibilities to the public by consistently providing a professional, measured response to problems that confront law enforcement, in general, and the Metropolitan Police Department, in particular. To this end, the standards established in this order focus on reasonably addressing the problems encountered in dealing with communicable disease and unsanitary conditions, and preventing abuses that tend to feed misconceptions and fears.

b. Members should be aware that the risk of contracting a communicable disease during the performance of duty is highly unlikely. This is evidenced by the face that transmission of a communicable disease from an occupational exposure is very rare among law enforcement, fire and rescue, and emergency medical personnel.

c. Members should also understand that the wearing of protective equipment conjures up certain negative connotations. The decision to wear particular items

of equipment must be based on the standards established in this order, as well as a consideration of its spirit and intent, as stated in the purpose. Unreasonable applications of the broader standards set forth in the order will not be tolerated. The wearing of equipment that is excessive and not likely to address a particular risk will similarly not be tolerated.

2. Members, especially field personnel, will approach many situations not knowing what they will encounter and therefore will on occasion not be protected with suitable protective equipment when they begin dealing with persons who are bleeding or excreting other body fluids. In the face of this kind of dilemma, however, members shall:

   a. Not shirk their responsibilities to protect life, preserve the peace, arrest criminal offenders, and perform their police duties generally; and

   b. If contact with body fluids has been made, be alert to the need for the prompt cleaning of affected body areas, once the member can be temporarily relieved of the assignment. Officials should take notice of a member who has been involved in blood or other body fluids and provide for his/her temporary relief as soon as possible to effect such cleaning.

C. To Planned Operations.

In planned operations, such as demonstrations, raids, or the service of warrants generally, the official in charge of the operation shall:

1. Consider the type of situation, and the conditions that are likely to exist in the particular situation, in determining what, if any, protective equipment should be utilized;

2. In determining the necessity for wearing or having available specific items for the operation, ensure that the selected items of equipment are consistent with the standards that are contained in this order for wearing such equipment; and

3. Be prepared to justify the reason why the selected equipment was chosen.

D. By Examples.

Below are some examples of situations and how they should be addressed:

1. In picking up a blood-stained knife from the ground as evidence, and officer should wear only the regular disposable gloves since only the hands should come into contact with the knife. In this case only the hands need to be protected. Most passive situations involving crime scenes and individuals in which body fluids are present will require the wearing of regular disposable gloves only.

2. When processing a scene where a large quantity of blood is present, it may be necessary for a crime scene search officer to wear rubber gloves and a jumpsuit in order to prevent the blood from splashing into the mucous membranes of the member's eyes and mouth.

3. The handling of a combative prisoner who is bleeding or has open sores may require the wearing of rubber gloves and a jumpsuit in order to avoid contact with the blood or other body fluid.

4. Evidence technicians should wear masks and goggles when there is danger of inhaling chemicals, powders, or other particulate matter, or of any of these substances entering the eyes.

5. Members maintaining security over a crime scene which contains foul odors may wear a mask to repel the odors.

6. In searching a vehicle, members should use extra precaution when reaching with their hands into areas hidden from view. Rubber gloves should be worn, and a flashlight should serve as a guide for dark areas.

7. Upon receipt of a radio call for a large fight in profess, members may put on rubber gloves when they expect that they may become involved in altercations on the scene. The purpose of the gloves is to prevent blood from a subject involved in an altercation from coming into contact with abrasions on the member's hands, which might be caused during the altercation. In an incident of this kind it must be emphasized that the risk of acquiring a serious communicable disease through such contact is extraordinary low.

8. In executing search warrants in drug-related cases where contact with dangerous chemicals or paraphernalia may occur, members should wear rubber gloves to avoid burns and reduce the risk of cuts or punctures.

9. At the scene of a serious traffic accident where there are large amounts of blood and other hazards, such as glass and debris, members should wear rubber gloves and a jumpsuit if there is going to be significant and involved contact with bleeding victims.

10. Searching prisoners with regular disposable gloves is a long established practice that will remain an option for members. However, because of the hazards involved in drug-related cases, such as needle sticks, special care should be taken in searching such prisoners. If a member believes that a prisoner has a syringe on his person, he/she should carefully search with rubber gloves do not have the same tactile qualities as the regular disposable gloves and the member cannot be assured that a thorough search has been performed.

PROTECTIVE EQUIPMENT

A. Protective Equipment

1. Protective Equipment Kits shall consist of:

a. A mask.

The main purposes of the mask are:

(1) To protect a member from inhaling or ingesting chemicals, powders, or other particulate matter, and from being splashed with blood or other body fluids; and

(2) To repel foul odors.

b. An apron.

The main purpose of the apron is to prevent a member's clothing from becoming soiled or splashed with blood or body fluids.

c. A jumpsuit.

The main purpose of the jumpsuit is to prevent a member from coming into general contact with large amounts of blood or body fluids, or in having to handle a combative prisoner who is significantly bleeding or covered with blood or other body fluids, or has numerous open sores on his/her person.

d. Two types of gloves:

(1) Regular disposable gloves.

The main purpose of the regular disposable gloves is to prevent the member from coming into contact, with his hands, with blood and other body fluids, and unsanitary, hazardous, and possibly infectious conditions.

(2) Rubber gloves.

The main purposes of the rubber gloves are:

(a) To prevent contact with significant quantities of blood or other body fluids; and

(b) To prevent abrasions and reduce the risk of punctures, in cases where an altercation is likely, as previously described, or when dealing with hazardous situations, such as searching in areas hidden from view.

e. Alcohol preps.

The main purpose of the alcohol preps is to provide members with an immediately available cleaning agent when contact is made with blood or other body fluids or unsanitary conditions. However, affected areas should be properly washed with soap and water as soon as possible after the contact has been made.

f. Goggles.

The main purpose of the goggles is to prevent blood or other body fluids and chemicals, powder, or other particulate matter from getting into the eyes.

g. A sealable five-gallon container.

This container houses all the items in the kit.

2. All the items in the Protective Equipment Kit, except the rubber gloves and goggles, are disposable.

3. All items of protective equipment shall be issued by the Department and are the only items which may be carried or used by members.

B. Protective Equipment Required In Vehicles and Issued to Members.

1. Protective Equipment Kits shall be required equipment in all vehicles assigned to:

a. The Crime Scene Examination Section;

b. The Crime Scene Search Sections;
c. The Homicide Branch;

d. The Sex Offense Branch; and

e. Lieutenants and Sergeants in the Field Operations Bureau and the Morals Division.

2. All other police vehicles shall be equipped with:

   a. A box of regular disposable gloves; and

   b. A box of alcohol preps.

3. Each member assigned to a patrol district, the Special Operations Division, and the Morals Division, and who routinely performs field duties, shall be issued a pair of rubber gloves for his/her use.

   a. These rubber gloves are not disposable.

   b. They should be cleaned according to the instructions provided in Attachment A, and kept for re-use.

   c. They may only be discarded if they tear or become excessively discolored.

C. Protective Equipment Required in Stations.

All stations that have booking facilities and the units within the Identification and Records Division that process prisoners and evidence shall maintain, in a location readily available for immediate use at any time of day:

1. Three (3) protective equipment kits;

2. A supply of individual protective equipment items necessary for handling situations where body fluids are present; and

3. A container of bleach.

D. Protective Equipment Required in Special Circumstances.

1. In special circumstances, such as a planned police operation, the official in charge of the operation shall ensure that an adequate supply of appropriate protective equipment items are obtained for use in the operation.

2. In special circumstances, when the availability or wearing of protective equipment is determined to be appropriate, the official in charge of the operation is authorized to equip involved members and vehicles with appropriate protective equipment.

E. Issuance of Protective Equipment Kits and Separate Items.

1. Protective Equipment Kits and individual items shall be ordered through normal supply channels.

2. In the event that the Property Division is closed and there is an immediate need for certain protective equipment items, a request for the items may be made directly to the Crime Scene Examination Section.

F. Disposing of Protective Equipment

1. When disposable protective equipment items are used, they shall be discarded in a plastic bag which shall be sealed.

2. The sealed bag shall then be placed in a second plastic bag which shall also be sealed.

3. The sealed, double bag shall then be disposed of routinely.

G. Review of Protective Equipment by the Uniform and Equipment Board.

The Uniform and Equipment Board shall:

1. Maintain a continuing review of protective equipment to ensure that the items the Department utilizes adequately protect our members and are cost-effective.

2. Be responsible for recommending to the Chief of Police any changes in the items which compose the Protective Equipment Kit.

CORRECTIONAL FACILITIES

Fresno County, California

CORRECTIONAL FACILITIES

AIDS presents correctional facilities with two specific tasks: one, the need to manage inmates within the system; and, two, the need to take advantage of an opportunity to educate inmates about AIDS. On the latter point, incarceration is a somewhat unique opportunity to educate people who are hard-to-reach on the outside, many of whom are involved in high risk activities.

Key issues confronting correctional authorities in the management of prisoners vis-a-vis AIDS are: safety of prison workers; testing of inmates; segregation of inmates; and educating personnel and inmates. All of these issues center upon the circumstance of incarceration: prisoners are held in close quarters with the potential for violent behavior against fellow inmates as well as against prison personnel. Furthermore, high risk behaviors may take place (i.e., unsafe sex, including involuntary sex; and drug use with sharing of IV drug paraphenalia).

Officials are faced with policy questions on whether or not segregation and testing of inmates are useful tools in managing AIDS in the prisons. These issues are briefly outlined below, followed by a sample inmate management policy from Fresno County, California.

- The Fresno County policy calls for segregation of AIDS/ARC patients from the general prison population for their protection against other inmates. In addition, "informed consent" testing and medical evaluation procedures are used for inmates who self-report HIV postive status or inmates who exhibit symptoms of AIDS/ARC. Inmates who show no physical evidence of disability are reintegrated into the general prison population. The policy also outlines procedures to follow in the event of exposure to patient fluid, and transporting prisoners with AIDS/ARC.

Segregation of Inmates

The policy of segregating inmates on the basis of AIDS, ARC, and HIV status is motivated by concerns over (1) preventing HIV positive inmates from infecting HIV negative inmates (through unsafe sex, prison/jail rape, drug use); and (2) protection of prisoners with AIDS/ARC from harm by the general prison/jail population. This policy is affected, in turn, by:

- the cost of segregation; and
- the adequacy of the physical plant capabilities of prison facilities to maintain dual incarcerated populations.

Testing

Routine testing of all inmates is probably beyond the financial means of most prison and jail systems. Furthermore, it is unclear, in the absence of a dual system (segregation of HIV positive inmates and HIV negative inmates) what purpose would be served by testing all inmates.

Specific situations in which testing may be desirable include:

- Testing of asymptomatic inmates who self-report HIV positive status. This provides officials with an opportunity to provide risk reduction counseling to the inmate in question.
- Testing of symptomatic inmates. The facility will thus be prepared in dealing with the medical needs of the inmate.

All testing of inmates should be accompanied by pre- and post-test counseling, including counseling inmates to not reveal their status to fellow inmates.

Education of Inmates and Staff

Education provided to inmates and staff should include: definition of AIDS, its cause, how AIDS is transmitted, how AIDS is not transmitted, risk reduction methods. For staff, education should additionally discuss protective measures to undertake in various situations: transport of inmates, handling of disruptive inmates, responding to trauma situations, custodial procedures, clean-up of blood spills, and reporting of possible exposure incidents.

Memorandum

February 10, 1988

TO: Philadelphia Prisons
FR: Philadelphia Department of Public Health
RE: Prison AIDS Protection Policy

The Department of Public Health recommends that the Philadelphia Prisons institute a comprehensive AIDS protection plan. It is essential to the health of the entire community as well as to inmates that prisons do not become a locus for acquiring or spreading AIDS. The City of Philadelphia is responsible for protecting the health of inmates. Moreoever, it is important to assure that persons released from prison do not become a source of infection to the communities to which they return. Currently, persons who are at highest risk of acquiring AIDS are young members of poor minority groups. Members of these groups also constitute the overwhelming majority of incarcerated persons.

A comprehensive AIDS protection plan must include the following components:

1. AIDS education programs which stress transmission routes. All prisoners should be given information that AIDS is spread through body fluids, specifically semen and blood. These programs must explain the dangers of unprotected sex.

2. Prisoners should have access to condoms and to disinfectants for needles.

3. Anonymous HIV testing and counseling should be available to all prisoners. HIV testing, when accompanied by counseling, has been demonstrated to be an effective educational tool.

4. Treatment services should be available for inmates who have AIDS or AIDS-related conditions. The prison Health Services Unit has established AIDS treatment services to assure that inmates receive care during their incarceration.

The Philadelphia Department of Public Health will, of course, assist the Prisons in developing and implementing a comprehensive AIDS protection program.

FRESNO COUNTY, CALIFORNIA

DEPARTMENT OF HEALTH SERVICES

INMATE MANAGEMENT MANUAL FOR AIDS/ARC/HIV

Department of Health Services
Detention Facilities
AIDS/ARC/HIV Patient Management
Policies and Procedures

1. SUBJECT: Overview of AIDS and ARC.

SUMMARY: Definition, transmission—including symptoms and prognosis.

DEFINITION: Acquired Immune Deficiency Syndrome (AIDS), and AIDS Related Condition (ARC), are caused by a virus, HIV, which weakens the immune system of the body and permits development of rare cancers and opportunistic infections.

TRANSMISSION: AIDS/ARC has a transmission pattern similar to hepatitis B, through sexual contact or by sharing blood products through contaminated needles, transfusions, or receipt of blood products.

AIDS is not transmitted by casual contact. There is no risk in touching or being around a person with AIDS, ARC, or individuals who are HIV positive. The vast majority of person have contracted the disease sexually or by way of intravenous blood contact.

INCUBATION: The incubation period is six (6) months to five (5) years, but there may be a longer period of time during which an infected individual may not experience symptoms but can transmit the virus. **It is estimated that many persons currently infected with the virus may be asymptomatic carriers.

SYMPTOMS: Initially persons infected with the HIV virus have no symptoms. Blood tests at this time may reveal HIV antibodies and may show a defective immune system. The first symptoms of disease may be:

a. low grade fever
b. fatigue
c. weight loss
d. swollen glands
e. diarrhea
f. night sweats
g. seborrheic dermatitis

PROGNOSIS: Only 14% of persons with AIDS have survived more than three years after diagnosis; half of them will die within one to two years. There is no current treatment for AIDS, outside of treating the opportunistic infection.

2. SUBJECT: HIV Antibody Testing.

SUMMARY: Testing of asymptomatic and symptomatic individuals, pre-test and post-test counseling.

HIV Antibody Testing for Symptomatic Individuals

1. Complete social and medical history must be taken to enable the medical staff to fully assess the inmate.

2. Even though medical personnel feel that an HIV antibody test is indicated, to be used in conjunction with other diagnostic tools, the inmate must sign an "informed consent." Education and information regarding possible outcome must be given prior to specimen collection.

3. Medical assessment relating to AIDS/ARC/HIV must be protected in the medical record as outlines in Attachment 2.

4. Inmate who is still in custody must be advised of test results with follow-up information and education given regarding the results, transmission and prevention.

5. If test results are negative, however, the inmate is exhibiting signs of illness, the individual should be isolated until further medical assessments can be done, i.e., Valley Medical Center. Blood/body fluid precautions (see Attachment 6) should be followed until otherwise indicated.**

** Currently it is estimated that 6% to 15% of all persons tested, may be antibody negative, antigen positive.

6. If the test results are positive and the inmate is exhibiting symptoms of AIDS/ARC, the inmate should be isolated and blood/body fluid precautions should be followed. Further medical evaluation should be done to determine diagnosis and/or treatment (Attachment 7).

7. If the inmate receives a diagnosis of AIDS/ARC, a report must be made to the Fresno County Department of Health, Marilyn Mitchell at (209) 445-3434.

Isolation is recommended to enable medical staff to monitor the inmate and to protect the inmate from physical harm. Movement of these individuals, i.e., family, attorney visits, court appearances, should be done in a manner to protect the inmate from the general population.

3. SUBJECT: Management of HIV antibody positive with AIDS or ARC.

SUMMARY: Inmate placement, medical evaluation, precautions, and inmate movement.

Management of Inmates Who Test Positive for HIV Virus If an individual discloses at the time of booking that he or she has been tested for AIDS via HIV antibody testing with positive results, the booking officer should notify jail medical staff. The medical staff should place the inmate in isolation for blood/body fluid precautions until the next sick call.

At the soonest available time, the inmate should be evaluated by a clinician for a history and physical workup. If there is no evidence of physical disease, the inmate should be placed into the general population and cautioned not to share results with anyone for his or her own protection.

Management of Persons with ARC At the time of booking, if the individual discloses that he or she has a diagnosis of AIDS Related Condition (ARC). the procedure shall be the same as outlined in AIDS management. However, these individuals should be placed in isolation areas separate from persons with AIDS and blood/body fluid precautions followed to protect both patient and staff.

For the inmate who is diagnosed with ARC while in custody, the procedure again is the same as for the person with AIDS. Designated isolation area will be 2C or 2D area.

The ARC patient should be given information and education about medical status, ARC, e.g., transmission and risk reduction strategies, and be advised of appropriate support services.

Management of Person with AIDS If an individual discloses, at the time of booking, that he or she has AIDS, medical staff should be notified to evaluate the patient. If the inmate is found to be in distress due to AIDS illness, the inmate should be transported to the appropriate medical facility for evaluation.

If the medical staff finds no evidence of current medical problems, the individual should be placed in isolation and scheduled for sick call as soon as possible. The designated isolation units will be 2D or 2C area. Normal blood/body fluid precautions should be taken to protect both the patient and staff. **NOTE: Persons with AIDS are not to be isolated with persons with ARC.

Efforts will be made by medical staff to confirm this diagnosis by calling the Public Health Investigator at 445-3434. After evaluation and consultation, if no confirmation of diagnosis can be made, and there is no medical evidence of disease process, inmate should be removed from isolation and transferred to the general population.

For the inmate who receives a diagnosis of AIDS while in custody, normal isolation blood/body fluid precautions will be followed. Inmate should be transferred to 2D or 2C area.

All inmates with AIDS should be cautioned by the designated clinician not to disclose their diagnosis to fellow inmates or correctional staff for his or her own protection.

All inmates with AIDS will be given information and education regarding AIDS. e.g., transmission and risk-reduction strategies and offered support services for themselves and/or family members.

Medical staff should follow strict confidentiality guidelines and be reminded not to share this information with correctional staff.

Jail Movement of Persons with AIDS or ARC Persons with AIDS or ARC should be managed separately from the general population in regard to visit with attorneys, family, etc., and should be transported to court or medical appointments apart from other inmates.

This is done to protect the inmate from potential physical harm by other inmates, rather than to protect others from them.

4. SUBJECT: Puncture would and/or patient fluid exposure and isolation procedures.

SUMMARY: Procedures and criteria for reporting exposures, cleanup of spills and management of infective material.

POLICY: A Supervisor's Investigation Report (Attachment 8) will be completed on all puncture wounds or patient fluid exposures and will be consistently evaluated for treatment by Detention Facility medical staff.

PURPOSE: All employees who receive accidental puncture wounds or exposures will notify their supervisor and initiate an investigation report identifying the circumstances, the object involved (glass, needle, etc.) and prior contaminating source such as urine, blood, etc., (naming patient, medical record number, and attending physician).

The employees incident would be classified in one of the eight following groups:

1. Clean or sterile puncture, i.e., sterile needle, clean towel clip:

    a. No lab studies needed.
    b. Scrub with Providone-iodine solution for five minutes.

2. Contaminated exposure, no patient fluids, unknown source, i.e., broken glass:

    a. No lab studies.
    b. Scrub with Povidone-iodine solution for five minutes.
    c. Check for tetanus update, if more than ten years, immunize.

3. Contaminated exposure to patient fluids/puncture wound unknown source, e.g., high risk area, patients with liver disease or recently transfused or dialyzed or contaminated exposure from needle box or trash exposure:

    a. Determine employee's HBsAG status.
    b. Scrub with Povidone-iodine solution for five minutes.
    c. Evaluate employee's tetanus history.
    d. If not previously immunized, encourage employee to receive the HBIG.
    e. Recheck HBsAG in three months.

4. Contaminated exposure to patient fluids, known patient source but with unknown hepatitis history:

    a. Determine patient's HBsAG status.
    b. Determine employee's HBsAG status if patient source but with unknown hepatitis history:
    c. Scrub with Povidone-iodine for five minutes.
    d. Evaluate employee tetanus history.
    e. If patient HBsAG positive and employee HBsAG negative, give HBIG according to package insert within seven days, and encourage hepatitis B vaccine. If vaccine refused, second dose of HBig in 30 days.
    f. If patient testing all negative then no medication or follow-up for employee.

5. Contaminated exposure to known patient source, known hepatitis B positive:

    a. Determine employee's baseline HBsAG status.
    b. Scrub with Povidone-iodine for five minutes.
    c. If not previously immunized, encourage hepatitis B vaccine series to exposed employee.
    d. Evaluate tetanus history.
    e. Then give HBIG according to package insert within seven days and repeat in 30 days if employee refuses hepatitis B vaccine.
    f. If vaccine is refused, repeat employee HBsAG three months and six months following exposure.

6. Contaminated exposure to known patient source, known hepatitis B negative, employee who has history of positive HBsAG three months and six months following exposure.

    a. No lab studies.
    b. Scrub with Povidone-iodine solution for five minutes.
    c. Check for tetanus update, if more than five years, immunize.

7. Management of contaminated parenteral (needle stick or cut) or mucous membrane (splash to the eye or mouth) exposure to blood or other body fluids from patient source with unconfirmed Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) diagnoses:

    a. Scrub skin areas with povidone-iodine solution for five minutes. Rinse exposed eye and/or mouth tissue with either available isotonic saline solution or running water immediately for

five minutes.

b. Assess the source patient clinically and epidemiologically through the Hospital Physician Epidemiologist and the patient;s primary physician to determine the likelihood of HIV infection.

c. If the assessment of the patient source suggests that infection may exist, the patient shall be informed of the incident and request to consent to serologic testing for evidence of HIV infection.

d. If the source patient is seronegative and has no other evidence of HIV infection, no further follow-up for the employee is necessary.

e. If the source patient cannot be identified, the Employee Health Physician and the Hospital Physician epidemiologist will make decisions regarding appropriate follow-up individualized based on the type of exposure and the likelihood that the source patient was infected.

f. If the source patient has AIDS or other evidence of HIV infection, declines testing, or has a positive test, the employee shall be evaluated clinically and serologically for evidence of HIV infection as soon as possible (within 10 days) post-exposure by the Employee Health Services (EHS).

g. If the employee is seronegative on the initial test, retest after 6 weeks, 3 months, 6 months and 12 months following exposure to determine if transmission has occurred. If seropositive, no further testing will be required.

h. Exposed employees shall receive counseling by the EHS regarding risk of infection and follow U.S. Public Health Service recommendations for preventing transmission of AIDS.

i. If employee seroconversion occurs, EHS will conduct further case monitoring.

8. Management of contaminated parenteral (needle stick or cut) or mucous membrane (splash to the eye or mouth) exposure to blood or other body fluids from patient source with confirmed AIDS or ARC diagnoses:

   a. Scrub skin areas with Povidone-iodine solution for five minutes. Rinse exposed eye and/or mouth tissues with either available isotonic saline solution or running water immediately for five minutes.

   b. The employee shall be evaluated clinically and serologically for evidence of HIV infection as soon as possible (within 10 days) post-exposure by the Employee Health Services (EHS).

   c. If the employee is seronegative on the initial test, retest after 6 weeks, 3 months, 6 months, and 12 months following exposure to determine if transmission has occurred. If seropositive, no further testing will be required.

   d. Exposed employees shall receive counseling by the EHS regarding risk of infection and follow U.S. Public Health Service recommendations for preventing transmission of AIDS.

   e. If employee seroconversion occurs, EHS will conduct further case monitoring.

NOTE:

In general, all puncture wounds should receive vigorous cleansing and the person should be instructed to seek medical care at the first sign of bacterial infection. Although there is very little risk of tetanus associated with needle stick injuries, the person;'s tetanus immune status should be ascertained; if inadequate, prophylaxis may be provided. Tetanus toxoid should suffice in most instances. For those rare documented stick exposures to other potentially transmittable diseases, such as active syphilis or acute malaria, prophylaxis can be decided individually or in consultation with an infectious disease specialist. It is unnecessary to provide routine antibacterial prophylaxis for puncture wounds from needles used in patients with bacterial sepsis, the risk of transmission of infection is extremely low. It is far more likely that those rare bacterial infections originating form needle stick injuries derived from inoculation of the person's own skin flora into the tissues at the time of the needle stick.

COMMUNICABLE DISEASE
ISOLATION PROCEDURES

NAME:_____ LOCATION_____

REASON FOR ISOLATION:_____

I. Cleaning the Cell

a. Inmate should be given a plastic bag for all trash.
b. Inmate is responsible for sweeping and general cleaning of cell.
c. Trash should be collected daily.
    1. Officer should take large plastic bag and hold it open.
    2. Inmate should drop his trash bag into open bag.
    3. Tie outer bag and dispose of in regular trash.

II. Feeding

a. Use only paper plates and cups and disposable utensils.
b. After use, inmate should place all leftover food, plates, cups and utensils in the plastic trash bag.

III. Laundry

a. Inmate should be given a special dissolvable plastic laundry bag which can be obtained from either the Clothing Room or Infirmary.
b. Inmate places soiled clothing into this special bag.
c. Officers hold open a large, regular plastic bag.
d. Inmate places special dissolvable bag into bag officer is holding.
e. Officer ties bag shut.
f. Officer labels outside of bag "Isolated Laundry".
g. Clothing Room staff opens outside bag and without touching the inside bag, drops the inside bag into the washer (hot water will dissolve the bag).

IV. Showers

a. Inmate should be allowed to shower according to cell schedule.
b. No special cleaning of shower area is required.

V. Phone

a. Inmate should be allowed to use telephone per cell schedule.
b. No special cleaning of shower area is required.

VI. Isolation cell is to be scrubbed down with bleach upon release of inmate from isolation.

VII. Inmate is able to attend:

a. Court
b. Interviews
c. Visiting (Non-contact)

Health Care Workers

New York City, New York

HEALTH CARE WORKERS

Medical protocols are commonplace for health care workers in dealing with infectious situations (e.g., Hepatitis B). AIDS, however, made clear the degree to which procedures were not being followed. Thus, reappraisals of existing procedures have included the re-education of employees about adhering to proper techniques.

A fundamental basis for review of health care worker policies has been adoption of "Universal Blood and Body Substance Precautions," under which health care workers utilize barrier precautions (e.g., gloves, masks) when contact with blood or other body fluids is anticipated. This policy differs from protocols based upon diagnosis of the patient; the latter is inadequate in dealing with HIV given that patients may be HIV infected and yet show no signs or symptoms of illness.

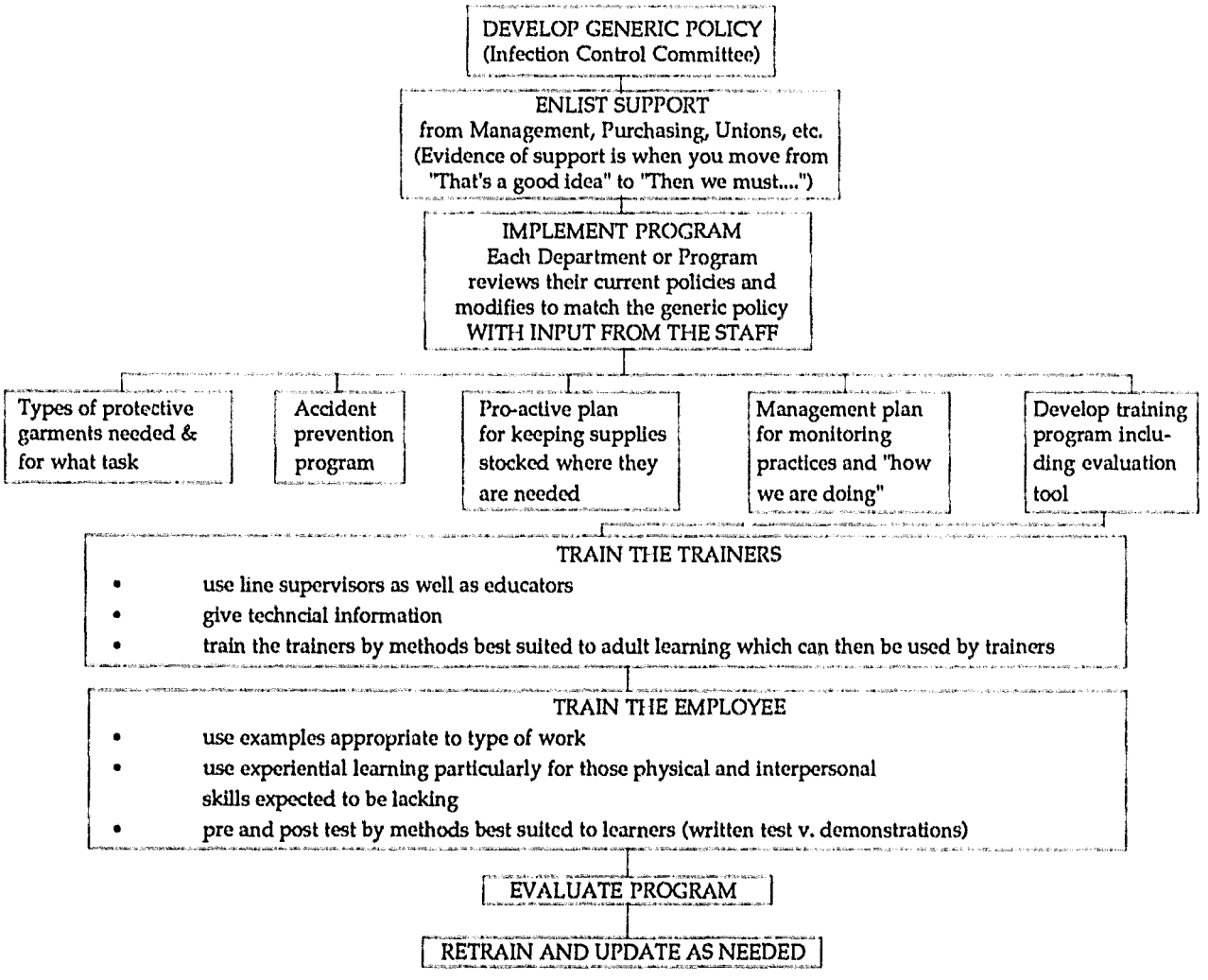
AIDS-related policies for health care workers deal with protective measures to follow when dealing with blood and body fluids, including: use of gloves, disposal of needles, clean-up of spills, reporting of possible exposure incidents, and ongoing education of workers. Following is a reprint of the New York City Health Department Infection Control Policy, adopted April 1988.

Implementing Body Substance Precautions in a Health Care Facility

A model for increasing employee safety and decreasing AIDS anxiety while preserving quality health care

Grace Lusby, RN, MS; Infection Control Coordinator, San Francisco General Hospital

A major step in reducing AIDS anxiety has been taken when the employee increases his/her control over work conditions by being allowed an opportunity to have constructive input into the implementation of Infection Control practices.



CITY OF NEW YORK

DEPARTMENT OF HEALTH
INFECTION CONTROL POLICY

MARCH 30, 1988

I. INTRODUCTION

Purpose and Use of the Policy

This Manual is designed to help Department of Health employees protect themselves and their patients from the risk of infection in the workplace. It is promulgated as an Executive Order of the Commissioner of Health, meaning that it is the Department's official policy and must be observed under all circumstances. This Policy conforms to guidelines set by the Federal Centers for Disease Control and to State and local laws. It represents the "state of the art" in its field and provides a single standard of practice.

Concerns about implementing this service order which are not satisfactorily addressed by the immediate supervisor should be brought to the attention of the Infection Control Coordinator for the site in question. Normal Agency procedures should be followed to resolve any grievance or disciplinary issues.

Following these basic safety guidelines will minimize direct and indirect exposure of health care employees to potentially infectious agents, such as human immunodeficiency viruses (HIV) and hepatitis. DOH employees working in clinical, field or laboratory settings should read this document carefully and use it as a reference. It contains standard precautions for use in daily activities and guidelines for handling accidents and emergencies.

For more specific guidance, each clinical service and program will maintain a written protocol, specific to its own program, carrying out the policies in this document. These protocols and any revisions to this policy will appear as service orders.

Under the impact of the AIDS epidemic, some previously accepted guidelines and precautions have changed markedly. This Department has joined other health authorities in adopting the policy that all blood and bodily fluids must now be considered as potentially infectious. This Manual reflects that assumption. Employees should follow all recommended procedures in order to ensure a safe workplace. Adhering to proper infection control procedures is the responsibility of every Department of Health employee. Disregarding them can jeopardize not only one's own health but the health of co-workers and patients.

II. SUPERVISION AND MONITORING OF INFECTION CONTROL PRACTICES

Program Responsibility. Each program will be responsible for implementing this Policy in the context of its own operations. The Program Director or a designee will coordinate the program's infection control protocol, monitor compliance internally, ensure that materials required for infection control are available, and represent the program with respect to infection control matters. Employees at each site must know who their infection control coordinator is and how to contact him or her. Backup personnel must be designated to assume these responsibilities in the absence of the infection control coordinator.

Health Service Managers. The Health Service Manager for each Health District will be responsible for routine cleaning and appropriate disposal, storage and removal of waste within each District.

Bureau of Laboratories. In addition to developing its own internal infection control protocol, the Bureau

of Laboratories will establish protocols for all field laboratories. The Bureau of Laboratories will also be responsible for ensuring the proper functioning of autoclaves at all sites.

Agency-wide Monitoring. The Division of Medical Affairs will have final responsibility for quality assurance regarding infection control. Medical Affairs will establish procedures to conduct regular monitoring of infection control compliance and will help resolve any conflicts which cannot be resolved by the program's infection control coordinator. A separate service order will outline Medical Affairs procedures for infection control monitoring.

III. PREVENTIVE PRACTICES

A. Procedures and precautions in clinical settings

1. Handwashing

Handwashing is among the most basic and important infection control procedures. The purpose of handwashing is to remove transient bacteria and other pathogens passed between patient and staff or acquired from contaminated surfaces. Accordingly, hands should be washed thoroughly with soap both before and after each patient contact, even when gloves are used.

a. Soap - Because most transient bacteria and other pathogens are easily removed by the mechanical action of thorough handwashing, standard soap is sufficient.

b. Handwashing technique - Hands should be washed immediately and thoroughly before and after each patient and after gloves are removed. Care must be taken to soap and rinse all parts of both hands, including the wrists.

c. Skin contamination - Care must be used to avoid hand injuries during procedures. If any skin comes in contact with blood or body fluids, the area must be washed thoroughly. DO NOT SCRUB VIGOROUSLY, as this may damage the skin, increasing the possibility of infection. If gloves are torn, cut or punctured, they must be removed immediately. Hands must be thoroughly washed and then regloved.

d. Skin care - Caution must be exercised in providing patient care when any break in the skin is present. If there is any doubt regarding a skin condition, gloves should be worn. The daily use of hand lotion is recommended to prevent chronic dry skin due to repeated handwashing.

2. Protective Clothing/Barriers

a. Gloves - Gloves must be worn when there is the potential for contact with blood, saliva, bodily fluids, mucous membranes or non-intact skin of any patient, and particularly when drawing blood. Gloves must be changed after every patient contact. Employees who will have contact with patients and have non-intact skin on their own hands must wear gloves, and may want to consult their supervisor.

Non-sterile gloves are adequate for all procedures provided in DOH clinics. Standards for use of gloves for particular procedures are specified in each program protocol.

b. Face masks - Face masks should be used for procedures that are likely to generate aerosols or a splatter of blood or bodily fluids. Standards for use of masks in particular procedures are specified in each program protocol.

c. Protective eyewear - Protective eyewear or face shields should be worn during procedures that generate aerosols or splatter blood or other bodily fluids. Eyewear should be cleaned frequently to keep lenses clear.

d. Clothing - Reusable lab coats or disposable gowns must be worn when clothing is likely to be soiled with blood or other body fluids. Gowns which fasten at the back offer the best coverage. Gowns/ coats should be changed at appropriate intervals, or when visibly soiled with blood. They are not to be worn outside the clinic area.

Appropriate protective clothing worn during clinical procedures should continue to be worn until all potentially infectious waste has been properly disposed of an requires no further handling. No procedure or series of procedures is complete until this protective clothing has itself been properly disposed of in waste or laundry receptacles.

3. Waste Disposal

The proper handling and disposal of wastes is essential to infection control. The procedures below must be observed and enforced.

a. Biological wastes include body secretions and excretions, exudates, drainings or suctionings. These include blood and blood by products, saliva, urine, and feces, and small quantities of such wastes contained in other disposables such as gauze, tissue, diapers and cotton. Such wastes should be handled with care and put in black bags for incineration. Any tubes with blood should be autoclaved before disposal into black bags. If no autoclave is available, liquids should be flushed away in the sewer system and the tube should be placed in a sharps container.

b. Excess vaccines or serums should be returned to the manufacturer. If opened or partially used, they should be autoclaved on-site and put in black bags. If no autoclave is available, such items should be placed in red sharps containers, which must then be sealed whether or not they are full.

c. Pathology wastes include human tissues and anatomical parts and are produced in the Medical Examiners' facilities and in dental clinics. Tissue samples and extracted teeth should be autoclaved and disposed of in black bags for incineration. Extracted teeth may also be placed in a sharps container as an alternative.

d. Laboratory waste includes all clinical specimens and supplies (slides, smears, etc.) used in performing laboratory tests. These wastes should be placed in bags designated for autoclaving and should be autoclaved at appropriate intervals. After it is autoclaved, custodial staff will rebag in black bags and transport it to the secure area designated as a pickup site for black-bag waste by the City Department of Sanitation. In the absence of a working autoclave, it is acceptable as an interim measure to place laboratory wastes in a sharps container.

e. "Sharps" (needles, scalpel blades, other sharp instruments) should be considered potentially infectious and must be handled with great care to prevent unintentional injuries during procedures, cleaning, disposal and all other handling after procedures.

Disposable syringes, needles, scalpels, blades and other sharp items should be placed into DOH-approved red puncture-resistant containers located as close as practical to the area in which they are used. To prevent needlestick injuries, disposable needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. When no more than two-thirds full sharps containers should be capped and brought to a designated secure area from which they will be collected by a licensed private carter.

All sticks should be reported immediately to the supervisor. See detailed instructions in the attached Needle Stick Protocol (Appendix A-Executive Order #54).

f. Within any clinic setting, covered waste receptacles must be placed in any area where there is direct patient contact. Waste receptacles will be lined with black plastic bags. Wastes (other than sharps) wil be collected and disposed of at the end of each session of patient care and at the end of the day. Designated as hospital waste, these will be collected by the City Sanitation Department and incincerated. Receptacles should not be allowed to overflow. If the bag is filled to capacity, it

should be replaced and disposed of by designated personnel.

4. Regular Daily Cleaning

Instruments - Resusable instruments must be carefully scrubbed free of debris using detergent prior to disinfection. After the instruments are disinfected, they must be rinsed with water and sterilized. Protective gloves, mask and eyewear must be worn during this process.

Surfaces - Exposed surfaces should be disinfected aftr each work shift. Visible splatter should be disinfected immediately.

Floors - Floors should be swept clean and mopped with a 10% bleach solution each week.

Disinfection destroys pathogenic organisms but not spores. Disinfectants are used in two ways: SURFACE DISINFECTION is accomplished by applying a disinfectant solution to an environmental surface (e.g., cabinet top) and IMMERSION DISINFECTION is accomplished by submerging instruments in the disinfectant solution for a prescribed period of time. To assure the appropriate use of a disinfectant, the manufacturer's instructions must be carefully followed. Disinfectants must not be mixed with other cleaning agents such as ammonia.

Sterilization neutralizes bacteria, viruses and spores. Reusable instruments must be sterilized. The most common methods are steam autoclaving, dry heat sterilization, and pressurized chemical vapor sterilization. All instruments must be placed in dated packs or sterilizing bags. The use of indicator tape will verify that instruments have been elevated to prescribed temperatures. Biological spore monitors are used to demonstrate that sterilization has occurred and are the only accurate test for sterilization. Spore monitoring must be done weekly under the supervision of the Bureau of Laboratories and records must be maintained for each sterilizer.

5. First Aid - CPR

Disposable mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas where the need for emergency resuscitation may occur.

6. Food

Food must not be stored or eaten in clinical and laboratory areas. Refrigerators and freezers used for drugs or clinical specimens must never be used for food storage. Hands must be washed before and after eating.

B. Procedures and precautions in field settings

In general, all procedures applicable to the clinic setting are desirable in the field. When necessary facilities are lacking, the best possible approximation to clinic procedures must be made. Program-specific protocols must be followed when conducting procedures and handling waste. Where specimens are collected, equipment and methods specified under III.D., "Packaging and Transportation of Specimens" will be observed.

1. Handwashing

Whenever possible, field staff should attempt to use soap and water for routine cleaning before and after each patient contact. When a sink is not available, field staff should use towelettes to wash hands before and after each patient contact and after contact with potentially hazardous material. Use towelette to wet hands and wrists thoroughly. Do not re-use towelette.

2. Protective Clothing/Barriers

Gloves should be used whenever a field procedure is to involve skin puncture or mucosal contact. Other

protective equipment, such as masks, coats or uniforms will be issued to field staff as needed.

If clothing becomes soiled with blood or bodily fluids, flush area immediately with soap and water. If these are unavailable, use towelettes and/or alcohol preps.

3. Procedures for Handling Sharps

Sharps protocols should be followed as in the clinic setting. A red sharps container will be provided to staff conducting phlebotomy or similar procedures in the field. The container should be dropped off at the nearest DOH clinic for storage at the end of the day. It should be dropped off for disposal when 2/3 full.

The Needle Stick Protocol is to be followed in field settings as well as in clinic settings (see Appendix A - Executive Order #54).

4. Waste Disposal

Alcohol preps, cotton balls, towelettes and other items used in patient contacts as well as disposable gloves and protective garments should be disposed of in a black plastic bag provided to field staff for this purpose. This bag should be disposed of at the nearest available DOH site (e.g., a District Health Center) as soon as practicable. Sharps should be disposed of in a portable sharps container.

C. Procedures and precautions in the laboratory setting

Laboratory settings include the Bureau of Laboratories itself and the field sites throughout the Department in which laboratory procedures are conducted. The Bureau of Laboratories will oversee infection control in its own building as well as in outlying sites.

1. Laboratory Access

Laboratory work areas are restricted to authorized personnel specified in the program-specific protocol.

2. Handwashing/Personal Hygiene

All personnel must wash their hands following the completion of laboratory activities and the removal of protective clothing, and before beaving the laboratory. Procedures for handwashing in a clinical setting should also be observed in the laboratory setting.

3. Clothing

Protective clothing must be worn by all staff involved in laboratory work. Protective clothing is to be worn only in the laboratory setting and only during working hours, not in common service areas, lunch facilities or outside the work area.

a. Laboratory coats/gowns may be either disposable or made of fabric. Disposable gowns must be discarded daily in black bags. Fabric coats must be changed at appropriate intervals, or when visibly soiled. Soiled coats are to be autoclaved prior to laundering.

b. Gloves should be used when handling any clinical specimen. Auxiliary staff involved in specimen handling, cleanup and laboratory preparation must also wear gloves.

c. Face Masks must be worn when procedures create the potential of an aerosol (e.g., removal of stopper from tube containing body fluid, dilution of clinical specimens, homogenization of specimens). Masks purchased by DOH will meet federal standards.

d. Eye Protection Devices (goggles or face shields) are to be used in addition to masks, when a prcedure may create an aerosol, in the absence of an approved biosafety cabinet.

4. Work Areas

a. Biosafety cabinets (class I or II) should be used whenever procedures/manipulations are conducted that have a potential for creating aerosols (i.e., removing stoppers from tubes containing blood or other body fluids, dilution and inoculation of clinical specimens, homogenization of specimens, etc).

Wearing a mask and face shield or goggles is an appropriate alternative if a biosafety hood is not available. Chemical exhaust hoods are not comparable to biosafety hoods. Accordingly, sera and blood specimens should not be placed in chemical hoods.

b. Each work area (biosafety cabinets and benchtops) should be supplied with a wash bottle containing a freshly prepared disinfectant. The work area must be cleaned and wiped with the disinfectant at the beginning and end of each day's work and as spills and/or contamination occur.

5. Specimen storage

All specimens for refrigerated or frozen storage must be placed exclusively in refrigerators or freezers bearing the biohazard symbol prominently displayed. Such facilities must never be used for food or beverages.

6. Equipment Utilization

It is extremely important for supervisors to be certain that persons moving between various laboratory settings becomre fully acquainted with all infection control standards relevant to all equipment they may encounter in each setting.

a. Sharps. All "sharps" (needles, scalpel blades, other sharp instruments) should be considered potentially infective and must be handled with great care to prevent unintentional injuries during procedures, cleaning, disposal or other handling.

b. Pipetting Devices. Mouth pipetting is prohibited. Mechanical pipetting devices must be used for the manipulation of all liquids. Automatic pipettes with disposable plastic tips or pipettes with rubber bulbs are to be used for fluid transfers.

Contaminated pipettes must not be placed on the laboratory bench; they should be placed gently in a flat discarad pan filled with 10% Clorox solution and should subsequently be autoclaved. Any rubber bulb that may have become contaminated internally during use should be disinfected and discarded with laboratory waste.

c. Hematofluorometers, Microscopes, etc. Equipment using fresh blood preparations should be swabbed immediately after use with a 10% Clorox solution. Slides should be deposited in pans containing 10% Clorox solution for at least 30 minutes.

d. Homogenizers, Vortex's, Sonicators, etc. Equipment used to concentrate or purify biologic materials must be used in a class II biosafety cabinet. (This class of equipment is used only in central laboratory sites.)

e. Traps. When biological liquids or cells are aspirated the primary container and secondary backup trap must contain a freshly prepared 10% Clorox solution to provide decontamination. The traps must be autoclaved either weekly or when the primary trap is half full.

f. Centrifuges. Safety cups must be used during centrifugation. Following centrifugation, tubes should be opened in a biosafety cabinet or with appropriate protection from mask and goggles. If a tube breaks in the centrifuge, the bucket containing the spilled blood and broken glass should be placed carefully in a pan of disinfectant. The surfaces of the cetrifuge head, bowl, trunnions and

remaining buckets should be swabbed with a disinfectant or autoclaved.

Microhematocrit Centrifuges and bloodbank serofuges should be cleaned daily with a disinfectant.

The top of the centrifuge should always be closed when the unit is in operation, and the top of the centrifuge should not be opened until the unit has come to a complete standstill.

Centrifuge tubes to be used in an angle-headed centrifuge must never be filled to the point that the liquid is in contact with the tip of the tube when it is placed in the rotor.

g. Flourescent activated cell sorters generate droplets that could result in infectious aerosols. Translucent plastic shielding between the droplet collecting area and the equipment operator should be used to reduce this risk.

h. Automated biosassay equipment presents potential risks, particularly in the handling, preparation and delivery of specimens to the automated equipment. Tubes must be capped until insertion into the automated system, at which time the caps are removed under a biosafety hood. Plastic tubing or glass containing blood should be cleaned and disinfected periodically during the day's work. Protective clothing must be worn at all times by the operators of the equipment. If blood or serum is collected in a reservoir, it should be autoclaved before disposal.

7. Waste Disposal

Wastes generated in DOH laboratories should be disposed of in bags designated for autoclaving, and should be autoclaved at appropriate intervals. Custodial staff will then transport it to the secure area designated for pickup by the City Department of Sanitation. Sharps are the only items to be handled differently from above.

Appropriate protective clothing worn during waste removal procedures should continue to be worn until waste requires no further handling. The procedure is not complete until this protective clothing has itself been properly disposed of.

8. Regular Daily Cleaning

a. Routine Disinfection. Common areas such as table/bench tops, worktrays, instruments, telephones etc must be disinfected at the conclusion of each work shift. A fresh daily preparation of 10% bleach (sodium hypocholite) is recommended. A working solution of bleach may be prepared by mixing one-half quart of household bleach with one gallon of water. The mixture should be kept in a tightly capped inert container. A 2% dilution of glutaraldehyde may also be used.

A disposable cloth or towel heavily dampened with disinfectant may be used to wipe these working surfaces. After areas are air dry, an alcohol saturated towel may be used to remove residual sodium hypocholorite crystals from the surface. Unused bleach solution should be discarded at the end of each day.

Floors should be swept clean and mopped with a 10% bleach solution each week.

b. Sterilization. All reusable instruments will be sterilized following use. Sterilization may be accomplished either by steam autoclaving or by dry heat. Dry heat is the preferred choice for instruments and syringes. Indicator tapes and ampules must be used to insure adequate sterilization.

D. Packaging and Transportation of Specimens

When handling or transporting specimens infection control measures consist of secure packaging, appropriate labeling and warning, and careful handling.

1. All specimens

   a. All specimens must be carefully packed in sturdy, closed containers (e.g., polyfoam or equivalent).
   b. Petri dishes are to be transported in polyfoam or equivalent petri dish carriers.
   c. Outer containers should be clearly marked with laboratory/clinic destination and biohazard status.

2. Cultures

   a. Cultures of etiologic agents (e.g., M tuberculosis) should be transported in a double mailing container with a biohazard label and the appropriate laboratory designation.
   b. Each TB sputum bottle is to be placed in a special 2-pouch plastic bag with teh biohazard label clearly visible. One pouch contains/seals the bottle; the other pouch contains the laboratory request form, to avoid contamination.
   c. Other types of multiple cultures, throat swabs in transport medium, vaginal swabs, etc. should be inserted in a protective polyfoam sleeve, rubber banded, then inserted into manila envelopes with a biohazard label and the appropriately labeled laboratory request form.

3. Blood Specimens

   a. Packaging. To prevent or minimize the possibility of breakage or leakage, tubes containing blood should be transported in leakproof secondary containers (polyfoam containers or equivalent). Several tubes may be transported in a single mailer. Alternatively, tubes can be placed in cardboard secondary mailers or sturdy plastic bags with a separate pouch for the specimen and request form. All containers must bear the biohazard and blood symbols. Tubes will not be accepted unwrapped or in conventional envelopes.

   b. Transportation. From 9AM to 5PM, blood specimens brought to the Bureau of Laboratories should be delivered to room 136 of the Bureau of Laboratories. After 5PM, specimens should be hand delivered to room 110, which has a refrigerator bearing the biohazard symbol. Refrigerators and incubators in all DOH sites shall bear the biohazard symbol.

4. Spills: Equipment, Procedures and Reporting

When specimens are packaged according to the guidelines above, staff transporting them do not need to wear any special clothing or protective equipment. Specimens should not be accepted for transportation from the originating site unless they are properly packaged.

In case of breakage or a spill in transit, protective clothing and equipment will be available for transportation staff. Cleanup procedures described in Section IV below should be followed. In addition, the incident should be reported to the Transportation Office.

IV. HANDLING ACCIDENTS AND EMERGENCIES

Accidents and emergency situations must be anticipated as much as possible. This can be achieved by placing appropriate equipment in sites (including vehicles transporting specimens) where it may be needed, training staff in emergency procedures, and ensuring that suitable emergency instructions (i.e., this Policy and implementing protocols) are immediately available for review. Staff training should be conducted on a regular schedule by individual programs at their own worksites whenever possible.

Exposure to infectious agents can occur indirectly by contamination of the environment (area exposure) or directly through puncture or contact to the skin or mucosa (employee exposure).

A. Equipment

Spill kits should be present in all locations where specimens are taken or handled, including vehicles. Each kit should contain:

1. Disposable gloves
2. Disposable gown
3. Disposable face mask
4. Goggles
5. Biohazard bags
6. Long forceps
7. Pint bottle of bleach
8. Gallon bottle of tap water
9. Paper towels or Powersorb (absorbent material)
10. A copy of these instructions for handling spills

B. Area Exposure

1. In the event of an accident or specimen spill:

a. Immediately determine if there is any danger of an aerosol. This may be suspected in the case of a large spill (e.g., a beaker) or concentrated or cultured pathogenic material. If so, clear the room to avoid contamination of personnel. Only personnel involved in the decontamination of the area should remain. These individuals must wear complete protective coverage, including disposable shoe coverings.

Ordinary breaks of blood collection tubes usually do not present an aerosol hazard. Decontamination can proceed without clearing the room.

b. Exposed personnel must remove exposed clothing and other coverings, which must be autoclaved or discarded into biohazard bags. Face and eyes must be cleansed.

2. Decontamination Procedure

a. Using forceps, carefully remove large pieces of glass. Place them items in a container of 10% solution of bleach. Under transportation conditions, items should be placed directly in a bag, which then should be placed in a separate bag to avoid puncture.
b. Carefully flood the spill area with 10% bleach solution. Allow area to soak for 30 minutes. Note: In a laboratory area, if the spill involves large quantities of concentrated or cultured infectious agents, this step should be taken first.
c. Apply adequate quantities of "Powersorb" absorbent pads or sheets to soak up the liquid. Place the saturated pads in a biohazard bag for subsequent autoclaving.
d. Using forceps, remove any papers such as specimen slips, site records, etc. Place these papers in a separate autoclave bag and seal the bag.
e. Any other specimen tubes that have come in contact with teh spilled specimen should be wiped with the bleach solution and allowed to air-dry.
f. Remaining debris must be swept up and transferred to a biohazard bag.
g. The spill area may then be mopped with a 10% bleach solution and allowed to air-dry.
h. Protective clothing should be worn until all waste has been properly disposed of and requires no further handling.
i. Protective clothing should be placed in a biohazard bag and autoclaved. Cleaning implements must be either autoclaved or soaked for 3 hours in a 10% bleach solution before being rinsed and dried for reuse.
j. After autoclaving, the specimen slips should be returned to the site of origin.

3. Reporting Procedure

The incident must be reported to the supervisor, who will document it on the Agency's Incident/ Accident form and file a report with the Quality Assurance office and EHS. In the case of spills in transit, a report is to be made to the Transportation Office, giving the following information:

a. Date, time, place
b. Brief description of what happened and how you handled the spill.
c. Person(s) involved
d. If spill involves specimens, name(s) and address(es) of the physician(s) who submitted them.

C. Employee Exposure

1. Procedures
a. Exposure of the skin and/or mucous membranes of the eye, mouth and nose to clinical specimens or dilutions thereof, must be dealt with immediately.
b. The skins, mouth or nose must be washed free of any contaminating material and then cleansed with a mild soap. Note: do not scrub the affected area vigorously, as damaging the skin may increase the likelihood of infection.
c. Eyes should be washed with copious amounts of eye wash solution.

2. Reporting
a. Exposures of the skin or mucous membranes must be reported to the clinic manager, who must file a report with the Quality Assurance office and Employee's Health Services (EMS).

[Note: See the Needlestick Protocol attached as Executive Order #54 and existing Quality Assurance guidelines.]

D. First Aid - CPR

To minimize the need for emergency mouth-to-mouth resuscitatin, disposable mouthpieces, resuscitation bags, or other ventiliation devicies should be available for use in areas where the need for resuscitation may occur. Each DOH site is responsible for a CPR action plan in which provision is made for these materials in appropriate locations. Infection control standards governing other aspects of first aid follow clinic/field guidelines stated above with respect to contact with body fluids, mucosal contact and other sources of infection.

V. STAFF TRAINING AND EDUCATION

All new employees will be given an orientation on infection control. The orientation session will cover, but not be limited to, all items covered in this Policy. The objective of these sessions is to give each employee an understanding of the nature and sources of infection (both on the job and off) and the DOH infection control policy and its role in the workplace.

Each new employee will be provided with a copy of this Executive Order for reference. Employees currently assigned to laboratory, clinic, and field sites will take part in a biohazard safety training program and will receive a copy of this Policy, along with program-specific protocols, for reference. Because of their different requirements, separate training modules will be developed for clinical, laboratory, field, custodial and support personnel.

VI. ADDITIONS AND REVISIONS TO THIS POLICY

Once approved by the Commissioner, program-specific guidelines will be appended to this policy manual.

Updates and revisions of this Policy will be promulgated from time to time by the Agency. Policy updates will be circulated to all employees. They will be discussed in all employee Infection Control orientation sessions and in special update sessions if necessary.

APPENDIX A

Policy on Employee Needle Sticks

Introduction

This policy outlines proper procedure in response to accidental needle sticks or mucous membrane exposures to potentially infecitious materials occurring to Department of Health personnnel while on duty.

The policy delineates resonsibilities for (1) the prevention of illness from accidental exposure to infectious agents which can cause tetanus, syphilis, hepatitis B and illnesses related to the human immunodeficiency virus (HIV); (2) the reporting of information on all such incidents.

All employees should take precautions to prevent injuries caused by needles, scapels and other sharp instruments or devices during or after procedures, when cleaning used instruments, and during disposal of used needles.

To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades and other sharp items must be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area.

Definitions

1) A needle stick exposure is defined as a skin puncture with a needle or any other sharp object (e.g., PPD) that has been used to inject a patient, draw blood from a patient, or penetrate the patient's skin or mucous membrane.

2) Mucous membrane exposure means that blood, serum, or other potentially infectious fluid or material originating from a patient is sprayed up and enters the employee's eyes, nose or mouth or penetrates an open wound or sore of an employee.

Note: Sticks with sterile needles or needles used to draw up medicines prior to patient contact do not need to be reported but they should be washed carefully with soap and water and covered with a bandage.

Each Program must designate individuals responsible for the tasks described below. All employees should be familiar with these designees. At each DOH site, the clinic manager is responsible for ensuring that the procedures below are followed. Medical procedures are the responsibility of the the senior medical person at the site (e.g., Physician in Charge). The following guidelines apply to all Programs.

1. IMMEDIATE ACTIONS

Employees should notify the physician in charge and clinic manager of needle stick or mucous membrane exposures immediately. The employee should see to it that the needle stick puncture is thoroughly cleaned immediately with soap and water. The employee should also seek medical care if signs of infection appear, such as redness or swelling. Sprays to the eyes, nose, or mouth should be rinsed thoroughly with water.

2. EMPLOYEE CARE AND FOLLOW-UP

For all needle stick and mucous membrane exposures, the clinic manager should contact the Employee Health Service (EHS), and speak to the nurse, Office Associate or the physician on duty. The manager should make an appointment for the employee to be seen at EHS for immeidate follow-up. The manager should initiate an incident report (Form EH-9) which should be delivered to EHS as soon as it is completed. EHS will give the manager at the incident site an incident number to be recorded on the EH-9 form. This form must also be marked with a sticker identifying the specimen submission code of the source patient.

3. EMPLOYEES' HEALTH SERVICES

A. At EHS, a physician or nurse will interview the employee to review the needle stick incident in detail. With the employee's consent, a blood sample may be taken to be submitted to the Bureau of Laboratories for hepatitis B core antibody testing (HBcAb), syphilis testing (RPR) and HIV antibody testing. EHS will advise the employee about treatment for syphilis, tetanus and hepatitis B.

B. EHS will counsel the employee about the risk of HIV infection from the needle-stick or mucous membrane exposure, the need for risk-reduction behavior during the follow-up period, and about HIV antibody testing. The employee will be counseled that testing is advisable within two weeks after a needle stick both to ensure adequate medical follow-up and to provide baseline data inthe event that the employee wants to make a clam that (s)he became infected with syphilis, Hepatitis B, or HIV as a result of an occupational exposure. Failure to provide a baseline sample may make it more difficult to demonstrate that infection resulted from an occupational exposure. If the employee refuses HIV testing, (s)he will be asked to sign a statement indicating that testing was offered and refused.

C. With the informed, written consent of the employee, blood testing will be conducted in accordance with the New York City Department of Health protocol, which requires adherence to procedures which protect the confidentiality of the employee and his/her test results. Three blood sampls will be drawn and sent to the Bureau of Laboratories (see 4.c. below). The blood samples should be labeled "HCW Blood: EHS Incident # _____."

D. EHS will schedule a follow-up appointment to inform the employee of his/her laboratory test results and refer the employee for any necessary treatment. If the initial specimen is negative for HIV antibodies, the employee should be retested after 6 weeks and 3 and 6 months thereafter to determine if seroconversion has occurred (MMWR August 21, 1987, vol. 36/No. 2S: 16S-17S). If test results from the source patient are available, EHS will report the results (without personal identifiers) to the health care worker and discuss the implications of these results for the worker's follow-up.

4. SOURCE PATIENT FOLLOW UP

Note: OCME employees should consult the OCME needle stick protocol. Procedures for follow-up with a deceased source are somewhat different from those outlined below.

A. After a needle stick incident, the physician in charge of the clinic site should immediately follow up with the patient involved in the incident according to the procedures outlined below. If the patient has left the clinic, the physician should attempt to contact him/her and have the patient return for follow-up.

B. The physician should counsel the patient about DOH procedures following needle stick or other exposures. The physician should request the patient's consent to draw blood to test for syphilis, hepatitis and HIV antibody, using the counseling and consent form attached to this policy. The patient should be informed that his/her consent is voluntary and why this consent is desirable. The confidentility of results should be emphasized, but the patient should understand that test results will be disclosed to the exposed health care worker, though without personal identifiers.

The patient's consent form should be forwarded to EHS with the incident report form. A notation of the incident number should be made in the patient's medical record. No other record of the patient's name or in the patient's record should be made.

C. Upon consent, the physician should draw 3 blood samples (minimum of 5 milliliters each). The samples should be sent in vaccum tubes to:

1) Virus Serology Laboratory, Bureau of Laboratories.
2) Syphilis Serology Laboratory.
3) Retrovirology Laboratory.

The tubes should be labeled: "Source Blood: EHS Incident #_____." In addition, the tube directed to the Retrovirology Laboratory should be labeled with a specimen submission code sticker from the form "Request/Report for HIV Antibody Analysis." Another sticker should be affixed to Form EH-9.

Source patient test results will not be returned to the physician at the clinic site. The submission form should indicate EHS as the return address.

SEE SAMPLE FORMS ATTACHED.

D. The physician in charge or other person counseling the patient should immediately arrange an appointment for the patient at a location (e.g., an ACT site) where communication of test results can be accompanied by appropriate counseling. This appointment information should be provided to EHS on the incident report. If the incident took place in an STD or TB clinic where HIV testing is conducted, a post-test counseling appointment should be scheduled within the clinic.

E. Laboratory results for the source patient will be returned to EHS. On receipt, it is responsibility of EHS:

a. To inform the test site where the patient will receive post-test counseling of the patient's test results.
b. To counsel and treat the exposed employee, maintaining the anonymity of the source patient.

If the source patient does not consent to testing, EHS will counsel, test and prophylactically treat the exposed employee according to the protocol for unknown risk.

F. The patient's post test counseling site is responsible for referring the patient for any follow-up medical care indicated by the test results.

Checklist: Delineation of Responsibilities

A. Employee

1. Cleans area of needlestick or exposure.

2. Reports needle stick incident to Clinic Manager/designated on-site Supervisor.

3. Visits EHS for follow up.

4. Seeks medical care of punctured area becomes infected.

B. Clinic Manager/Designated On-Site Supervisor

In performing the following duties, the on-site supervisor should ensure that medical information is kept confidential. The supervisor:

1. Has primary responsibility for assuring proper protocol is followed.

2. Alerts physician in charge or designated physician to the need for follow up with source patient.

3. Alerts EHS of the incident immediately and arranges an appointment for the employee.

4. Completes Form EH-9 and arranges immediate delivery to EHS.

5. If source patient has consented to testing (see below), arranges immediate delivery of test samples to laboratory through the Bureau of Transportation.

C. Physician in Charge/Designated Physician

The physician in charge or other supervising medical person, in performing the following duties, should ensure that medical information is kept confidential. The physician in charge:

1. Ensures that puncture or contact site has been thoroughly cleaned with soap and water.

2. Instructs employee to seek medical care if area becomes infected.

3. If source patient has left, requests the patient to return to the clinic within 24 hours for follow up.

4. If source patient is known, counsels patient about HIV antibody testing after an employee exposure and obtains source patient's permission to collect blood for testing:

   a) 5-10 ml for Virus Serology Lab (Hepatitis B)

   b) 5-10 ml for Syphilis Serology LAb (RPR)

   c) 5-10 ml for Retrovirology Lab (HIV Antibody)

   Labels tubes: "Source blood: EHS incident # _____."

5. Arranges appointment for patient at nearest DOH site which routinely offers post-test counseling for HIV antibody testing. Appointment should be made for a date when all test results will be available. If incident took place in STD or TB clinic where antibody testing is conducted, post test counseling should be arranged within the clinic.

D. Employee Health Service:

Physician/Nurse:

1. At intake, thoroughly informs the employee of the right to confidentiality and the importance of maintaining it on the employee's part.

2. Interviews the employee in detail, utilizing Form EH-10.

3. Advises employee about prophylactic treatment, if needed.

4. Reviews with employee:

   a) Hepatitis B status and prophylactic treatment

   b) Tetanus immunization history and prophylactic treatment

   c) Potential exposure to HIV

      1) counsels employee about the HIV antibody test and seeks consent for testing

      2) If first specimen is negative arranges for

         i) retest after 6 weeks

         ii) again after 3 months

         iii) If the employee declines testing, requests employee to sign a statement that testing was offered and refused.

5. Arranges immediate delivery of test samples to laboratory through the Bureau of Transportation.

6. At each visit, counsels employee about risks of infection and transmission in clinic and home settings.

7. Coordinates the recording and distribution of all lab results from source patient and employee. All lab test results are to be kept confidential.

8. Notifies employee of source patient's test results, without personal identifiers, only after source patient's scheduled appointment to receive test results and post-test counseling.

9. Notifies individual who will provide post test counseling to source patient of patient's test results.

E. Bureau of Transportation

1. Transports blood specimens from site of source patient's testing to the Laboratory within 24 hours after they are drawn.

2. Transports employee blood specimens from EHS to the Laboratory within 24 hours after they are drawn.

F. Bureau of Laboratories

Virology and/or serology lab results will be sent to EHS by Lab personnel within 24 hours of test completion.

INCIDENT # _____

Employees' Health Services; Leona Baumgartner Health Center, 303 Ninth Avenue, Room 34
New York, New York 10001

Supervisor Form For Employee Needle Stick
or
Mucous Membrane Exposure
(To be Sent to EHS Upon Completion or Hand Delivered)

The following information should be collected immediately at the time of notification of the accident by the clinic supervisor.

DATE OF ACCIDENT	NAME OF CLINIC		ADDRESS OF CLINIC		
EMPLOYEE'S NAME	EMPLOYEE'S WORK TELEPHONE # ( ) Area Code	CIVIL SERVICE TITLE	AGE	SEX	

Type of Exposure:

- ☐ Puncture
- ☐ Spray
- ☐ Laceration
- ☐ Other _____

Part of Body Exposed: _____

Brief Description of How Exposure Occurred: _____

_____

_____

If Source Is Known:

Does Source Patient Have a History of Hepatitis B Infection?

- ☐ Yes
- ☐ No
- ☐ Unknown

Is Patient a Hepatitis B Carrier?

- ☐ Yes
- ☐ No
- ☐ Unknown

Does patient have an increased risk of exposure to HIV or other blood borne infections (i.e. intravenous drug use, sexual contact with person at risk)

- ☐ Yes
- ☐ No
- ☐ Unknown

Was a Sample of the Source Patient's Blood Obtained:

- ☐ Yes
- ☐ No *(If No, explain briefly)* _____

HIV Specimen Submission Code: _____

NAME OF SUPERVISOR *(Please Print)*	SUPERVISOR'S WORK PHONE NUMBER ( ) Area Code

_____
Supervisor's Signature

EH-9 (4/88)

Needle Stick Consent Form: Source Patient
(For HIV Antibody Testing and Other Related Tests)

An accident has occurred in which one of the health care providers caring for you has been inadvertently exposed to you blood. Because blood-borne infections are not uncommon, your consent to blood testing is requested, in order to monitor this worker's health, and to protect his/her rights to worker's compensation. These tests will include those for syphilis, hepatitis B. and HIV antibodies, and may help your doctor decide how best to treat you for some illness or exposure. Testing for HIV antibody is especially important because most experts now recognize that the human immunodeficiency virus (HIV) can cause AIDS (acquired immunodeficiency syndrome).

Antibodies are substances produced by the body, in response to an infection. A positive HIV antibody test indicates an infection with the virus and the body's immune response to it. A positive antibody test does not mean a person has AIDS, but is does mean that you are infected and can transmit virus to others, and should seek medical follow-up. A negative test result means that you are probably not infected with the virus; because it may take three to six months for the body to respond to infection by producing antibodies, there is a slight chance that an infected person will have negative test results.

The following are at increased risk for HIV infection:

- Men who have sex with other men
- People who have shared needles
- Recipients of blood or blood products from 1979 to 1985
- Individuals from countries where patterns of transmission are unclear (eg. Haiti, some countries of Central Africa)
- Sex partners of those in above groups
- Individuals with sex partners whose sex or drug histories are unknown

If you are not at risk for any of these reason, your chances of being infected are small. Nevertheless, these test results may help both you and the health care worker.

Your antibody test results may help your doctor decide how best to treat you for some illness such as tuberculosis or syphilis. It may also help you to make personal decisions to avoid getting the virus or giving it to someone else through blood or semen.

The test result will help the health care worker by helping his/her doctor decide whether (s)he should also receive treatment for syphilis or TB of take special precautions to prevent HIV transmission.

Disclosure

If your HIV test is positive and the test result is known by others, you might be wrongfully discriminated against by friends, family, employers, landlords, insurance companies and others, even though there are laws against discrimination in New York State and New York City. Therefore,

you should be extremely careful in disclosing your test results to anyone.

New York State and New York City have laws and regulations that protect the confidentiality of medical records and laboratory test results. Nevertheless, as with any sensitive information, there is the potential for release or unauthorized disclosure of the information. Should this occur, contact the Department of Health for assistance.

I have read (or have had read to me) the above description of the HIV antibody test and understand the limitations and possible consequences of the test. I have also had the blood drawing procedures explained to me.

I understand that an appointment has been made for me to receive my test results on a confidential or anonymous basis. I understand that the Department of Health will never disclose my name. The test results alone will be disclosed only (1) to the health care worker, (2) to that worker's physician(s) and (3) in proceedings inititated by the health care worker for worker's compensation or other insurance claims.

I understand and consent to testing for HIV antibodies. (Please write in ink using your own handwriting and test number: "I am #_____ and consent to be tested.")

_____

Signature

I understand and do not consent to testing for HIV antibodies. (Please write in ink using your own handwriting and the incident number: "This is incident #_____ and I do not consent to be tested.")

_____

Signature

THIS FORM SHOULD BE DELIVERED TO EMPLOYEES' HEALTH SERVICES WITH INCIDENT REPORT FORM EH-9.

7859E

Needle Stick Consent Form: Health Care Worker (For HIV Antibody Testing and Other Related Tests)

You have inadvertently been exposed to a patient's blood due to a needle stick or mucous membrane exposure. In order to ensure adequate medical follow-up your consent to syphilis, hepatitis B, and HIV antibody testing is requested. If in the future you wish to make a workers' compensation or other insurance claim, failure to provide a baseline sample may make it difficult to demonstrate that an infection resulted from occupational exposure. If a baseline sample is taken immediately (within 2 weeks), it can be used to indicate your serostatus at the time of the incident.

Most experts now recognize that the human immunodeficiency virus (HIV) can cause AIDS (acquired immunodeficiency syndrome). Tests ar now available to determine the presence of antibodies to HIV in the blood. Antibodies are substances produced by the body, in response to an infection.

The following are at increased risk for HIV infection:

- Men who have sex with other men
- People who have shared needles
- Recipients of blood products from 1979 to 1985
- Individuals from countries where patterns of transmission are unclear (e.g., Haiti, some countries of Central Africa)
- Sex partners of those in above groups
- Individuals with sex partners whose sex or drug histories are unknown

If you are not at risk for any of these reasons, your chances of being infected are small. Studies have consistently shown that infection of health care workers from occupational exposures to infected blood is extremely rare. Nevertheless, testing is advisable to provide baseline information and medical follow-up.

If you are testted within 2 weeks of the incident, a positive HIV antibody test indicates that you were infected with HIV before the incident. A positive antibody test does not mean that you have AIDS, but it does mean you are infected and can transmit the virus to others and should seek medical follow-up. A negative test result means that you were probably not infected with the virus prior to the incident unless you recently engaged in risk behavior. If you have been infected with HIV as a result of this occupational exposure, you may not have a positive test result for three to six months, because it may take this long for your body to produce antibodies. Therefore, even if your first test is negative, you should return for additional testing.

Your HIV antibody test results may help your doctors decide how best to treat your for some illnesses. They may also help you make personal decisions to avoid giving it to someone else through blood or semen.

Disclosure

The Department of Health strives to maintain complete confidentiality, and complies with all State and City laws regarding discrimination. New York State and New York City have laws and regulations that protect the confidentiality of medical records and laboratory test results. Nevertheless, as with any sensitive information, there is the potential for release or unauthorized disclosure of the information.

If your HIV test is positive and the test result is known by others, you might be wrongfully discriminated against by friends, family, landlords, insurance companies and others, even though there are laws against discrimination in New York State and New York City. Therefore, you should be extremely careful in disclosing your test results to anyone.

I have read (or have had read to me) the above description of the HIV antibody test and understand the limitations and possible consequences of the test. I have also had the blood drawing procedures explained to me. I understand that other related blood tests will be conducted.

I understand that my test results may be released in proceedings for any claim I make for worker's compensation or other insurance. I agree not to release information about the source patient's test results to any other party.

I understand and consent to testing for HIV antibodies

_____

Signature

I understand and do not consent to testing for HIV antibodies

_____

Signature

7978E

Department of Health - City of New York
Bureau of Laboratories
455 First Avenue Room 110
New York, New York 10016

SAMPLE COPY:
EMPLOYEE EXPOSURE – Source Patient Follow Up

REQUEST/REPORT FOR HIV ANTIBODY ANALYSIS

408V REV. 8/87

092783

INSTRUCTIONS: PLEASE READ CAREFULLY, TURN PAGE AND FILL OUT FORM.

PHYSICIAN/HEALTH WORKER DRAWING BLOOD

- This request for Analysis Form must be filled out completely and all forms must be sent to the reporting Laboratory under permit for such testing without any name identifier to assure confidentiality.
- There must be a signed consent form of the person tested which should be kept on file. Pre-test and post-test counseling on the results must be provided to the person tested.
- A red top tube containing 10 ml. blood should be delivered to the laboratory with forms within 24 hours in an appropriate biohazard metal container (or plastic bag).

FOR REPORTING LABORATORY PERMIT I (Screening)

- Non-reactive screening test results should be reported on form and returned to AIDS unit and Physician/Test site. Retain your copy.
- Inconclusive or reactive test results must be confirmed. Forward specimen and ALL copies of form to confirmatory Laboratory.
- Confirmatory test must be done by Permit II Laboratory.

FOR LABORATORY PERMIT II (Confirmatory)

- When confirmatory test is completed results should be reported on form and returned to reporting laboratory for distribution. Retain your copy.

LABELS

Please use pre-coded labels to ensure confidentiality of person tested. Labels should be used as follows:

Attach to Form EH-9

- Attach to tested person's appt. card.
- Attach to specimen.
- Attach to test site records.
- For Laboratory (screening) use.
- For Laboratory (confirmatory) use.

092783
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092783
092783
092783

. . . Thank You For Your Cooperation.

Department of Health -
City of New York

SAMPLE COPY: EMPLOYEE EXPOSURE

REQUEST/REPORT FOR HIV ANTIBODY ANALYSIS

408V
REV. 8/87

PATIENT/LABEL # 092783

PRINT CLEARLY AND PRESS FIRMLY FOR MULTIPLE COPIES. LABORATORY-RETURN THIS COPY TO PHYSICIAN ETC.

PATIENT DATA TO BE COMPLETED BY PHYSICIAN/HEALTH WORKER DRAWING BLOOD

DATE DRAWN (M M D D Y Y)	HOME ZIP CODE	SEX (Check One)	DATE OF BIRTH (M M D D Y Y)	ETHNIC/RACE (Check One)	For Health Dept. Use Only
		1 ☐ MALE 2 ☐ FEMALE		1 ☐ WHITE 3 ☐ HISPANIC 2 ☐ BLACK 4 ☐ OTHER	4 0 1

RISK INDICATOR (Please answer all six items)

	YES	NO	UNKNOWN
1 GAY/BISEXUAL MALE	1 ☐	2 ☐	3 ☐
2 IV DRUG USER	1 ☐	2 ☐	3 ☐
3 BLOOD PRODUCT RECIPIENT	1 ☐	2 ☐	3 ☐
4 PERSON'S FROM COUNTRIES WITH NO KNOWN RISK	1 ☐	2 ☐	3 ☐
5 SEXUAL PARTNER OF PERSON AT RISK	1 ☐	2 ☐	3 ☐
6 OTHER RISK(S)	1 ☐	2 ☐	3 ☐

INDICATION (Check One) 1 ☐ AIDS 2 ☐ HIV SYMPTOMATIC 3 ☐ ASYMPTOMATIC

I certify that the patient has received information about limitations, risks, and the voluntary nature of the test through pre-test counseling and post-test counseling and has signed an informed consent.

PHYSICIAN/AUTHORIZED INDIVIDUAL'S SIGNATURE
X

PHYSICIAN PLEASE PRINT NAME

PHYSICIAN'S LICENSE #

PHYSICIAN/DRAWING POINT ADDRESS
Employees' Health Services
Leona Baumgartner Health Center
303 Ninth Avenue, Room 34
New York, NY 10001

TELEPHONE #

TO BE COMPLETED BY THE LABORATORY

REPORTING LABORATORY - INITIAL SCREENING TEST

NAME AND ADDRESS

LAB #

DATES OF SPECIMEN: RECEIVED (M M D D Y Y) REPORTED (M M D D Y Y)

INDICATE (Check One) 1 ☐ NON-REACTIVE 2 ☐ INCONCLUSIVE 3 ☐ REACTIVE (Must Be Confirmed)

RECORDED BY SIGNATURE X

CONFIRMATORY LABORATORY

TEST USED:

NAME OF CONFIRMATORY LAB AND ADDRESS (IF DIFFERENT FROM REPORTING)

LAB #

DATES OF SPECIMEN: RECEIVED (M M D D Y Y) REPORTED (M M D D Y Y)

INDICATE (Check One) 1 ☐ NON-REACTIVE 2 ☐ INCONCLUSIVE (RESUBMISSION RECOMMENDED) 3 ☐ REACTIVE

RECORDED BY SIGNATURE X

CONTACTS

CONTACTS

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(612) 348-3925

Minneapolis, Minnesota
Minneapolis Health Department
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Minneapolis, MN 55415
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New York City, New York
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New York, NY 10013
(212) 566-7103

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