MHMR Concho Valley
My Health My Resources

INFECTION CONTROL PROGRAM
FY '26 – '27

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DESIGNATION OF MHMRCV STAFF

I. MHMR CONCHO VALLEY (MHMRCV) STAFF

A. The following MHMRCV employees are designated as performing the following functions. In their absence, designees will perform the related tasks.

1) Human Resources Development (HRD) Coordinator: Brandi Sablan

2) Chief Human Resources (HR) Officer: Monica Tello

3) Infection Control Officer: Lalanie Dohrse, R.N.

4) Quality Management (QM) Director: Melinda McCullough

5) Risk Management/Safety Officer: Melinda McCullough

6) Risk Management Coordinator: Selina Villarreal

PURPOSE/RESPONSIBILITY/AVAILIBILITY/REVIEW

I. Purpose - This program is designed to comply with the Texas Administrative Code and OSHA requirements and eliminate or minimize employee exposure to bloodborne pathogens.

II. Responsibility - The Chief Executive Officer (CEO) has overall authority for implementation and management of the Infection Control Program. This responsibility is delegated to the Infection Control Officer, Quality Management Director and Risk Management/Safety Officer. Program directors, managers, and supervisors are responsible for exposure control and compliance with universal precautions within their departments. Staff development personnel are responsible for the coordination of general orientation and annual training of employees. The Infection Control Officer and HRD Coordinator are responsible for the content of training curriculum. Employees are responsible for knowing what tasks they perform that have occupational exposure, complying with universal precautions, attending pre-service and annual update training, and observing good infection control and personal hygiene habits. (The term employee includes those individuals that contract with MHMRCV to provide services to individuals served).

III. Availability - The Infection Control Program is available to employees at any time in an electronic format posted in the MHMRCV SharePoint site under the heading of “Documents/Forms.”

IV. Review - The program will be reviewed by the CEO and Medical Director, and revisions and updates will be completed as needed whenever occupational exposure changes.

STANDARD PRECAUTIONS

I. STANDARD PRECAUTIONS

A. Blood and body fluid precautions should be promptly implemented for all individuals served at the time of admission.

1) There are no additional precautions for individuals served with communicable blood-borne diseases, including individuals served with AIDS, individuals served with HIV-positive blood, and individuals served undergoing a diagnostic work-up for AIDS.

2) All body substances from any individual should be considered potentially infectious because every individual is a potential disease carrier, and the undiagnosed case represents the greatest risk of transmission.

B. Hands should be washed routinely after caring for an individual served and immediately if soiled with a body substance. Hand washing is the only precaution necessary for most consumer contact.

C. Disposable gloves are recommended for all direct contact with a body substance, or with items soiled with a body substance. This is particularly important if the employee has fresh cuts or breaks in the skin.

1) Gloves are an adjunct, not a substitute for hand washing.

2) **RUBBER GLOVES ARE REQUIRED FOR CLEANING BLOOD AND BODY SUBSTANCE SPILLS.**

3) **HEP-Aid Bodily Fluid Disposal Kits are available in each location and Center vehicles that routinely transport individuals served.**

D. Needles and sharps should be handled with extreme care and minimal manipulation to prevent accidental punctures. **Do not recap, bend, break, or remove needles from syringes.**

E. Masks are provided for staff to reduce the risk of exposure to Tuberculosis. Employees should be trained in the use of masks during Infection Control training.

F. One-way CPR masks are available in each location and Center vehicle. Employees should be trained in the use of a one-way CPR masks during CPR training.

HANDLING OF SHARPS

I. GENERAL INFORMATION

A. All needles and/or sharps will be disposed of in a hospital approved, impervious container designated for sharps.

B. Sharps containers will be kept in all patient rooms and patient care areas as well as in medication areas, laboratory, or other areas in which sharps are used.

C. Containers will be routinely checked by department staff and replaced when 2/3 full.

D. Containers will be secured and placed in the designated biohazard box for disposal.

E. Sharps will be disposed of at the closest point.

F. Exposed sharps are not to be carried from one area to another.

G. Safety needles and devices will be used whenever possible.

BLOOD-BORNE PATHOGEN SPILLS

I. HEP-AID BODILY FLUID DISPOSAL SPILL KITS

A. HEP-AID BODILY FLUID DISPOSAL SPILL KITS are provided in each facility and the instructions for use are printed on the kit.

B. If a kit is not available, the following instructions are to be followed:

1) Blood and body fluid spills should be cleaned up promptly with a 1:10 bleach/water solution.

2) Wearing gloves, place disposable towels over spill to remove gross organic matter and discard as infectious waste.

3) Clean up the remaining blood and/or body fluid using the water/bleach solution.

4) Remove gloves.

5) Wash hands immediately after the task has been completed.

HAND HYGIENE PROCEDURE

I. PROCEDURE

A. Stand away from the sink so as not to have clothing in contact with the sink.

B. Turn on the water. Keep the water slightly warm to prevent chapping and keep it at this temperature during the entire process.

C. Wet hands and wrists under running water.

D. Soap hands thoroughly, work up lather, and wash well between fingers and under nails.

E. Wash palms and backs of hands with brisk friction motion. Scrub hands for at least 20 seconds.

F. Rinse hands well with hands pointing downward so “dirty” water does not run down the arms toward the elbows.

G. Dry hands thoroughly by patting gently with a paper towel or air dry them.

H. Turn water off by using a paper towel for hand-controlled faucets. This prevents your clean hands from touching dirty faucets.

I. Use lotion or cream if necessary, to further prevent chapping.

II. WHEN TO WASH HANDS

A. After removal of disposable gloves.

B. Before, during, and after preparing, serving, or handling food.

C. Before and after eating and drinking.

D. Before and after feeding or assisting in the feeding of individuals served.

E. After hands have been in contact with contaminated objects such as diapers, urinals, toilets, bandages, dressings, menstrual pads, garbage, door handles, or gas pumps.

F. After use of toilet or assisting individuals with toileting.

G. Before and after giving intimate personal care.

H. Before and after treating a cut or wound.

I. After contact with blood or other body fluids.

J. After handling pet food or pet treats.

K. After blowing your nose, coughing, or sneezing.

L. Before touching your eyes, nose, or mouth.

III. STAFF TRAINING

A. Proper hand-washing procedures will be part of staff training.

DISPOSABLE GLOVES REQUIREMENTS

I. STAFF IS REQUIRED TO WEAR DISPOSABLE GLOVES:

A. When providing direct care involving contact with all body fluids such as blood, fecal matter, urine, saliva, tears, semen, or vaginal fluids.

B. While handling objects that might be soiled with blood, saliva, or other body fluids (e.g., diapers, menstrual pads, clothes, or equipment).

C. When handling all laundry.

D. When employee has open oozing lesions on his/her hands or lower arms.

E. When cleaning toilets.

F. When removing waste or receptacle liners.

G. When cleaning an area contaminated with body fluids.

H. When working with irritating solutions.

I. When food is being handled directly.

J. While feeding or assisting in the feeding of individuals served.

K. While giving any intimate personal care.

L. While applying topical medications to individuals served.

M. When performing needle sticks of any kind (i.e., giving injections, performing venipuncture).

ROUTES OF TRANSMISSION OF DISEASE

I. FOUR MAJOR ROUTES OF TRANSMISSION OF DISEASE

A. Airborne Route: Airborne transmission occurs when infectious pathogens are carried by fine respiratory particles or aerosols that remain suspended in the air for extended periods and can be inhaled by others, even when the infectious persons is no longer in the area. Airborne diseases include tuberculosis, measles, and varicella.

B. Droplet Route: Droplet transmission occurs when respiratory droplets carrying infectious pathogens are expelled during coughing, sneezing, talking or close contact, and travel a short distance before falling out of the air. These droplets do not remain suspended and generally require proximity for transmission. Droplet spread illnesses include influenza, pertussis, Covid-19, and certain types of meningitis.

C. Direct Contact Route: These pathogens are spread by directly touching infectious materials or persons, then touching yourself or someone else. These pathogens are found in body fluids such as saliva, nasal discharge, eye drainage, infected oozing sores and stool. Examples include the transmission of scabies, impetigo, herpes simplex, and MRSA.

1) Blood-borne pathogens are spread directly when infected blood enters the blood stream of another person through sexual contact, cuts, or breaks in the skin.

2) Some diseases are spread by having direct person-to-person contact with certain parasites such as mites, which cause scabies, lice with infestation of the head or body, or by pinworms. Having direct or indirect contact with infected stool spreads giardia, an organism that causes severe diarrhea.

D. Indirect Contact Route: These pathogens are spread by touching contaminated articles or surfaces and then touching yourself or someone else. For example, if germs that are airborne land on items that eventually go into the mouth, they may cause viral illnesses, meningitis, ear infections or strep throat.

1) Some direct contact organisms found in the body secretions and excretions may also be infected indirectly.

2) They rest on items such as toys, food, and dishes. They may also be found on tabletops, sink faucets, toilet flush handles and diaper areas.

3) If hands are accidentally placed in the eyes, nose, or mouth after having contact with these contaminated surfaces, a person could develop a cold, pink eye, food poisoning, Hepatitis-A, or infectious diarrhea.

E. Vector-borne Route: Vector-borne transmission occurs when infectious pathogens are carried and transmitted to humans by insects or arthropods such as mosquitoes, ticks or fleas. The vectors acquire pathogens by feeding on an infected host and then transferring the infection through bites or blood feeding to another host. Common vector-borne diseases relevant to Texas include West Nile virus, Zika, dengue and tickborne illness such as Lyme disease and ehrlichiosis.

REPORTING INFECTIOUS/CONTAGIOUS DISEASES & CONDITIONS

I. REPORTING

A. Unit Nurses, Program Directors, and Supervisors will be responsible to report all infectious and contagious diseases among the individuals served and employee populations to the MHMRCV Infection Control Officer.

B. Infectious and contagious diseases will be reported for both individuals served and employees. The individual responsible for reporting will call the MHMRCV Infection Control Officer and complete an incident report following the MHMRCV procedure #4.15.01.00.

II. REPORTABLE DISEASES

A. The following communicable diseases and conditions have been recommended by the Texas Department of State Health Services (DSHS) to be reported to the local health department.

1) Diseases and conditions that are reportable by name, age, sex, and race:

Arboviral Diseases (such as West Nile virus, eastern and western equine encephalitis)	Ehrlichiosis	Legionnaire disease (legionellosis)	Syphilis, including congenital syphilis
Babesiosis	Foodborne disease outbreak	Listeriosis	Toxic shock syndrome (other than streptococcal)
Campylobacteriosis	Genital Herpes	Lyme disease	Tuberculosis
Chancroid	Giardiasis	Novel Influenza A virus infections	Vancomycin intermediate Staphylococcus aureus (VISA)
Chickenpox	Gonorrhea	Pesticide-related illnesses and injuries	Vancomycin resistant Staphylococcus aureus (VRSA)
Chlamydia	Haemophilus influenza, invasive disease	Poliovirus infection, nonparalytic	Vibriosis
Coccidioidomycosis	Hantavirus pulmonary syndrome	Rabies (human and animal cases)	Viral hemorrhagic fever (including Ebola virus, Lassa virus, among others)
Coronavirus, novel	Hemolytic uremic syndrome, post-diarrheal	Salmonella Para typhi and typhi infections	Waterborne disease outbreak
Cryptosporidiosis	HIV Infection	Severe acute respiratory syndrome-associated coronavirus disease	Zika virus disease and infection (including congenital)
Cyclosporiasis	Invasive pneumococcal disease	Shiga toxin-producing Escherichia coli (STEC)	
Dengue virus infection	Lead, elevated blood level	Shigellosis	

2) Tuberculosis – Consumer and employee Tuberculosis cases are individually reported by the Infection Control Officer on the state Tuberculosis report form and include name, address, birth date, sex, race, and social security number, with pertinent information on the status of the disease. For such cases, an MHMRCV incident report will also be completed by unit staff for consumers or by the supervisor of an employee.

3) Sexually Transmitted Diseases

(a) The Texas Department of Health (TDH) will be notified of test results suggestive of Syphilis, Gonorrhea, and Chlamydia Trachomatis on HIV/STD Reporting Form. The TDH forwards the report to the director of the local health department.

(b) The Infection Control Officer will report a diagnosis of Syphilis, Gonorrhea and Chlamydia Trachomatis to the county health department and will also complete the confidential report of venereal disease and local health department forwards to the regional STD office.

(c) For HIV/AIDS, the Infection Control Officer will notify the local health department and then complete "HIV/STD Reporting Form" or telephone the San Angelo Health Department at (325) 657-4214 within 7 calendar days (to be reported only once per case, following initial physician diagnosis).

4) Disease reportable by numerical totals: Influenza.

5) Diseases reportable by number and age group only: Chicken pox.

6) Diseases reportable by number, age group, and sex only: Human Immune Deficiency Virus (HIV) Infections.

7) Diseases to be reported immediately by telephone:

(a) Botulism

(b) Cholera

(c) Diphtheria

(d) Measles

(e) Pertussis

(f) Plague

(g) Poliomyelitis, paralytic

(h) Rabies, human

(i) Rubella

(j) Smallpox

(k) Yellow Fever

(l) Anthrax

(m) Coronavirus, novel

(n) Meningococcal infection

B. In addition to the requirement of individual case reports, any unusual or group expression of illness, which may be of public concern, will be reported to the local health authorities by the most expeditious means.

C. Aggregate reports of all communicable diseases will be presented to the Risk Management Committee on a quarterly basis.

REPORTING PERSONAL ILLNESS

I. NOTIFICATION & TRACKING

A. The supervisor who is notified that their staff member is going to be absent with an infectious illness must notify the Infection Control Officer.

B. When an employee calls out for illness, the supervisor should ask sufficient information to determine if infectious symptoms are present.

C. It is the responsibility of the Infection Control Officer, Risk Management, and Quality Management Departments to track trends or patterns of personal illness.

D. If a staff member is ill for more than three consecutive days, written clearance should be obtained (Procedure #3.08.07.02).

EMPLOYEE HEALTH PROGRAM

I. PURPOSE

A. To maintain a health standard required of all employees to perform their assigned duties.

B. To ensure employees are not at risk of acquiring communicable diseases nor are they potentially disseminating infectious agents to other personnel or individuals served.

II. REPORTING

A. All employees who have signs and symptoms of infectious diseases, or who are believed to be incubating diseases that are communicable by respiratory or by contact, will report such illnesses to their immediate supervisor.

B. Employees diagnosed or suspected of having a communicable disease will not return to work until the period of communicability has ended, as determined by a licensed healthcare professional or local health authority (TAC §97.8).

C. Any employee who is absent from work with undiagnosed diarrhea, “viral” infections, and chronic illnesses, will report such illness (es) to their immediate supervisor. The Infection Control Officer is responsible for evaluating reported illnesses and may initiate further medical action, including referral for medical evaluation or diagnostic testing, to prevent potential outbreaks.

D. Any employee with an infectious or communicable disease, who is at their work location, will promptly report such illness to his/her supervisor. The supervisor will take appropriate action.

III. MHMRCV ACQUIRED ILLNESSES

A. If an illness is determined to be work-related, all associated medical, laboratory and therapeutic costs will be covered under the MHMRCV Workers' Compensation program. In such cases, Workers' Compensation law will take precedence over this Infection Control Program.

B. The employee's supervisor will notify the Infection Control Officer of any claimed MHMRCV acquired illness. The Infection Control Officer will investigate the probability and report findings to the Human Resources and Quality Management Departments.

IV. EMERGENCIES

A. Employees requiring emergency care while at MHMRCV will be directed to the nearest appropriate healthcare facility.

1) In the event of a potential exposure to HIV/AIDS or other communicable diseases, the employee must receive immediate evaluation and access to post exposure prophylaxis from a qualified healthcare provider.

2) MHMRCV will ensure timely treatment in accordance with Texas law and Workers' Compensation requirements.

B. Employees who receive emergency medical treatment must submit a copy of the physician’s medical report to the Infection Control Officer within 24 hours. The Infection Control Officer will coordinate all relevant documentation with Human Resources and the Risk

Management/Safety Officer to ensure compliance with Texas Workers' Compensation and communicable disease control requirements.

C. The treating facility will be a licensed authorized health care provider with the signature of the physician.

EMPLOYEE EXPOSURE TO COMMUNICABLE DISEASE

I. PROTOCOLS

A. Employees exposed or believed to have been exposed to any communicable diseases will report the incident promptly to their immediate supervisor.

B. The supervisor will document the incident and report it to the Infection Control Officer for review and further investigation if necessary.

1) Documentation will include whether the employee had taken any precautionary measures prior to the incident.

2) If the incident is believed to have resulted from neglect in following proper aseptic technique, this determination must be documented in the report.

C. The Infection Control Officer will provide recommendations to the Quality Management Director and Risk Management/Safety Officer.

II. RESPONSIBILITIES

A. Employees are responsible for promptly reporting any exposure to communicable diseases to their immediate supervisor.

B. The supervisor is responsible for documenting the incident and taking immediate action to prevent further exposure.

1) The report must be referred to the Infection Control Officer for review and investigation, if necessary.

C. The Infection Control Officer is responsible for maintaining an incident log and coordinating health or personnel referrals as needed.

1) Medical referrals must be documented using the “Information to Emergency Room” memorandum.

III. PROCEDURES

A. Employees exposed to highly communicable diseases, such as Pulmonary Tuberculosis, Viral Hepatitis (A, B Non-A, Non-B), etc. must report to their supervisor by using the MHMRCV Incident Report Form.

1) Include the time/location/person exposed whether the source was a consumer or employee.
2) Record duration of exposure, if known.

3) Record mode of exposure (e.g., needlestick, mucous membrane contact).

4) Identify disease, if known.

B. Human Resources must retain a copy of the incident report in the personnel health record, regardless of whether the reported incident has been proven to require further referral.

C. The employee's private healthcare physician will determine prophylactic or therapeutic treatment.

D. In the event of a potential HIV exposure, the employee must be referred immediately for clinical evaluation and access to post-exposure prophylaxis.

E. Therapeutic treatment for medical incidents, including accidents, will be provided by the employee's private physician.

F. No medical referral is required when the reported incident has been determined to pose no epidemiological risk to the individual.

IV. DOCUMENTATION

A. The Infection Control Officer will maintain all necessary documents according to health standards as recommended by the Texas Department of State Health Services.

V. HEPATITIS B VACCINE

A. The Hepatitis B vaccine is offered free of charge to all MHMRCV employees.

B. At-risk employees are identified based on their work category assignment as outlined below. All Category I employees are encouraged to receive the Hepatitis B vaccine series.

1) Category I: All employees who routinely have contact with blood or body fluids and/or used sharps.

2) Category II: Employees who rarely, if ever, have contact with blood or fluids and have no contact with used sharps.

3) Category III: Employees who are not required to have direct contact with individuals served and will not handle blood, body fluids or used sharps. Category I tasks are not a condition of employment.

C. Employees will receive information regarding the Hepatitis B vaccine and must sign informed consent prior to receiving vaccination.

D. Those who decline vaccination must sign a statement acknowledging their decision.

VI. RESPONSE TO SPECIFIC DISEASE EXPOSURES

A. Rubella: Rubella titers must be obtained for any pregnant employee with known exposure. Employees with negative titers should receive counseling from qualified healthcare personnel. When ordered by physicians, immune serum globulin may be administered. However, it does not prevent infection and only reduces severity. Immune serum globulin is not recommended for exposed pregnant employees due to the risk of congenital rubella in infants.

B. Meningococcal Meningitis: Exposure to an unrecognized case of meningococcal meningitis can occur through close contact such as mouth to mouth resuscitation or direct exposure to contaminated respiratory secretions or bodily fluids. Such exposures must be documented promptly. Recommendations for post exposure prophylaxis depend on the type of contact and risk level.

C. Acquired Immune Deficiency Syndrome (AIDS): Please see MHMRCV's procedures regarding Infection Control (#4.15.02.01) and HIV/AIDS in the Workplace (#1.04.10.03).

D. Varicella: Staff who are exposed to chickenpox, and for whom antibody status to varicella is unknown, should have an antibody titer done as soon as possible. Incubation for varicella is 14-21 days. The disease is most contagious 2 days prior to eruption of the vesicles and continues until 5 days after eruption, when in most cases lesions are crusted and dried. If positive varicella antibody status is not determined or status is negative, staff should be removed from consumer care from 8 days after exposure until day 21.

E. Coronavirus, novel: Staff with a known COVID-19 exposure should promptly notify their supervisor and begin daily symptom monitoring. If symptoms develop, they must test immediately and isolate according to current CDC guidelines. Asymptomatic staff may test around day 5, post exposure if required by MHMRCV policy or local health authority. Isolation is only required for staff who test positive or develop symptoms.

ACCIDENTAL BLOOD/BODY FLUID EXPOSURE

I. PURPOSE

A. To provide a guideline for the management of employees injured with contaminated needles or sharp instruments.

II. GENERAL GUIDELINES

A. Needle sticks and injuries occurring from sharp instruments will be managed according to procedures delineated below.

B. The administrative management of the injured employee is the responsibility of the Infection Control Officer and will include documentation and follow-up indicated to ensure optimal delivery of care is provided.

III. RESPONSIBILITIES

A. The employee is primarily responsible for **IMMEDIATELY REPORTING** the injury to their supervisor.

B. The employee's supervisor is responsible for completing an incident report form and notifying the Infection Control Officer.

C. The employee's private physician is responsible for the medical management of the injured employee according to protocol. If the exposure is suspected to be to HIV/AIDS, the employee will be referred to Shannon Medical Center for assessment and treatment.

D. The Infection Control Officer is responsible for investigating and implementing preventative measures where applicable and the administrative management of the injured employee. Appropriate documentation and follow-up will be noted on the employee's personnel health record in Human Resources.

E. The Risk Management/Safety Officer and Quality Management Director are responsible for assisting the Infection Control Officer with investigating and implementing preventative measures where applicable.

F. The Risk Management Coordinator is responsible for providing in-service education to all employees to prevent unsafe events through means available in the facility.

IV. PROCEDURES

A. Employee

1) Allow or induce punctured site to bleed (if bleeding has not already taken place.) This step may prevent further injury through infection(s).

2) If wound is dirty, use soap and running water to cleanse the site. A contamination to the eye should be immediately rinsed out.

3) Report injury **IMMEDIATELY** to supervisor. The supervisor initiates the completion of the MHMRCV incident report.

4) If the wound is profusely bleeding, initiate first aid principles.

5) Consult with a medical staff person, or a private physician. Should the exposure to HIV/AIDS be suspected, the individual would be referred to Shannon Medical Center for assessment and treatment.

6) Follow prescribed treatment.

7) Respond to follow-ups as recommended. Some diseases need to be monitored for prolonged periods of time. The employee is expected to respond appropriately.

B. Infection Control Officer

1) Receive and process the incident report within 24 hours of incident.

2) Ensure the consumer or injured employee is processed according to MHMRCV policy and contact departments/services needed for follow-up.

3) Maintain documents and follow-up schedule as needed. Follow-up will include documenting that post exposure treatment is completed by the individual receiving the exposure. The individual will also be monitored for signs and symptoms that may develop.

C. Human Resource Department

1) Tracks exposure for possible Workers Compensation reporting.

V. MANAGEMENT OF ACCIDENTAL EXPOSURE TO BLOOD/BODY SUBSTANCES

A. "Exposure" in the MHMRCV setting is defined as a percutaneous injury (e.g., needle stick or other penetrating puncture of the skin with a used needle or other item) or contamination of a mucous membrane, (splatter/aerosols into the eyes, nose, or mouth) or significant contamination of an open wound or non-intact skin with blood, semen, vaginal secretions or other body substances which contain visible blood.

B. Under the conditions previously defined, appropriate counseling will be given by trained counselors and will include information on the potential risk of infection and specific measures to prevent transmission.

VI. REQUIRED ACTIONS

A. If an employee has a parenteral (needle stick or cut) or mucous-membrane (splash to eye or mouth) exposure to blood or other body fluids, or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood (especially when the skin is chapped, abraded, or afflicted with dermatitis) the following actions will be taken:

1) The source should be assessed clinically and epidemiologically to determine the likelihood of HIV infection.

a) If the source is a consumer, MHMRCV cannot compel a consumer to be tested for HIV; however, every effort will be made to encourage him/her to do so.

2) If assessment suggests the infection may exist, the source should be informed of the incident and requested to consent to serologic testing for the evidence of HIV antibody formation. Trained counselors will give appropriate counseling. Written informed consent from the source consumer is required to perform this test.

3) If the source has AIDS or other evidence of HIV infection, or has a seropositive HIV antibody, the affected employee should receive immediate counseling and clinical evaluation, including consideration for post-exposure prophylaxis within 72 hours of exposure.

   a) Written informed consent from the employee is required to perform this task.

   b) The employee will be advised to report and seek medical evaluation for any acute febrile illness (particularly one that is characterized by fever, rash, or lymphadenopathy).

   c) Follow-up HIV testing should be performed at baseline, 6 weeks, and 3 months (or as recommended by current CDC guidelines) and counseling should include PEP adherence and measure to prevent secondary transmission.

4) Seronegative health-care workers should be retested zero (0) weeks post-exposure and periodically thereafter, six (6) weeks and six (6) months to determine if transmission has occurred.

   a) During this follow-up period (especially the first 6-12 weeks and after exposure when most infected persons are expected to seroconvert to positive) the exposed health care worker should be counseled to follow U.S. Public Health Service recommendations to prevent transmission of HIV.

5) If the source is negative, no further follow-up of the exposed employee is necessary unless the source consumer is at high risk of HIV infection. In this situation, a subsequent specimen (12 weeks following exposure) may be obtained for the employee for antibody testing.

6) If the source will not be tested, decisions regarding appropriate follow-up should be individualized based upon the type of exposure and the likelihood that the source consumer was infected.

7) If a consumer has a parenteral or mucous-membrane exposure to blood or the body fluid of an employee, the consumer should be informed of the incident and the same procedure outlined above should be followed for both the source and the exposed consumer.

HUMAN IMMUNODEFICIENCY VIRUS

I. COUNSELING

A. Pre and post-test counseling must be provided to all individuals who are to be tested for the HIV antibody.

II. SIGNS, SYMPTOMS & METHODS OF TRANSMISSION

A. Routine screening of individuals served, including new admissions, is not to be performed. However, all persons admitted should be assessed for their risk of having become HIV infected and, as appropriate, should be encouraged to be tested for the HIV antibody in order that early treatment interventions can be offered.

B. Signs, symptoms, and methods of transmission as follows:

1) Signs and symptoms of HIV**:** Immune suppression phase can produce night sweats, weight loss, diarrhea, nerve pain, fatigue, rashes, mouth ulcers and slowing of thinking.

2) Signs and symptoms of AIDS: AIDS represents the advanced stage of HIV infection, marked by severe immune suppression and increased susceptibility to opportunistic infections such as pneumonia, tuberculosis, and certain cancers.

3) HIV/AIDS transmission - Direct contact with person's blood, semen, or vaginal fluids, or breast milk:

(a) By having unprotected sexual intercourse; that is, not using latex condom when having anal, vaginal, or oral intercourse;

(b) By sharing needles, syringes, or other injection equipment;

(c) From an HIV-infected mother to her baby during pregnancy, birth, breastfeeding; or

(d) By receiving HIV-infected blood or blood products. (Risks from transfusions are now very rare because of blood screening which started in 1985).

III. SCREENING

A. Screening may be performed only when, in the judgment of the attending or admitting physician, the consumer:

1) Clinically exhibits signs that are consistent with the Centers for Disease Control (CDC) criteria for HIV-related illnesses.

2) Is considered to have significant potential, because of behavior characteristics, to transmit the infection;

3) Has been potentially exposed to HIV infection;

4) Has previously been diagnosed as having HIV infection or AIDS, and confirmation is required (HIV testing have been run elsewhere);

5) Is documented to be the source of a significant exposure of another person, and then in accordance with established infection control protocols; or

6) The physician requiring the screening will document the medical/behavioral necessity for the screen in the Physician's Order section or Progress Notes section of the consumer's medical record.

IV. INFORMED CONSENT

A. Requirements for informed consent for HIV testing are set forth in Texas Health and Safety Code 81.105.

B. HIV testing may not be conducted without informed consent, except under specific conditions allowed by law. The following are exceptions:

1) "A person or entity may not require another individual to undergo any medical procedure or test designed to show or help show whether a person has AIDS or infection, or HIV antibodies ... unless the medical procedure or test is necessary…

(a) HIV testing of individuals under mental health or intellectual disability services may be conducted **only if**:

(i) The result would significantly affect medical or social management of the individual providing care;

(ii) The test is performed in accordance with guidelines approved by the Texas Department of State Health Services (DHS) or its designated authority.

2) While specific exceptions permit testing under certain circumstances, it is strongly recommended that informed consent, preferably documented, be obtained from individuals prior to HIV testing whenever possible.

V. EMPLOYEE SCREENING

A. Routine screening of employees or prospective employees is not to be performed.

B. The risk of acquiring or transmitting HIV infection is related to the degree of percutaneous contact or mucous membrane contamination, with blood or semen containing HIV.

C. Studies have shown that there is a very low risk of transmission and seroconversion in employees who deal with persons with HIV infection, so long as standard precautions are utilized in the health care setting and there is no sexual contact with the HIV infected individual.

D. The same very low risk of seroconversion for HIV has been shown in studies of employees who sustained needle sticks with no other risk factors present.

VI. CONFIDENTIALITY OF TEST RESULTS

A. The results of HIV tests are **confidential** by law under Texas Health and Safety Code 81.103 and 81.105.

B. Reports, records, and related information may not be released or made public except as provided by the Communicable Disease Prevention and Control Act as amended by SB 959. Strict penalties for violations are set forth therein.

C. Requests from insurance companies, the Social Security Disability Determination Division of the Texas Rehabilitation Commission, or other agencies or entities MUST be accompanied by the appropriate signed release form authorizing the release of HIV specific information (Consistent with the policies and procedures of the Association of Medical Records Technicians and MHMRCV's Administrative Procedure on Confidentiality).

D. No identifying terms such as AIDS, ARC, or HIV infection will appear on the exterior of any consumer record.

E. Lists or other documentation that specifically identify individuals by these conditions will NOT be maintained.

F. All individuals will be cared for using standard precautions without exception.

G. Disease specific signage, including notices for "Blood/Body Fluid Precautions", will not be posted on any surface.

VII. DOCUMENTATION OF TEST RESULTS

A. HIV antibody test results may be documented in the consumer's electronic health record.

B. Electronic access to these results must be restricted to authorized personnel in compliance with HIPAA privacy and security requirements.

C. Diagnostic coding (ICD-10 or applicable codes) may be included in the record as required for clinical and billing purposes.

VIII. REQUIRED REPORTING OF TEST RESULTS

A. Positive HIV (Western Blot) results on staff or individuals served initially screened at MHMRCV will be reported to the local health authority in accordance with the Communicable Disease Prevention and Control Act(Texas Health and Safety Code Chapter 81) and 25 Texas Administrative code 97.132-.133.

B. The Infection Control Officer will be designated as the reporting authority and will ensure that reports required by law are completed.

IX. LIMITATION OF CONSUMER ACTIVITY

A. The behavior and medical considerations of each consumer will be evaluated by the Infection Control Officer (along with treating professional) with appropriate consultation, and only those restrictions recognized to be necessary relative to containment of infection in each case will be imposed.

B. Individual cases will be thoroughly reviewed by the Infection Control Officer in consultation with appropriate members of the interdisciplinary team in accordance with the Texas Communicable Disease Prevention and Control Act, restrictions regarding confidentiality of the information.

C. Reviews will occur at intervals specified in the consumer's treatment plan or when there are significant changes in the consumer's behaviors that might affect the consumer's potential for infecting other individuals served or staff.

D. If risk potential is identified, the interdisciplinary team will implement only the least restrictive intervention necessary to ensure the safety of staff and consumers.

E. **Any restrictions which employ the use of seclusion as an isolation procedure must meet the criteria detailed in the relevant departmental rules (Chapter 405F (405.128)).**

1) Seclusion as part of isolation procedures for an individual with a contagious disease will be utilized when medically indicated to protect the health and safety of other individuals until the individual infected is no longer contagious.

F. Individuals served who are too ill medically to benefit from MHMRCV facility services will be expeditiously referred to an appropriate medical facility.

X. PERSONNEL ISSUES

A. All employees, as indicated by their job descriptions, are expected to perform their duties, including providing care for individuals served with all communicable diseases, one of which is AIDS.

B. Employees who refuse to work with individuals served or with other employees who have HIV infections or who exhibit discriminatory behavior toward these individuals may be considered insubordinate. Their actions will be evaluated and managed in accordance with MHMRCV procedures.

C. All employees, including those with HIV infection, will be hired and/or retained in their jobs based on their ability to perform the job adequately and safely. Strict confidentiality of employee medical information will be maintained.

CORONAVIRUS (COVID-19)

I. CORONAVIRUS DISEASE

A. COVID-19 is a respiratory illness caused by SARS-CoV-2 that primarily spreads from person to person through respiratory droplets.

II. TRANSMISSION

A. COVID-19 spreads mainly through respiratory droplets and aerosols when an infected person coughs, sneezes, or breathes.

B. Transmission risk is highest in indoor, poorly ventilated spaces.

C. Surface transmission is possible but not considered the primary route.

III. SYMPTOMS

A. Fever or chills;

B. Cough;

C. Shortness of breath ;

D. Sore throat;

E. Muscle or body aches;

F. Headache;

G. New loss of taste or smell;

H. Fatigue;

I. Congestion or runny nose;

J. Nausea or vomiting;

K. Diarrhea.

IV. PREVENTIVE ACTIONS

A. Avoid close contact with people who are sick.

B. Avoid touching your eyes, nose, and mouth with unwashed hands.

C. Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

D. Follow current CDC masking guidance: Masks are recommended in healthcare setting and during outbreaks or high transmission periods.

E. Routine cleaning and disinfection of high touch surfaces per CDC guidelines.

F. Improve ventilation in indoor spaces.

G. Physical distancing is no longer required but may be implemented during outbreaks or high risk situations.

V. ACTIONS TO TAKE IF YOU ARE SICK

A. Stay home when you are sick and avoid contact with others.

B. Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

C. Clean and disinfect frequently touched objects and surfaces.

D. Report illness to your supervisor who will then report the illness to the Infection Control Officer.

VI. ACTIONS RECOMMENDED BY CDC AND OSHA AND IMPLEMENTED AT MHMRCV

A. Post signs at all entrances advising individuals with symptoms not to enter.

B. Maintain symptom-based screening for staff and visitors as required by local health authorities.

C. Post handwashing signs at all sinks.

D. Use the CDC standards regarding cleaning and disinfection.

E. Require masks for individuals who are coughing or symptomatic in healthcare settings.

F. Restrict participation in programs (IDD ISS/Vocational) for individuals with flu-like symptoms until cleared.

G. Discourage sharing of phones, desks, offices or other work tools or equipment.

H. Ensure Direct Care Staff use appropriate personal protective equipment (PPE) when providing care, especially during outbreaks or when exposure risk is high.

ACUTE EXPOSURE TO BLOOD THAT CONTAINS *(OR MIGHT CONTAIN)* HEPATITIS B SURFACE ANTIGEN (HBsAg)

I. GENERAL INFORMATION

A. Hepatitis B infection is caused by the Hepatitis B virus (HBV).

B. The incubation period is 45 - 160 days and the onset of acute disease is generally insidious.

C. Clinical symptoms and signs include anorexia, malaise, nausea, vomiting, abdominal pain, and jaundice.

II. TRANSMISSION AND INFECTION

A. HBV is transmitted primarily through percutaneous or mucosal routes, and infective blood or body fluids can be introduced at birth, through sexual contact, or needle stick injuries from contaminated sharps.

B. Infection can also occur in settings of close personal contact, presumably via unapparent or unnoticed contact of infective secretions with skin lesions or mucosal surfaces.

III. HBsAg POSITIVE EMPLOYEES

A. Employees who test positive for HBsAg do not require restriction from consumer contact unless epidemiologically linked to HBV transmission and adhere strictly to standard precautions and aseptic techniques.

IV. HBV CARRIERS

A. HBV carriers have an increased risk of developing primary liver cancer that is 12 - 300 times higher than non-carriers. In Texas, thousands of deaths occur annually from HBV-related cirrhosis and liver cancer.

B. The decision to provide HBV prophylaxis must consider several factors. Discuss these with your private physician.

1) The Hepatitis B vaccination status of the exposed person.

2) Whether the source is known or unknown.

3) Whether the HBsAg status of the source is known or unknown.

V. EXPOSURE

A. Any percutaneous, mucous membrane, or significant exposure to blood or body fluids should be treated as a potential exposure.

B. Unvaccinated individuals should begin the Hepatitis B vaccine series immediately.

VI. POST-EXPOSURE PROPHYLAXIS

A. The following information summarizes prophylaxis for percutaneous (needle stick, bite, cut, etc.), ocular, or mucous-membrane exposure to blood according to the source of exposure and vaccination status of the exposed person.

1) EXPOSED PERSON:

a) Unvaccinated: Initiate HB vaccine series as soon as possible.

b) Vaccinated: Test exposed person for anti-HBs antibody levels.

c) If inadequate antibody (less than 10 SRU by RIA, negative by EIA), administer HBIG xl dose immediately plus HB vaccine booster dose.

d) SOURCE: Known low-risk HBsAg positive.

2) EXPOSED PERSON

a) Unvaccinated: Initiate HB vaccine series.

b) Vaccinated: No action required.

c) SOURCE: Unknown

VII. EXPOSED PERSON NOT PREVIOUSLY VACCINATED

A. Hepatitis B vaccination should be considered the treatment of choice in the case of an exposed person not previously vaccinated.

B. Depending on the source of the exposure, HBsAg testing of the source and additional prophylaxis of the exposed person may be warranted.

C. Screening the exposed person for immunity should be considered if such screening is cost-effective and if this will not delay treatment beyond seven days.

D. SOURCE: Known HBsAg-**Positive**

1) Administer Hepatitis B Immune Globulin (HBIG) as soon as possible, ideally within 24 hours of exposure.

2) Begin the Hepatitis B vaccine series immediately (first does at a separate site from HBIG) Complete the series at 0, 1 month and 6 months.

3) If HBIG is unavailable, do not delay vaccination, start the Hepatitis B vaccine series promptly.

E. SOURCE: Known HBsAg Status **Unknown**

1) The following guidelines are suggested based on the relative probability that the source is HBsAg-positive and on the consequent risk of HBV transmission:

a) **HIGH RISK THAT THE SOURCE IS HBsAg POSITIVE** - Such as individuals served with a high risk of HBV carriage or individuals served with acute or chronic liver disease (serologically undiagnosed). The exposed person should be given the first dose of Hepatitis B vaccine within one week of exposure and vaccination completed

as recommended. The source person should be tested for HBsAg. If positive, the exposed person should be given HBIG within seven days of exposure.

b) **LOW RISK THAT THE SOURCE IS POSITIVE FOR HbsAg** - The exposed person should be given the first dose of Hepatitis B vaccine within seven days of exposure and vaccination completed as recommended.

VIII. EXPOSED PERSON PREVIOUSLY VACCINATED AGAINST HBV.

A. For percutaneous exposures to blood in persons who have previously received one or more doses of Hepatitis B vaccine, post exposure management will depend on source HBsAg status and the exposed person's anti-HBs antibody level.

IX. SOURCE KNOWN HBsAg POSITIVE

A. When ordered by a physician the exposed person should be tested for anti-HBs unless they have been tested within the last 12 months.

1) If the exposed person has adequate antibody, no additional treatment is indicated.

2) If the exposed person has not completed vaccination and has inadequate levels of antibody, one dose of HBIG should be given immediately and vaccination completed as scheduled.

3) If the exposed person has inadequate antibody on testing or has previously not responded to vaccine, one dose of HBIG should be given immediately and vaccination completed as scheduled.

4) If the exposed person shows inadequate antibody on testing but is known to have had adequate antibody in the past, a booster dose of Hepatitis B vaccine should be given.

X. SOURCE KNOWN HBsAg STATUS UNKNOWN

A. High risk source (suspected HBV carrier, acute/chronic liver disease). Additional prophylaxis is necessary only if the exposed person is non-responsive to known vaccine. In this circumstance, the source should be tested for HBsAg and, if positive, the exposed person treated with one dose of HBIG immediately and a booster dose of vaccine at a different site. In other circumstances, screening of the source for HBsAg and the exposed person for anti-HBs is not routinely recommended because the actual risk of HBV infection is very low, less than 1:1,000.

B. Low risk that the source is HBsAg positive. The risk of HBV infection is minimal. Neither testing of the source for HBsAg nor testing of the exposed person for anti-HBs is recommended.

C. Source Unknown The risk of HBV infection is minimal. No treatment is indicated.

Y. IF SOURCE CANNOT BE TESTED

A. Decisions should be based on risk assessment.

B. If the exposed person is fully vaccinated and has documented adequate antibody response, no action is needed.

C. If antibody response is inadequate or unknown, give HBIG and a booster dose.

HEPATITIS C PREVENTION AND CONTROL

I. OVERVIEW

A. Hepatitis C is a disease of the liver caused by infection with the hepatitis C virus (HCV).

B. Hepatitis C is spread when someone comes into contact with blood from a person with HCV infection.

C. One-third of people in the U.S. who have hepatitis C are unaware of their infection.

D. The best way to prevent hepatitis C is by avoiding behaviors that can spread the virus.

E. Ther is no vaccine for hepatitis C, but there are treatments that cure most people.

II. HOW IT SPREADS

A. The virus usually spreads when someone comes into contact with the blood of a person infected with HCV. The blood might be in amounts too small to see.

B. Spread can happen in the following ways:

1) Sharing items infected with HCV

a) Most people get infected with HCV by sharing needles, syringes, or other paraphernalia used for injection drug use.

b) You can also get infected by sharing razors, nail clippers, toothbrushes, or personal medical equipment like glucose monitors.

2) Birth – Infants born to people with HCV infection are at risk of infection.

3) Health care associated outbreaks – Poor infection control has led to outbreaks in health care facilities.

4) Sex with a person infected with HCV – While uncommon, hepatitis C can spread during sex. Most reported cases of transmission have been among men who have sex with men.

5) Tattoos or body piercings in unregulated settings – Hepatitis C can spread when getting tattoos or body piercings in unlicensed facilities, informal settings, or with non-sterile instruments.

III. WHO IS AT RISK

A. Some people with certain risk factors or exposures are at higher risk for hepatitis C and should be tested at least once, and periodically if exposure persists.

B. This includes people who inject drugs or have previously injected drugs, people with HIV, and children born to people infected with HCV.

C. Certain medical conditions

1) People who have received maintenance hemodialysis and those with persistently abnormal alanine aminotransferase (ALT) levels (an enzyme found with liver cells) are considered at increased risk of HCV infection.

D. Bood transfusion and organ transplant recipients – Certain people who have received blood transfusions or organ transplants are at risk for hepatitis C, including those who:

1) Received clotting factor concentrates before 1987.

2) Received blood or other transfusions before July 1992.

3) Received an organ transplant before July 1992

E. Exposure in health care settings – Health care, emergency medical, and public safety personnel can come into contact with blood that is infected with HCV. This can happen through:

1) Needle sticks;

2) Sharp objects;

3) Mucosal exposures;

4) Instruments and devices that re not sterilized properly;

5) Contamination of intravenous (IV) medications.

IV. PREVENTION

A. There is no vaccine to prevent hepatitis C.

B. The best way to prevent hepatitis C is by avoiding behaviors that can spread the disease, including:

1) Sharing needles, syringes, or other drug equipment.

2) Practicing poor or unsanitary procedures in healthcare facilities.

3) Engaging in sexual activity with a person who is infected with HCV.

4) Getting unregulated tattoos or body piercings.

5) Receiving a blood transfusion or organ transplant from a donor with HCV infection.

V. TREATMENT

A. Most treatments involve just 8-12 weeks of oral therapy (pills).

B. Treatment cures more than 95% of people with hepatitis C, usually without side effects.

INFECTION RISKS AMONG INDIVIDUALS SERVED

I. LIFESTYLE

A. The communal living arrangements in consumer residences creates a unique infection control challenge.

B. Frequent close contact through group activities and family style eating in some homes and programs can pose infection control obstacles.

II. POPULATIONS

A. Certain programs of MHMRCV are associated with an increased incidence of specific infectious diseases.

1) Adolescent populations – sexually transmitted disease, pediculosis, and common childhood illnesses.

2) Intellectual and Developmental Disability populations - Hepatitis A and B.

3) Geriatric populations – pressure ulcers (decubitus) and urinary tract infections.

4) Adult MH population- sexually transmitted diseases, Hepatitis A, B, C, HIV/AIDS.

III. BEHAVIORS

A. Some of the individuals served by MHMRCV attempt to do bodily harm to themselves or others.

B. There is a higher incidence of the following behaviors among MHMRCV individuals served:

1) Lacerating, puncturing, or abrading skin and mucous membranes.

2) Irritating wounds or injuries by picking or scratching.

3) Avoiding or resisting treatment of these injuries.

4) Inflicting injuries on others through biting or striking. This type of assault may result in local infections that may spread to underlying tissue or structures.

5) Ingesting harmful objects or chemicals that may traumatize internal organs and predispose to infection.

IV. INTERVENTIONS

A. Provide training to individuals served to reduce risk of transmission of HIV/AIDS, HEP-B, Tuberculosis.

B. Provide an environment that minimizes opportunity for injury and infection.

C. Treat psychiatric illness to help reduce destructive behaviors.

D. Implement appropriate infection control measures. .

V. HYGIENE

A. Individuals served may be disoriented or unable to perform basic hygiene practices. Risks associated with these behaviors include:

1) Accumulation of organic debris or microorganisms near body orifices, resulting in infections of the oral cavity or skin.

2) Inoculation of self or others with enteric pathogens when sharing food or cigarettes.

3) Environmental contamination through dispersal of organic material (e.g., feces).

These behaviors may result in enteric infections for the individual or for the consumer group.

B. Interventions

1) Assist disoriented individuals served with performing basic hygiene practices.

2) Incorporate basic hygiene into the treatment program.

3) Reinforce essential hygiene activities like bathing, handwashing, tooth brushing, toilet training, nutrition, skin care, exercise, and rest.

4) Avoid assigning these individuals to kitchen duty or food preparation.

VI. CHANGE IN SYMPTOMS

A. Individuals served may be unable to detect changes in sensations or may be unwilling to identify and report the sensations of pain, heat, swelling, itching or nausea. Associated risks include:

1) Skin breakdown may develop at pressure points and remain undetected by the individual served or staff.

2) Delayed treatment of pressure ulcers (decubiti) or lacerations may result in failure to heal an infection of underlying tissue.

3) Minor local infections may progress to systemic infections if treatment is delayed (e.g., group A streptococcal throat infections or gonorrhea).

B. Interventions

1) Refer individuals to a private physician when illness is suspected.

2) Administer prompt medical treatment when infection is noted.

3) Develop infection surveillance and reporting system designed to accommodate the special needs of the individuals served.

VII. TREATMENT COMPLIANCE

A. Individuals served may choose not to participate in the treatment of their medical condition or in following isolation precautions. Risks associated with these behaviors include:

1) Individual may transmit the microorganism to others, resulting in individual infections or an outbreak.

B. Interventions

1) Survey individuals served on a routine basis for evidence of infections.

2) Consider cohorting individuals served during outbreaks.

3) Restrict activity until disease is no longer communicable, effective treatment has been administered, or the illness has run its course (e.g., sexually transmitted disease, pediculosis, group A streptococcal infection or chicken pox).

VIII. FALSE SYMPTOMS

A. Individuals served may report imagined conditions such as lice, pain, sexual contacts, etc. Risks associated with these behaviors include:

1) The individual may receive unnecessary treatment.

2) A real infection or exposure may not be recognized or treated because of the frequency of imaginary conditions.

B. Interventions

1) Perform routine physical assessment of individuals served having these complaints.

RESIDENTIAL/RESPITE PROGRAMS

I. RESIDENTIAL PROGRAMS

A. Individuals served must be considered by a physician to be medically stable for residence in the community or be under the care of a private physician if any medical conditions are present.

B. The following infectious illnesses can be safely treated in the residential programs. Individuals experiencing any of the identified illnesses will only be considered for admission to the program if a private physician has prescribed medical treatment.

1) AIDS
2) Amebiasis
3) Brucellosis
4) Chlamydia Trachomatis
5) Common Cold
6) Conjunctivitis – bacterial and/or viral
7) Coronavirus, novel
8) Gastroenteritis, viral
9) Gonorrhea
10) Herpes Simplex
11) HIV
12) Impetigo
13) Measles
14) Mumps
15) Pediculosis
16) Pinworm
17) Ringworm of scalp
18) Scabies
19) Scarlet Fever
20) Streptococcal: sore throat
21) Syphilis
22) Trichinosis
23) Tularemia
24) Chicken Pox
25) Hepatitis, viral: Type A, Type B, and type unspecified
26) Rubella
27) Other infectious diseases will be evaluated on a case-by-case basis

C. If an individual contracts the illness while in the residential program, or the illness is identified by MHMRCV staff, they will be referred to their private physician for treatment.

D. Prospective residents will be assessed for symptoms of infectious illnesses during the admission process as part of the admission physical. If illnesses cannot be safely treated in the residential programs, individuals experiencing these illnesses will not be considered for admission to the program during the communicable phase of the illness.

E. The 24-hour residential staff members will be trained to observe and report to the residential nurse or the Infection Control Officer, any of the following signs or symptoms that might indicate an infectious process is taking place:

1) Fever of 100 degrees Fahrenheit or above.

2) Abdominal pain accompanied with fever.

3) Purulent drainage.

4) Diarrhea.

F. Since no department has the capacity for total isolation, individuals who have minor contagious infections (i.e., flu, colds, coronavirus, etc.) should have limited exposure to other persons in the environment following instructions of the physician/nurse.

G. Significant infections must be treated by a physician and reported to the Health Department, since they may spread quickly from person to person through direct or indirect contact. The physician/nurse will determine the appropriate placement based on the individual's infection and needs.

IDD INDIVIDUALIZED SKILLS & SOCIALIZATION (ISS)

I. IDD/ISS

A. Individuals served must be considered by a physician to be medically stable for admission and participation in IDD/ISS programs.

B. Individuals experiencing any of the identified illnesses will only be considered for admission and/or continued participation if a physician has prescribed medical treatment and provided a written statement that the individual can safely return to programming.

1) AIDS
2) Amebiasis
3) Brucellosis
4) Chlamydia Trachomatis
5) Common Cold
6) Conjunctivitis – bacterial and/or viral
7) Coronavirus, novel
8) Gastroenteritis, viral
9) Gonorrhea
10) Herpes Simplex
11) HIV
12) Impetigo
13) Measles
14) Mumps
15) Pediculosis
16) Pinworm
17) Ringworm of scalp
18) Scabies
19) Scarlet Fever
20) Streptococcal: sore throat
21) Syphilis
22) Trichinosis
23) Tularemia
24) Chicken Pox
25) Hepatitis, viral: Type A, Type B, and type unspecified
26) Rubella
27) Other infectious diseases will be evaluated on a case-by-case basis

C. If an individual contracts the illness while in the IDD/ISS program, or the illness is identified by MHMRCV staff, they will be referred to their LAR or residential provider for medical treatment.

D. Staff members will be trained to observe and report to the residential provider nurse or provider staff, any of the following signs or symptoms that might indicate an infectious process is taking place:

1) Fever of 100 degrees Fahrenheit or above.

2) Abdominal pain accompanied with fever.

3) Purulent drainage.

4) Diarrhea.

E. Since no department has the capacity for total isolation, individuals who have minor contagious infections (i.e., flu, colds, etc.) should have limited exposure to other persons in the environment following instructions of the physician/nurse.

F. Significant infections must be treated by a physician and reported to the Health Department, since they may spread quickly from person to person through direct or indirect contact.

STAFF DEVELOPMENT

I. ORIENTATION AND TRAINING

A. All new employees attend pre-service orientation (prior to assuming work duties) and annual update training in Infection Control.

B. The material presented is appropriate in content and vocabulary to educational level, literacy, and language of employees.

C. Infection Control training is computer based and in-person at New Employee Orientation (NEO).

D. Employees have the opportunity for interactive questions with a person knowledgeable on the subject matter.

E. Infection Control training consists of an orientation to the nature of nosocomial infections and ways of preventing and controlling them.

1) The broad goals of this training are to:

a) Provide an understanding of the basic concepts, sources, and prevention of infection, including the concept of standard precautions.

b) Provide a working knowledge of the susceptibility of the employee and the factors of that susceptibility.

c) Teach each employee that they have a personal responsibility and role in the control of infection within MHMRCV.

d) Provide an understanding of two specific blood borne diseases, AIDS, and Hepatitis B.

F. Human Resources Development staff maintains records of this attendance.

II. IN-SERVICE EDUCATION

A. In-service education, pertinent to the identified Infection Control needs of each program or department is reported to the Human Resources Development Coordinator and documented in each employee's individual training record.

III. CONTINUING EDUCATION AND ANNUAL TRAINING UPDATES

A. Continuing education is offered, and annual training updates are required in Infection Control.

B. This education is documented in each employee's individual training record.

HOUSEKEEPING SERVICES

I. CLEANING AND DISINFECTION

A. Cleaning and disinfection techniques are updated to reflect the most recent in scientific advances in that area.

B. Housekeeping Services contracted by MHMRCV for clinics and other areas will adhere to the same standard of quality as that of MHMRCV.

C. Housekeeping services have the following duties and responsibilities in MHMRCV public areas.

1) To clean and dust furniture, fixtures, windows, doors, trim and all other furnishings.

2) To collect all wastepaper and trash.

3) To clean, disinfect, and service all lavatories and restrooms.

4) To dust or wash interior partitions, picture frames, doors, facings, etc.

5) To dust mop, vacuum, or scrub floors and other surfaces.

6) To wash and/or clean windows and glass doors.

D. USDA - approved germicidal detergents as recommended by the Infection Control Officer will be used throughout MHMRCV.

E. Any cleaner used should be nonirritating to the skin, eyes and nose when breathing the fumes.

F. Contaminated work surfaces will be decontaminated after completion of procedures. Surfaces will be cleaned as soon as feasible when they are overtly contaminated or after any spill of blood or other potentially infectious materials.

G. Broken glassware that may be contaminated will not be picked up directly with the hands. It will be cleaned up using mechanical items, such as brush, dustpan, tongs, or forceps.

H. All trash is placed in enclosed plastic bags prior to being transported through the facility.

I. No pesticides, rodenticide, or similar products or materials may be applied by anyone not conforming to local laws, and federal regulations.

J. Floors, walls, linen, and other selected items or surfaces may be cultured as ordered by the Infection Control Officer.

K. Linen should be changed weekly unless excessively soiled. An individual served should not sleep on linen that was used by another individual without first washing the linen.

L. The following procedures will be used when handling linens that have been contaminated with bodily fluids:

1) Linen that has been contaminated to the extent of oozing under pressure, caking or flaking, or pooling or puddling:

   a) Wear gloves.

   b) Wear the protective equipment included in the spill kit that is necessary.

   c) Carefully place the linen in a red bag to carry to the washing machine.

   d) Wash the linen in 1:10 bleach solution then launder again using soap.

   e) After laundering, sanitize the machine with a 1:10 bleach solution.

   f) Dispose of protective equipment used in the bio-waste container.

2) Linen that has not been contaminated to the above extent:

   a) Wear gloves.

   b) Wash the linen in a 1:10 bleach solution then launder again using soap.

   c) After laundering sanitize the machine with a 1:10 bleach solution.

   d) Dispose of protective equipment used in the bio–waste container.

NUTRITION SERVICES

I. FOOD PREPARATION

A. Sanitation procedures are developed as a basic guide for food preparation areas.

B. Maintaining strict sanitary conditions is of vital importance to prevent food contamination and reduce the risk of food-borne illness.

C. The objective of these rules is to establish, implement, and maintain firm sanitary procedures.

D. Persons handling food are not permitted to work in the service area if they are:

1) Infected with a communicable disease transmissible through food.

2) A carrier of organisms that cause communicable disease.

3) Afflicted with an infection, transmissible to others (e.g., a boil, infected wound, acute respiratory infection, diarrhea, etc.).

E. After being released from duty for one of the above health related problems, the person will not be allowed to work with food again until after the infectious period of the illness is ended.

F. All persons will be required to wash hands thoroughly with soap and warm water prior to handling food, eating, using the restroom, handling garbage or dirty dishes or touching exposed parts of his/her body.

G. Tobacco use is prohibited in all MHMRCV areas.

H. All persons handling food must maintain personal cleanliness.

I. All persons handling food will be trained according to an approved food handler training program.

II. RECEIPT OF FOOD, FOOD STORAGE, AND TRANSPORTATION

A. When shopping for food items, inspection should be made for signs of spoilage or damage prior to purchase.

1) Canned Foods: Swollen top and/or bottom; dents along seams.

2) Frozen Foods: Signs of thawing.

3) Perishable Foods: Warm to the touch.

4) Produce: Wilting, discoloration, blemishes, bruises.

B. Groceries must be properly stored in a timely manner. Perishable foods are stored first; frozen foods next; dry goods last.

C. All perishable food will be stored at 40 degrees Fahrenheit or below for cold foods.

D. Produce and fresh fruits will be stored in coolers maintaining temperatures of 40 degrees Fahrenheit or below.

E. Frozen foods will be stored in a freezer maintaining a temperature of –10 degrees Fahrenheit to 0 degrees Fahrenheit (-23’ to -17.8’ Celsius).

F. Dairy products (milk, cheese, butter/margarine) will be stored in refrigerators maintaining temperatures of 36 degrees Fahrenheit to 40 degrees Fahrenheit (2.22’ to 4.44' Celsius).

G. Meats, poultry, and fish will be stored in coolers maintaining the temperatures of 36 degrees Fahrenheit to 40 degrees Fahrenheit (2.22' to 4.44' Celsius), for short time storage not to exceed 1 to 2 days.

H. Dry storage temperatures should be 70 degrees Fahrenheit (21’ Celsius), or lower for proper shelf life of canned and dry goods (flour, meal, etc.).

I. All nonfood supplies will be stored in an area separate from where food supplies are stored. All supplies will be clearly labeled.

III. FOOD PRODUCTS

A. Agencies that provide MHMRCV Nutrition Services with staple and dry groceries are inspected and licensed by the F.D.A.

B. All warehouses should be arranged according to FDA specifications, with merchandise stored under controlled temperatures on properly prepared shelving and bins.

C. All warehouses are inspected by the F.D.A. for any type of infestation, damaged packages, and other issues.

D. Insecticides used must comply with state and city regulations.

E. Merchandise is rotated on a regular basis.

F. Outdated merchandise is not to be accepted by nutrition service staff.

G. Meats and meat by products are purchased from U.S.D.A approved sources and inspected by the state or local authorities.

H. U.S.D.A. eggs are purchased with proof of inspection certificates from vendors. All cartons are sealed and stamped.

I. All supplies are stored in accordance with the sanitation standards for Food Service Departments set by the Texas Department of Health (8050-07-05).

IV. FOOD HANDLING

A. Handle food with clean hands or use tongs or disposable gloves.

B. Food must be held below 40 degrees Fahrenheit (for salads, fruits, condiments) or above 140 degrees Fahrenheit (meats, vegetables, casseroles).

C. Food must be covered and dated when stored.

D. Cooked meat and other food items should never be sliced on the same board used for cutting raw meat. Cutting boards will be marked for raw meats, cooked meats, vegetables, etc.

E. All "hot" food must be heated to 165 degrees Fahrenheit (internal temperature) when served.

F. Frozen foods should never be refrozen.

G. Leftover food items will be cooled and stored at 40 degrees Fahrenheit or below. All leftover food items will be kept covered and away from raw, unprocessed food. All leftovers will be labeled and dated when stored.

H. Holding and Reuse of Leftovers

1) Meat

a) Meat, without gravy, sauce, or other accompaniments, whose internal temperature was maintained at 140 degrees Fahrenheit or higher may be retained for reuse within 24 to 48 hours if stored at 40 degrees Fahrenheit or below.

b) Casserole dishes, stews, meats in sauces and gravies will be discarded after the meal, or if the internal temperature was maintained at 140 degrees Fahrenheit, or above, these items may be placed in willow pans no more than two (2) inches deep, quickly cooled in 4 hours or less to an internal temperature of 40 degrees Fahrenheit and utilized within a 24 to 48-hour period.

2) Vegetables

a) Leftover vegetables with sauces are discarded.

b) Plain vegetables with nothing added except oleo/butter may be cooled rapidly to 40 degrees Fahrenheit or below, served within 48 hours, and unused food discarded.

3) Fruits

a) Fresh, canned, or frozen fruits may be held at 40 degrees Fahrenheit or below and served as soon as possible within five days, after which time they will be discarded.

4) Gelatins, Fruit Pies, Frozen Cakes

a) These foods may be retained at 40 degrees Fahrenheit or lower and served within 48 hours.

b) Such food items should be discarded after this amount of time has passed.

c) Fruit pies and frozen cakes may be refrozen.

5) Cream Pies, Custards, Food Containing Cream Fillings, Eggs, or Milk

a) Leftovers of any of these food items will be discarded.

V. CARE AND CLEANING OF EQUIPMENT

A. Dish washing equipment is maintained in good working order to ensure proper sanitizing of service ware to prevent contamination.

B. Pots, pans, utensils, and cutting boards that are washed by hand must be properly sanitized.

1) Use a clean rag with soapy water to clean the surface and a clean rag with clear water is used to rinse the soap off.

2) An abrasive cleaner may be used for some cleaning, but surfaces must then be rinsed thoroughly. Do not use abrasive cleaners on stainless steel. Stainless steel must be clear of foods before a cleaner is used.

3) When cleaning, work on small areas at a time.

4) Use 1/3-cup bleach for 5 gallons water. Immerse items for one minute for proper sanitizing. Allow to air dry.

C. Disposable containers and utensils are discarded after one use.

D. Any trays, cups or bowls that have lost their glaze or are chipped or cracked will be discarded to prevent bacterial growth.

INFECTION CONTROL PROGRAM APPROVAL

MHMR CCONCHO VALLEY INFECTION CONTROL PROGRAM REVIEWED AND APPROVED BY:

Grace Kang, DO Digitally signed by Grace Kang, DO Date: 2026.04.02 13:01:31 -05'00'

_____

Dr. Grace Kang, Medical Director

Gregory J. Rowe Digitally signed by Gregory J. Rowe Date: 2026.04.06 16:13:54 -05'00'

_____

Gregory J. Rowe, Chief Executive Officer

APPENDICES

TEXAS NOTIFIABLE CONDITIONS

HEPATITIS B VACCINE
CONSENT OR REFUSAL FORM

Hepatitis B infection is caused by a Hepatitis B virus that causes death in 1% to 2% of individuals served. Hepatitis B is an inflammation of the liver that can lead to chronic persistent Hepatitis, chronic active Hepatitis, cirrhosis, and liver cancer. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. The employee is at risk of acquiring this infection due to frequent exposure to blood and body fluids.

Hepatitis B vaccine (recombinant) is available and requires three injections for adequate immune response, although some persons may not develop immunity event after three doses. The duration of immunity is not known at this time. The vaccine has been tested extensively for safety and efficacy in large-scale clinical trials with human subjects.

The Hepatitis B vaccine is non-infectious recombinant DNA vaccine obtained by culturing a genetically engineered yeast cell that carries the surface antigen gene of the Hepatitis 6 virus. For this reason, any person with hypersensitivity to yeast should not receive this vaccine.

The vaccine side effects are very few. Tenderness and redness of the injection site and low-grade fever are the most common side effects, occurring about 10% of the time. Rash, nausea, joint pain, and mild fatigue have also been reported. This vaccine should not be taken if pregnant or nursing, because effects at this time are not known.

I understand that I should not take this vaccine if active infection, febrile illness, or hypersensitivity to yeast is present. I further understand that I should not take the vaccine if active infection is present or if I have an allergy to the following compounds: Formalin or Thimerosal (a mercury derivative) or Baker's yeast.

In consideration of MHMRCV providing the Hepatitis B Series vaccine, the undersigned employee does hereby waive, discharge and release MHMRCV, its agents, officers, and employees from any and all causes of action arising out of the administering of the three-shot series.

☐ I request the vaccine be given to me. ☐ I do <u>not</u> wish to participate.

Printed name	Signature	Date
_____	_____	_____

Signature of witness	Date of witness signature
_____	_____

DOSE	DATE	VACCINE	LOT#	EXPIRES	GIVEN BY
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

INFORMATION LETTER FOR PERSONNEL WHO HAVE HAD ACCIDENTAL EXPOSURE TO BODY FLUIDS

1) Inform your private physician and see them as he/she indicates.

2) If a baseline HIV Antibody Test is requested, your written informed consent is necessary.

3) You are encouraged to report and seek a medical evaluation for any acute febrile illness particularly one that is characterized by swollen glands, fever and/or rash that occurs within 12 weeks after exposure.

4) If your first HIV test results are negative, you are encouraged to retest in three and six months after exposure.

5) If you have never been vaccinated with Hepatitis B Vaccination, this series of vaccinations is available to you. Your written informed consent is necessary to administer or refuse the Hepatitis B Vaccination. The first injection may be received immediately, a second in one month, and a third in six months.

6) Your private physician will decide if a Tetanus Booster is appropriate at this time.

I have received a copy of this information and have been provided with an explanation of my choices. I understand the material presented to me.

_____	_____	_____	_____
Printed Name of Employee	Signature of Employee	Date	Time
_____	_____	_____	_____
Printed Name of Witness	Signature of Witness	Date	Time

cc: Infection Control Officer
Quality Management
Human Resources

EXPOSURE PROTOCOL
(Individuals Served)

1) Immediately wash the exposed area with soap and water. If the exposure is in the eyes, mouth, or nose, do not use soap; use cool water to slush the area.

2) If the injury is a puncture wound that is not bleeding, encourage bleeding by applying pressure to the surrounding areas.

3) If the injury is a ragged-edge bite or laceration and the area is bleeding profusely, or if you are a hemophiliac, apply pressure with a clean bandage (preferably sterile) to stop the flow of blood.

4) Notify the staff on duty, or your personal physician, nurse, or service coordinator.

5) Discuss the exposure with your physician, including risks of becoming infected by another person's blood.

6) Go immediately to your personal physician or the Emergency Room of your choice for evaluation and treatment of your exposure.

   (a) If you know your source of exposure is HIV positive, ask the physician to discuss the risks and benefits of immediate treatment with AZT or other agents with you.

   (b) Request that the physician order blood to be drawn for: HIV test, Hepatitis Profile (includes A, B, C, D, E), RPR

   (c) Ask the physician contact the Infection Control Coordinator and inform them of their recommendations for your treatment and follow-up, and activity level.

7) Follow your physician's recommendations for treatment, follow-up, and activity level.

8) Sign consent for Release of Information related to the exposure to include:

   (a) Treatment received
   (b) Results of evaluation
   (c) Recommendations for follow-up, activity level, & medications prescribed
   (d) Copy of physician statement and discharge slip from the emergency rm.
   (e) Bills, statements, etc.

9) See your personal physician to obtain the results of your blood tests and discuss any issues or concerns you may have about the tests and/or results.

MHMRCV staff & I have reviewed this protocol. I understand what is expected & necessary.

_____	_____	_____
Printed Name of Individual Served	Signature of Individual Served	Date
_____	_____	_____
Printed Name of Witness	Signature of Witness	Date

EXPOSURE PROTOCOL
(Employee)

1) Immediately wash the exposed area with soap and water. If the exposure is in the eyes, mouth, or nose, do not use soap; use cool water to slush the area.

2) If the injury is a puncture wound that is not bleeding, encourage bleeding by applying pressure to the surrounding areas.

3) If the injury is a ragged-edge bite or laceration and the area is bleeding profusely, or if you are a hemophiliac, apply pressure with a clean/sterile bandage to stop the blooding.

4) Notify your supervisor.

5) Ask your supervisor to complete the MHMRCV Incident Report.

6) Go immediately to your personal physician or the Emergency Room of your choice for evaluation and treatment of your exposure.

   (a) If you know your source of exposure is HIV positive, ask the physician to discuss the risks and benefits of immediate treatment with you.
   (b) Request that the physician order blood to be drawn for: HIV test, Hepatitis Profile (includes A, B, C, D, E), RPR
   (c) Ask the physician contact the Infection Control Coordinator and inform them of their recommendations for your treatment and follow-up, and activity level.

7) Follow your physician's recommendations for treatment, follow-up, and activity level.

8) Call your supervisor & notify them of the results & recommendations of your evaluation.

9) Call the Infection Control Officer to advise of your status and any additional needs.

10) Forward all information regarding the incident to Q.M. who will notify Human Resources.

    (a) Signed consent for Release of Information related to the exposure to include:
        i. Treatment received
        ii. Results of evaluation
        iii. Recommendations for follow-up, activity level and medications prescribed.
    (b) Copy of physician statement and discharge slip from the emergency room.
    (c) Bills, statements, etc.

11) See your personal physician to obtain the results of your blood tests and discuss any issues or concerns you may have about the tests and/or results.

My supervisor and I have reviewed this protocol. I understand what is expected and necessary.

_____	_____	_____
Printed Name of Employee	Signature of Employee	Date
_____	_____	_____
Printed Name of Supervisor	Signature of Supervisor	Date

INFORMATION FOR EMERGENCY ROOM STAFF
(Individuals Served)

To: **Emergency Room Staff**

From: **Primary Physician**_____

Nurse/Individual Service Coordinator_____

Subject: **Blood Borne Pathogen Exposure Management (Individual Served)**

Please be advised that _____is receiving
(Individual Served Name)
services from MHMR Concho Valley. This individual has just been exposed to a blood borne pathogen

via,_____at_____ _____, _____.
(Type of injury) *(Time)* *(Date)* *(Site of Injury)*

This individual is coming to you for immediate evaluation and treatment of the exposure. MHMR Concho Valley calls for:

1) Baseline serum tests for: **HIV test**, **Hepatitis Profile (includes A, B, C, D, E)**, **RPR.**

2) Counseling and discussion of the risks and benefits of beginning AZT therapy if the source of their exposure is known HIV+ or considered to be a high risk for + due to known risk behaviors.

3) Repeat the tests outlined in item 1, at 6-week, 12 week, and 6-month intervals.

4) Notify the consumer's primary physician, nurse or individual service coordinator of the results and recommendations of the evaluation.

If you have any questions or concerns, please contact the following:

_____ _____
Primary Physician Phone Number

_____ _____
Nurse Phone Number

_____ _____
Service Coordinator Phone Number

INFORMATION FOR EMERGENCY ROOM STAFF
(Employee)

To: **Emergency Room Staff**

From: **Primary Physician/Designee**_____

Nurse/Individual Supervisor _____

Subject: **Blood Borne Pathogen Exposure Management (Employee)**

Please be advised that _____is an
(Employee Name)
employee of MHMR Concho Valley. This employee has just been exposed to

a blood borne pathogen via,_____at_____ _____
(Type of injury) *(Time)* *(Date)*

_____.
(Site of Injury)

This employee is coming to you for immediate evaluation and treatment of the exposure. MHMR Concho Valley calls for:

1) Baseline serum tests for: **HIV test**, **Hepatitis Profile (includes A, B, C, D, E)**, **RPR.**

2) Counseling and discussion of the risks and benefits of beginning AZT therapy if the source of their exposure is known HIV+ or considered to be a high risk for + due to known risk behaviors.

3) Repeat the tests outlined in item 1, at 6-week, 12 week, and 6-month intervals.

4) Notify the named employee and the Workers' Compensation Representative/Chief Human Resources Officer of MHMR Concho Valley of the results and recommendations of the evaluation.

If you have any questions or concerns, please contact the following:

_____	_____
Employee	Phone Number
_____	_____
Supervisor of Employee	Phone Number
_____	(325) 658-7750
Worker's Compensation Rep./Chief HR Officer	Phone Number

NOTICES TO BE POSTED

AT MHMRCV CAMPUSES

HIV/TB TRANSMISSION and SIGNS & SYMPTOMS OF HIV, AIDS & TB

HIV: *TRANSMISSION*
Direct contact with person's blood, semen, or vaginal fluids:

1) By having unprotected sexual intercourse; that is, not using latex condom when having anal, vaginal, or oral intercourse;
2) By sharing needles, syringes, or sharps;
3) From an HIV-infected mother to her baby during pregnancy or birth; or
4) By receiving HIV-infected blood or blood products. (Risks from transfusions are now very low because of blood screening which started in 1985).

HIV: *SIGNS AND SYMPTOMS*
Immune suppression phase: can produce night sweats, weight loss, diarrhea, nerve pain, fatigue, rashes, mouth ulcers and slowing of thinking.

AIDS: *SIGNS AND SYMPTOMS*
Can last one to five years with severe infections such as pneumonia, tuberculosis, and tumors in any body system. This virus attacks every organ in the body. Hepatitis B only attacks the liver.

TUBERCULOSIS: *TRANSMISSION*
Tuberculosis (TB) is an airborne disease which primarily attack the lungs. It spreads from person to person when an individual with active pulmonary TB coughs, sneezes, speaks, or sings, releasing droplet nuclei into the air that others may inhale.

PARTICULATE MASKS ARE PROVIDED TO STAFF TO ASSIST IN THE REDUCTION OF RISK OF EXPOSURE TO TUBERCULOSIS.

TUBERCULOSIS: *SIGNS AND SYMPTOMS*
General Symptoms may include weakness, feeling sickness, weight loss, fever, mouth ulcers, rashes, and night sweats. Commons symptoms of TB of the lungs may include long term cough, chest pain, and coughing up blood

POST EXPOSURE ACTIONS/STEPS RECOMMENDED BY CDC FOR BLOOD & BODY FLUID SPILLS

IMMEDIATELY:

1) Needle sticks and cuts should be washed with soap and water.(No scientific evidence shows that the use of antiseptics for wound care or squeezing the wound will reduce the risk of transmission of HIV. The use of a caustic agent such as bleach is not recommended).

2) Splashes to the nose, mouth or skin should be flushed with water.

3) Eyes should be irrigated with clean water, saline, or sterile irrigants.

4) Report the exposure to your supervisor and/or Infection Control Officer (MR – xt. 355, MH – xt. 420). Prompt reporting is essential because, in some cases, HIV post exposure treatment may be recommended, and it should be started as soon as possible---preferably within 1-2 hours.

POST EXPOSURE FOLLOW-UP MONITORNG:

1) You should be tested for HIV antibody as soon as possible after exposure (baseline), and periodically for at least 6 months after exposure (e.g., at 6 weeks, 12 weeks, and 6 months).

2) If you are taking antiviral drugs for post exposure treatment, you should be checked for drug toxicity, including a complete blood count and kidney and liver function tests just before starting treatment and 2 weeks after starting treatment.

3) You should report any sudden or severe flu-like illness that occurs during the follow-up period, especially if it involves fever, rash, muscle aches, tiredness, malaise, or swollen glands. Such illness or symptoms may suggest HIV infection, drug reaction, or other medical conditions.

4) During the follow-up period, especially the first 6-12weeks when most infected persons are expected to show signs of infection, you should follow recommendations for preventing transmission of HIV. These include refraining from blood, semen, or organ donation and abstaining from sexual intercourse. If you choose to have sexual intercourse, using a latex condom consistently and correctly may reduce the risk of HIV transmission. In addition, women should not breast-feed infants during the follow-up period to prevent exposing their infants to HIV in breast milk.