A) Policy and Procedures

Protocol for Identification/Treatment of HIV Positive Women in the Office Setting

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Purpose: To outline the identification of HIV and treatment for HIV infected patients during the prenatal period.

Supportive Data: The CDC estimates that 40,000 new human immunodeficiency virus infections still occur in the United States each year. This includes 300 infants infected via vertical transmission. If pregnant women are identified as HIV positive and treated with antiretroviral medications and subsequently their infants are also treated, the transmission rate falls from 25% to 2% or less.

California Assembly Bill 1676, chaptered in 2003, went into effect January 2004. This bill amended the Health and Safety code to add HIV testing to the state mandated prenatal lab tests (currently Hepatitis B and Rh). The goal is to conduct definitive HIV testing in the prenatal period and to develop treatment options and delivery plans to ensure the least amount of vertical transmission to the fetus. Since the intent of the bill is prenatal identification, HIV testing, if originally refused by the patient, should be re-offered each trimester. If HIV testing was not completed because the patient refused, or the patient did not have prenatal care, the hospital will also offer testing. Intrapartum testing will usually be accomplished using a rapid HIV test, which is not as reliable as the tests used in the prenatal period, but allows treatment to occur prior to delivery or in the early newborn period.

In 1998, the Institute of Medicine concluded that testing should be offered as part of the standard battery of prenatal tests, regardless of risk factors or community prevalence rates. This is based on the statistic that 40% of mothers of HIV positive infants were unaware of their status at delivery.

The CDC is recommending the Opt-Out approach for offering HIV testing. Opt-out approach means notifying the patient that testing is occurring, unless she declines. This strategy is associated with greater testing rates than the Opt-In approach.

Policy:

1. Use Opt-out approach offer HIV testing as part of routine prenatal care.
2. Obtain patient signature on the consent for HIV testing.
3. Offer HIV education regarding safer sex, and importance of HIV status identification to prevent perinatal transmission, and HIV testing process.
4. Schedule appointment to discuss test results prior to 12-14 week gestation, if possible.
5. Ensure written communication of test results and plan of care to delivery hospital.
6. Refer HIV positive patients to Perinatologist or HIV specialist.
7. Develop plan of care including Intrapartum care (antiretroviral medication and mode of delivery).
8. Offer list of community resources.

Protocol:

1. During the first prenatal appointment, discuss the importance of knowing HIV status for maternal treatment and to reduce perinatal transmission. Inform the patient that HIV testing is now a part of routine prenatal lab testing. Provide the patient with a copy of the California Perinatal HIV Testing Information and Consent form in her spoken language (provided in 11 languages by the CA Office of AIDS at www.dhs.ca.gov/ps/ooa/Resources/oaforms.htm). The patient must decline, rather than agree to the test (opt- out of the testing).
    a. If patient accepts the testing:
        i. Obtain patient written acceptance on the state form. (This can be done by any prenatal care provider, not just a physician)
        ii. Order HIV testing with an FDA licensed enzyme immunoassay (EIA) followed by confirmatory testing of repeatedly reactive EIAs with an FDA-licensed supplemental test (Western blot)
        iii. Schedule follow up appointment to discuss test results prior to 12-14 week gestation, if possible.
    b. If patient declines testing:
        i. Re-offer test each trimester.
        ii. Inform patient that if HIV unknown at time of admission to the hospital, the L&D staff will offer the rapid HIV test, which is not as accurate as the tests done prenatally.
        iii. Inform the patient that their decision will not affect their care.
2. If HIV status is already known to be positive or HIV test results are found to be positive, assess:
    a. Degree of immunodeficiency with CD4+/percentage.
    b. History of prior antiretroviral therapy (ARV)
    c. Viral load (HIV-RNA)
    d. Gestational age

3. Refer to chart for treatment recommendations:

FOR ALL PREGNANT WOMEN (ANTEPARTUM)	1ST TRIMESTER ARV NAÏVE WOMEN	1ST TRIMESTER , WOMEN RECEIVING ARV THERAPY
Dose regimens: • ZVD 100mg po 5x daily, start after 14 weeks gestation *acceptable alternatives* • ZDV 200mg po TID or • ZVD 300mg po BID	• Evaluate woman's need for ARV therapy • Counsel woman on risk/benefits of starting ARV during this time • Consider delaying ARV until 12 weeks gestation	• Evaluate and counsel same as column to the left • If decision is to temporarily stop ARV therapy, stop all drugs together and restart them together after the 1st trimester to avoid inducing viral resistance to the drugs • If pregnancy identified after the 1st trimester, continue therapy

Adapted from Guidelines for Use of HIV Antiretroviral Therapy in Pregnancy, Francois-Xaivier Bagnoud Center, University of Medicine and Dentistry of New Jersey, Feb., 2004

4. Develop plan of care for L&D including/attaching the plan to the prenatal records and send it to the delivering hospital per the normal process.
    a. Discuss vaginal versus cesarean delivery based on viral load, medication regimen at time of delivery, and timing of labor.
5. Coordinate care of HIV positive patient with Perinatologist, HIV specialist, Pediatrician, and Pediatric HIV specialist.

References:

Revised Guidelines for HIV Counseling and Testing. CDC MMWR November 9, 2001/ 50(RR-19); 59-86.

Guidelines for Use of HIV Antiretrovial Therapy in Pregnancy. Francois-Xavier Bagnoud Center, University of Medicine and Dentistry of New Jersey, February, 2004.

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PROTOCOL FOR PERINATAL: IDENTIFICATION/TREATMENT OF HIV POSITIVE WOMEN IN LABOR

PURPOSE: To outline the identification of and nursing management and treatment for the HIV infected patient in Labor and Delivery to reduce the risk of HIV transmission to the newborn.

LEVEL: Interdependent

SUPPORTIVE DATA: Research indicates that vertical transmission of the HIV virus is significantly decreased through maternal and neonatal use of antiretroviral agents. The likelihood of transmission appears to be proportional to the level of HIV RNA present in the maternal serum. The serum viral load (HIV RNA) is a measure of the magnitude of active HIV replication. The goal of treatment is to suppress the viral load to an undetectable level.

While the most effective method of decreasing maternal viral load is prenatal treatment with a combination of antiretroviral agents, studies have shown that any therapy, whether prior to labor or **immediately before delivery**, or in the early (<72 hours) neonatal period can be of benefit. Consequently, the California Health and Safety Code (Sections 125085, 126090, 125092, 125107) require testing for HIV to be included in every woman's prenatal panel. The woman always has the right to decline the test

Transmission may occur as a result of fetal exposure to the virus during labor and delivery, through ascending infection, through exchange of blood between the mother and infant, or through direct contact of the infant with vaginal or cervical secretions. HIV positive pregnant women should receive antiretroviral medications even when they may not meet standard lab requirements for treatment. If vaginal delivery is planned, Zidovudine (AZT) should be administered in labor.

If the results of the prenatal HIV test is not listed among the prenatal test results, the pregnant woman shall be counseled, tested using the Ora Quick® Rapid HIV test and treated prior to delivery. The pregnant woman may **always refuse** the test after counseling.

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Neonates of those women at most risk for viral transmission (viral loads greater than 1,000 copies/ml of plasma) appear to benefit most from elective Cesarean delivery. ACOG recommends that all HIV infected women with unknown or viral loads greater than 1,000 copies/ml of plasma be offered elective Cesarean delivery prior to the onset of labor. If she is already in labor or has ruptured membranes, Cesarean delivery may not be of benefit. If the woman has a positive HIV result per the Rapid HIV test, counseling regarding her delivery route should take into account all other risk factors.

LABOR & DELIVERY
ASSESSMENT OF HIV STATUS:

1. Review the patient's prenatal form for results of the prenatal HIV test. If documented test results are negative or are positive with the woman being currently treated, proceed to the Intrapartum section of this protocol.

2. If no test results are available:
   a. Contact physician office for HIV test results if the prenatal indicates the test was done, but results are not on the chart.
   b. Counsel the patient regarding HIV testing using the Ora Quick® Rapid HIV test if:
      - the patient declined the test prenatally,
      - the patient has had no prenatal care, or
      - test results are not available from provider office.

3. Discuss the following in a confidential setting with any woman eligible for the rapid HIV screen:
   a. The purpose and rationale for the test.
   b. The risk and benefits of the test.
   c. Her ability to decline the test.

4. Provide the eligible woman with a copy of the Perinatal HIV Testing Information Form provided by the California Department of Health Services and the Office of AIDS. **Only simple consent is required for running the test.**

5. Document any refusal of the HIV test in the chart. Sample documentation includes:
   a. Patient has been provided HIV information. She declines the HIV test.
   b. Patient has been provided information about the HIV test, specific treatment options if a positive result and recommendations regarding future testing. She declines the HIV test.

6. Draw the tubes of blood (5mL lavender top and 7mL gold top tubes) for prenatal labs (RN or Lab) after obtaining simple consent for the HIV test. Order an L&D Rapid HIV test STAT (SHIPER, MS4 or by lab slip per institution) and transport tubes of blood to lab with the requisition. Results will be called by the lab to the RN/Charge Nurse.

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7. Ask the patient whom, if anyone, she would like to be present when she receives the results of the test.

8. Contact physician to provide positive test results along with treatment options to the patient. Lab will automatically run a confirmatory HIV test with results available within 7-10 days.

9. Contact the social work department for crisis intervention or postpartum counseling using the key words "Rapid Test Response." This wording alerts the social work staff that the patient is a newly diagnosed (screened) HIV patient and they will be prepared to connect them to appropriate community resources, i.e., WE CARE, County Social Services, etc.

10. Fax any HIV medication orders to pharmacy as a STAT order.

INTRAPARTUM CARE OF POSITIVE
HIV PATIENT:

NOTE: Contact the Perinatal Hotline (National Perinatal HIV Consultationa and Referral Serivce) at 1-888-448-8765 for 24/7 consultation and treatment advice from physicians at UCSF.

11. Use strict standard precautions during Labor and Delivery.

12. Maintain confidentiality of woman's HIV status at all times (HIV status **can** be shared between caregivers).

13. Notify nursery, pediatrician/neonatologist and pharmacy of upcoming delivery and the need for Zidovudine (AZT) for the neonate post delivery.

14. Notify Postpartum of delivery and plan for a private room, if possible.

15. Avoid the use of the following if possible to reduce the risk of HIV transmission during labor and delivery:
    a. Intrauterine catheters,
    b. Fetal scalp electrodes
    c. AROM
    d. Episiotomy
    e. Vacuum extractors or forceps

MEDICATIONS:

16. Obtain history of prior and current antiretroviral medications, including the last dose taken and schedule of administration from any woman previously diagnosed for HIV infection and treated prenatally.

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17. Send patient's current medication for HIV treatment to pharmacy for re-labeling and patient usage, if unable to obtain current medication from pharmacy. Otherwise, send medications home for use after discharge.

18.

18. Continue administration of the patient's prenatal antiretroviral medications per her usual schedule. Medications may be given prior to a cesarean delivery with a sip of water. NOTE: Oral Stavudine d4T and intravenous Zidovudine (AZT) should not be administered together.

19. Administer intravenous Zidovudine (AZT) during the intrapartum period, whenever feasible, for the patient who has not received Zidovudine (AZT) as a component of her antenatal anti-retroviral regimen or has been designated HIV positive using the Ora Quick® HIV test.

20. Administer intravenous Zidovudine (AZT) prior to delivery, as ordered:
    a. Standard solution is 1000 mg Zidovudine in 250 mL NS (4 mg/mL).
    b. The infusion is piggybacked into the mainline solution.
    c. The mainline infusion solution and rate is specified and ordered by the physician.
    d. Usual loading dose is 2 mg/kg, infused over one hour.
    e. Usual maintenance dose is 1 mg/kg infused until delivery.
    f. Infusion of the IV loading dose is begun a minimum of 3 hours prior to an elective cesarean section to achieve an adequate serum level.

POST DELIVERY:

21. Continue use of standard precautions for mother and baby.

22. Resume/continue patient's antiretroviral treatment.

23. Inform patient that breastfeeding is contraindicated for HIV positive women.

24. Carry out infant care practices in normal manner. Refer to Protocol for Newborn: HIV Exposed Infant: Management of.

25. Transfer to a private postpartum room, if possible.

PHYSICIAN NOTIFICATION:

26. Notify the physician for:
    a. Persistent nausea or other GI disturbances
    b. Severe headache
    c. Temperature > 100.4

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PATIENT TEACHING:

27. Instruct the mother how to formula feed her infant.

28. Reinforce the need for HIV follow up care for herself and her infant.

DOCUMENTATION:

29. Document the following:
    a. Counseling and any refusal of the Ora Quick® Rapid HIV test.
    b. The rapid test results, patient notification, and plan of care.
    c. Loading dose of Zidovudine (AZT)
        1) Solution used, time loading dose started, rate, IV site location and condition.
        2) Vital signs, FHR and any side effects of the medication.

References:

ACOG Committee Opinion #304, Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations. November, 2004

ACOG Committee Opinion #389, Human Immunodeficiency Virus*, December, 2007

Public Health Service Task Force Recommendations for use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the US, June 23, 2004.

Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings. MMWR Recommendations and Reports, Sept. 22, 2006/55 (RR14); 1-17.

Origination Date:	April 1995
Revision Date:	June, 2005, January, 2008
Written by:	Joni Stambaugh, RNC, BSN; Mary Campbell Bliss, RN, CNS; Jan Lanouette, MD
Revised by:	Mary Campbell Bliss, RN, CNS, WING Committee
Cross-References:	Protocol for Perinatal: Electronic Fetal Monitoring, Labor and Delivery Protocol for Newborn: HIV Exposed Infant: Management of

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PROTOCOL FOR
PERINATAL: IDENTIFICATION/TREATMENT OF
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APPROVALS

Obstetrics/Gynecological Committee

Medical Executive Committee

______________________________________ ________________________

Shelly McGriff, Chief Nurse Executive, SMC-S Date

	POLICY/PROCEDURE TITLE: **HUMAN IMMUNODEFICIENCY VIRUS PREVENTION OF PERINATAL TRANSMISSION**
RELATED TO:	☐ ADMINISTRATIVE ☒ CLINICAL PAGE 1 OF 2
☐ Medical Center Policy (MCP) ☐ Nursing Practice Stds.	Effective date: 10/01 Revision date: 10/04 Reviewed:
☐ JCAHO ☐ Patient Care Stds.	Unit/Department of Origin: L & D
☐ QA ☐ Other ☐ Title 22	Other Approval:

POLICY STATEMENT:

Human immunodeficiency virus may be transmitted from mother to infant during the perinatal period. The risk of infection for a neonate born to an HIV-positive mother has been reduced from 25% to less than 2% by the use of currently recommended prenatal antiretroviral therapy and obstetric interventions for women who are aware of HIV infection early in pregnancy. Rapid HIV testing on labor and delivery can reduce the risk for mother to child transmission among women who do not receive prenatal care or women who have not had an HIV test. It has been found that HIV prophylaxis, even when begun during labor and delivery can reduce mother to child HIV transmission by as much as 50%. The CDC recommends routine rapid testing for women whose status is unknown unless they decline the test. California Health and Safety Code require all pregnant women to be offered HIV testing as a routine part of care.

RESPONSIBLE PARTY:

XXXXX providers of prenatal, obstetric, and pediatric and emergency care. Nursing staff on the following units:,.

PROCEDURE:

1. Every woman will be offered counseling and prenatal testing for HIV.

2. Women who are identified as being HIV positive during prenatal screening will be referred to the Maternal Child Adolescent HIV Program as soon as possible for management. Client confidentiality should be respected.

3. Women who are admitted to the hospital without receiving prenatal care will be counseled about reducing the risk of mother to child HIV transmission and offered a rapid HIV test.

4. Women who do not have HIV test results available will be counseled about reducing the risk of mother to child HIV transmission and offered a rapid HIV test.

5. During HIV counseling, the following information should be given to a woman in labor in a confidential manner:
   A. HIV can be transmitted from mothers to infants during labor, delivery and breastfeeding; effective interventions can reduce this risk

   B. Rapid testing is available, effective and the results will permit interventions to protect the infant.

   C. A positive test is preliminary and a confirmatory test will need to be done; however, treatment can be offered immediately.

6. If the patient agrees to the test, obtain consent and send small red and purple top tubes to the lab; notify Virology/Serology Lab at xxxxx and add MD pager # on lab slip. Expect results in 2 hours.
   A. If the result is negative, inform the patient of the results and no further treatment is necessary.
   B. If the result is positive and the woman is not in labor
      1) Review the consent and if the patient "wants" the result before treatment discuss antiretroviral prophylaxis with the mother in a confidential manner.
      2) The patient will be referred to the Maternal Child Adolescent HIV Program as soon as possible to review therapy/method of delivery, infant care and follow up

   C. If the results are positive and the woman is in labor, antiretroviral therapy options include:
      1) Intrapartum IV Zidovudine (AZT): Begin loading dose 2mg./kg for 1 hour followed by a continuous infusion of 1 mg/kg until delivery **OR**
      2) Zidovudine 600mg PO and Epivir (Lamivudine) 150 mg at onset followed by Zidovudine 300mg PO q 3 hours and Epivir (lamivudine) 150 mg q 12 hours **OR**
      3) Nevirapine 200mg PO at onset of labor **OR**
      4) Nevirapine 200mg PO and IV Zidovudine: Begin loading dose 2mg./kg for 1 hour followed by a continuous infusion of 1 mg/kg until delivery plus a single dose of 200mg Nevirapine PO at onset of labor

7. Women who reveal their HIV positive status at the time of labor, who have not received antiretroviral therapy prenatally, may be offered treatment options as above in #6 C.

8. Women who are known HIV positive will receive HIV medications during their pregnancy and intrapartum period. These medications will be ordered by their obstetric providers and will be administered according to normal hospital practice.
   A. L&D Medications: (Standard of Care for all HIV + Women to reduce perinatal infection)
      1) Obtain weight. (To convert lbs to kg 2.2lbs = 1 kg)
      2) Begin IV Zidovudine infusion during labor
         a. (AZT) Loading Dose: 2mg /kg of body weight for ONE HOUR followed by
         b. Continuous Dose: 1mg/kg of body weight per hour until delivery
         c. Ideally, AZT infusion should be run for 4 hours pre delivery.
      3) Other HIV Medications:
         a. Stop Zidovudine (ZDV/AZT) containing medications (e.g., Combivir, Trizivir)
         b. Continue all other antiretroviral medication as prescribed.

9. Method of Delivery for Women with positive HIV results
    A. The delivery plan may be individualized according to HIV plasma viral load obtained in the third trimester.

    B. Patients followed by the Maternal Child Adolescent HIV Program may be scheduled for an elective C/S at 38 weeks gestation by xxx. If the woman presents in active labor and she is progressing rapidly, provide intrapartum treatment and deliver vaginally.

    B. Patients followed by the Maternal Child Adolescent HIV Program who do not have a scheduled c-section who are admitted in labor with intact membranes, may labor.

    C. Women diagnosed with HIV on labor and delivery who have not ruptured membranes may be offered a C-section as a potential strategy to reduce HIV transmission.

    D. Women who have had a rupture of membranes for >4 hours, may be offered a C-section (Rupture of membranes $\geq$ 4 hours increases the risk of Perinatal transmission and should be avoided; Page HO ASAP if ROM $\geq$ 4 hours)

10. Precautions
    A. If labor progresses and membranes are intact, avoid performing any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions, such as
        1) Artificial rupture of membranes
        2) Fetal scalp electrode
        3) Intrauterine pressure catheter
        4) Fetal scalp pH sampling
        5) Episiotomy (if possible)
        6) Forceps or vacuum extraction

    B. No breastfeeding.

11. Newborns delivered to HIV positive women will receive the following care:
    A. The newborn will be cleaned off of blood and body fluids immediately after delivery.
    B. The pediatric HO working in the ISCC will be called to the delivery and will immediately enter the "HIV Order Set" in CPOE.
    C. Labs will be drawn by the ISCC RN, as ordered
    D. The infant will receive Zidovudine (ZDV/AZT) suspension 10mg/ml at a dose of 2mg/kg/dose every six hours (part of the HIV order set); **This medication should be administered as soon as possible after delivery and must be given within eight hours of delivery.**
    E. If the infant is NPO, start ZDV 1.5 mg/kg IV q 6 hours for a total of 6mg/kg/day.
    F. Call the Maternal Child Adolescent HIV Program: weekdays (xxxx, nights weekends or holidays contact xxxxx If no response, contact the Pediatric Infectious Disease On-Call Physician through the Page Operator.
    G. Breastfeeding will be discouraged, as there is a risk of transmission of HIV through breastmilk. Feed the infant using iron-fortified formula unless otherwise specified by the pediatric provider.

12. Families will be given an appointment for follow up in the Pediatric Infectious Disease Clinic. These appointments will be scheduled prior to discharge by the ID staff.
    A. Families will be given instruction in administration of oral AZT to the infant. The discharging healthcare provider will be responsible to write a prescription for 6 weeks of AZT prior to discharge.
    B. Families will be referred to Primary Care Provider for well infant care.

REFERENCES:

Hauth, J. et al. ed. *Guidelines for Perinatal Care Fifth Edition.* American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2002.

Pickering LK, ed. *2003 Red Book: Report of the Committee on Infectious Diseases.* 26th ed. Elk Grove Village, IL: American Academy of Pediatrics.

Public Health Service Task Force. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1-Transmission in the United States, June 23, 2004. Available at http://aidsinfo.nih.gov/guidelines/perinatal\perinatal

PROTOCOL FOR

NEWBORN: HIV Exposed Infant: Management of

PURPOSE: To outline the steps necessary to screen and treat the HIV exposed infant
LEVEL: Interdependent (* = MD order required)
SUPPORTIVE DATA: Human Immunodeficiency Virus (HIV) is a subfamily of retrovirus.
HIV targets the receptor sites of the "T-helper cell" lymphocyte. "T-helper cell" lymphocyte normally has an essential role in activation of the body's immune system. Fetuses and newborns are especially vulnerable to HIV, in addition to other infections, as they have immature specific and non-specific immune system. The most common way for a fetus to receive the HIV virus from the mother is via vertical transmission across the placenta. Transmission of HIV to the fetus can be significantly reduced if the mother is treated, during her pregnancy and intrapartum period, with anti-retroviral drugs. Postpartum treatment of the newborn with anti retroviral drugs further reduces transmission risk and infection.
A variety of tests are available for determining if the HIV infection. Both the ELISA (enzyme-linked immunosorbant assay) and the Western Blot tests detect HIV antibodies, not the HIV virus. In the neonate, the presence of these antibodies may result from passive placental transfer from mother and not necessarily indicative of active neonatal disease. Specific tests, such as the p24 antigen test and PCR (polymerase chain reaction), are possible at an early age and detect the presence of the HIV virus.
Current literature suggests that the combination of antiretroviral therapy, Zidovudine (ZVD, AZT), during pregnancy, cesarean section for those mother's with high viral load and Zidovudine treatment for neonatal treatment with six weeks after birth can lower the risk of vertical transmission to the neonate to less than 5 %

PRIOR TO DELIVERY:

1. See "Protocol for Perinatal: Treatment of HIV Positive Women in Labor" for care of the
mother.
2. Standard infection precautions are used during delivery.
3. Carry out care practices in the normal manner, regardless of HIV status of infant.

ONCE INFANT DELIVERED:

PHYSICIAN RESPONSIBILITIES

4. Order HIV DNA PCR within 24 hours after birth.
5. Notify at Pediatric Infectious Diseases at xxxxx

a. Call (916) 734-3557
b. Leave message for Pediatric Nurse Practitioner at Pediatric Infectious Diseases with the following information:

1) Mother's name, medical record number and telephone number
2) Infant's name, medical record number and date of birth, and primary

pediatrician, if available
6. Fax any lab tests information to Pediatric Nurse Practitioner, Pediatric Infectious Diseases
7. Start infant on AZT 2mg/Kg/dose PO every 6 hours, within 24 hours of birth.
   a. Or continue infant on the same medications as mother, if known.
   b. Consult with Pediatric Infectious Diseases at xxxx as to appropriate dose especially if mother has drug resistant virus.
8. Write prescription for home medication early in hospitalization to allow time for parents to fill prescription prior to discharge. Most outside pharmacies need 48 hours to obtain AZT and fill the prescription.

RN RESPONSIBILITIES
9. Verify mother's HIV status and document status of mother's HIV serology on neonatal chart.
10. No special care practices or standards are required for the newborn.
11. Infant will be formula fed only, DO NOT breast feed.
12. *Obtain HIV DNA PCR within 24 hours after birth, per physician order.
13. Call lab prior to drawing the test: verify proper drawing and processing technique.
14. *Start infant on AZT 2mg/Kg/dose PO every 6 hours, within 24 hours of birth, unless otherwise ordered by physician.
15. Contact medical social worker or discharge planner to assist to CCS qualifying process forthe CCS HIV Screening Program.

MATERNAL OR PRIMARY CARE GIVER INFORMATION:
16. Instruct Mother or primary care giver on the following medication issues:
a. Procedure for accurately drawing up and administering drug (AZT)
b. AZT may be kept at room temperature
c. Importance of the drug be given at stated intervals (every 6 hours) to maintain adequate drug levels
d. AZT must be given for 6 weeks
e. Fill prescription for AZT as soon as it is received. Pharmacies can take 48-72 hours fill a prescription for AZT.
f. If other antiretroviral drugs are ordered, consult pharmacy as to specific drug and dosing issues.
g. If drug supply inadequate to contact her primary pediatrician or xxxx Pediatric Infectious Diseases
17. Discuss the importance of not breastfeeding.
18. Instruct mother to return to her Primary Pediatrician or Medical Care Provider for regular well baby care and immunizations. Medical Center Pediatric Infectious Disease Team does not provide primary care services
19. Ensure mother receives information regarding CCS HIV Screening Program. This program will cover costs of HIV testing, medications and follow up. Parents may call CCS at xxxxx to start the process.

DOCUMENTATION: In addition to usual unit standard documentation:
20. Document Zidovudine (AZT) dose and time per unit standards.
21. Document any side effects to medication.
22. Document instruction and education given to mother or primary care giver in medical record.

DISCHARGE:
23. *Check with physician to ensure prescription for home medication is written early in hospitalization to allow time for parents to fill prescription prior to discharge. Most outside
pharmacies need 48 hours to obtain AZT and fill the prescription.
24. Ensure infant has an appointment with Medical Center Pediatric Infectious Disease Team for 4-6 weeks of age.

References: Public Health Service Task Force Recommendations for Use of Antiretroviral
Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States, November 26, 2003 , Web site (http://AIDSinfo.nih.gov)

Origination Date: June 2004
Revision Date: