PACPI PEDIATRIC AIDS CHICAGO PREVENTION INITIATIVE

Illinois Perinatal Rapid HIV Testing Law

Staff Training Scenarios

In an effort to assist Managers and Educators to enhance staff understanding of the Illinois Perinatal Rapid HIV Testing law, the following scenarios are presented. Following each scenario, key learning points from the law are noted.

Scenario # 1

A.H is a 23yo G1P0 admitted in early labor. There is no prenatal record available on the unit. The patient tells the nursing staff that she had planned on delivering at a different hospital, but had changed her mind at the last minute. The staff is able to verify that this patient did have prenatal care, and her prenatal record is available at another local hospital. In terms of her HIV status, what would be the appropriate action?

Key Points for Learning: Because this patient is in early labor, and because the Illinois law allows for the sharing of HIV status between hospitals, the staff should attempt to obtain the prenatal record and HIV status from the other hospital. The intent of the law is not to retest patients but to verify status and to test if HIV status is unknown; there should be ample time to obtain results before this patient delivers.

Scenario # 2

J.L is a 31yo G3P2 admitted in active labor. Her prenatal record is available on the unit. She refused an HIV test prenatally. She tells the staff that she and her husband of 6 years are in a monogamous relationship. She reports that she was tested during her previous pregnancy for HIV, and she sees no reason to be retested. Her physician tells the nursing staff that retesting this patient isn't necessary. In terms of her HIV status, what would be the appropriate action?

Key Points for Learning: Illinois law requires that all women be counseled and recommended an HIV test with *each pregnancy*. This obligation under the law is not excused because of a physician's opinion that a patient doesn't need testing. The nursing staff must counsel and recommend rapid HIV testing to this patient. In addition, this patient needs to be informed that under state law, if she refuses, her infant will be tested at birth. This will lead to a delay in breastfeeding, and will cause the infant to undergo a heel stick at delivery. The purpose of testing all women is to remove the judgment of which patient is "low risk". Perceived risk should never be a factor in deciding which patient is offered counseling and testing.

Scenario # 3

K.T. is a 30yo G4P2 admitted for a scheduled caesarean section. She is a known HIV positive patient and orders for medications and treatment are available with the prenatal record. In the case of a known HIV positive patient, who should receive a Rapid Test upon delivery; the mom or the infant?

Key Points for Learning: The correct answer is neither. The mother doesn't need to be tested; she is a known positive. Rapid HIV tests are testing for antibodies. There are only one set of antibodies available per couplet at delivery, and those are the mother's. When we test infants, we are actually testing for maternal antibodies. We already know that this mother is HIV positive. Since the infant will still have mother's antibodies, then the only thing that testing the infant will tell us is that the mother is positive. Rapid HIV testing is not appropriate for a known HIV positive woman or an HIV exposed infant.

Scenario # 4

In the above scenario, would the appropriate action be to order a confirmatory Western Blot on the infant to determine if the infant was infected with HIV?

Key Points for Learning: No. A Western Blot should *not* be ordered on the infant. It is important to understand that a Western Blot is also an antibody test, just as a rapid test is an antibody test. The Western Blot simply confirms the presence of antibodies that were found by the rapid test. Again, the infant is going to have the same antibodies at birth as the mom. A Western Blot on the infant will simply confirm that the *mother* has antibodies for HIV. It only tells us that the infant has been exposed to HIV. The recommendation, as per hospital policy, is that a DNA-PCR test be drawn on the infant. This is a test that actually looks for the DNA of the virus, not the antibodies. If an infant has a negative DNA-PCR at birth, then that means that the infant *was not* infected during pregnancy. This test is repeated at specific intervals to determine if the infant was infected during the labor and delivery process.

Situation # 5

D. N. is a 25yo G2P2 who delivered yesterday. She received no prenatal care, and a Rapid HIV test was preliminary positive. The results of a Western Blot are still pending. D.N. had planned on breastfeeding. The staff assisted her in pumping her milk until the results of the Western Blot are returned. The patient turned on her call light and asked the staff to bring her the milk that she had pumped, so that she could feed her baby with a bottle. Based on this patient's question, what immediate teaching needs are evident?

Key Points for Learning: This patient may assume that the risk of infection to her baby comes from the physical contact with the breast, and doesn't understand that the risk comes from the milk itself. She needed to be educated on the fact that her milk carries the HIV virus, and if she is indeed HIV positive, this will put her baby at further risk of infection. It should be explained that the purpose of pumping and DUMPING is to maintain her milk supply, should she actually be confirmed HIV negative and still desire to breastfeed.