Immunisation and Prevention of Infectious Diseases

Contents

1. Entry to Clinical Programmes – Immunisation Status Report (ISR)

1.1. Guidelines

Health care workers need to be protected from diseases they will encounter and need to have evidence they have the necessary protection to be allowed to work. In addition, the Faculty of Science (FoS) needs to assure health training providers that students are unlikely to transmit serious infections either to patients or to other health care workers during their training in clinical environments.

1. The FoS requires all students enrolled in clinical programmes, and thus covered by the FoS Fitness to Practise Policy, to know their immunity and infection status by having the following tests done:

   - Blood tests to determine immunity to Hepatitis B and C, HIV, Rubella, Measles, Mumps and Varicella zoster (chicken pox).
   - Blood tests to detect chronic infection with Hepatitis B or C.
   - Quantiferon Gold TB test in association with a completion of a TB questionnaire to determine TB status.

   These tests should be commenced on admission to the programme and completed along with submission of the ISR by May 1 of Year 1 (see timeline in Step 4 below). The testing and administration charges for the above tests and required re-tests after vaccination are to be met by the student.

2. Students are expected to be up-to-date with other vaccines – tetanus, diphtheria, polio and Covid-19. Evidence of Pertussis vaccination within the preceding 4 years is required.

   In addition, they are advised to review their immunisation status with regard to infections that they may be at increased risk of acquiring as a result of increased social mixing with other young adults and changes in living circumstances (e.g. increased engagement in social activities, hostel or student flat accommodation, new relationships, etc). Students are strongly encouraged to consider annual immunisation with Influenza vaccine and both of the available meningococcal vaccines (conjugate quadrivalent ACWY meningococcal vaccine and MenB vaccine (Bexsero) and HPV vaccination (if not previously immunised).

3. For those with negative tests the following are required:
   - Vaccination for Measles, Mumps and Rubella (a further single dose if evidence of prior vaccination or two doses 4 weeks apart if never immunized)
   - Vaccination for Varicella zoster (two doses at least 6 weeks apart)
   - Vaccination for Hepatitis B (course depends on prior Hep B vaccination history and

may be 1-3 doses)

- (Re)-vaccination will be followed by further blood test to confirm immunity after receipt of the above vaccines.

The charges associated with immunisation or follow up chest X-rays or other testing will not be covered by FoS and are the student's responsibility. MMR is free for those not immune to measles. **Additional meningococcal vaccinations are fully funded for certain at-risk living situations including university hostels.**

4. The test results are to be collated on the Immunisation Status Report Form (ISR) and signed by the GP/University Health & Counselling Service. The ISR with copies of test results attached should be submitted by the student to the relevant Programme Director by 1 May after entry to the programme. These will be held on file separate from academic files. A student receiving further immunisations and follow-up tests will need to advise the Programme Director of the need for an extension to this date.

   It is the student's responsibility to provide the completed ISR as evidence of compliance with the policy. Noncompliance may lead to preventing the student having contact with patients until adequate clearance and immunity is demonstrated and/or referral to the Programme Director if considered a potential Fitness to Practise issue.

1.2. Student actions

First step:

Immunisation Programme Consent Document

The Immunisation Programme Student Information Sheet and Immunisation Programme Consent Document will be sent out to students when offered a place in the programme.

Each student must take the Immunisation Programme Consent Document to their Medical Practitioner to obtain a full record of their vaccine history including their COVID-19 vaccine record, and their NHI number. PDFs of the completed consent form and immunisation history should be emailed as a single email to uhcsgrafton@auckland.ac.nz.

Second step:

Immunisation Programme Consent Document

The electronic lab form (no paper form) will be generated upon receipt of the student's completed Immunisation Programme Consent form. The student must then attend a designated Awanui Labs Collection Centre within 10 days of advice from us to complete a blood test. Please note, there is no onsite blood testing on campus. Blood test results are electronically forwarded to UHCS.

Our current screening checks past vaccine history and confirms immunity to Hepatitis B, Measles, Mumps, Rubella, Varicella and Pertussis. We also check for any evidence of active Tuberculosis or HIV, Hepatitis B & C. If results confirm that a student is infected/carrier with/of HIV, Hepatitis B, C or TB the student is offered a treatment/management pathway and is informed as necessary to bring this information to the attention of the clinical coordinator of their course.

Third step:

Students Notified to attend for vaccination

Each student is individually contacted with details on how to meet the Immunisation Status Report requirements, the vaccines required, and when to do follow up blood tests.

Upon full completion (payment of admin fee and fees for any vaccinations & final blood tests) UHCS will generate and certify the Immunisation Status Report (ISR) which will be emailed to each student for them to then forward to their faculty contact person/Programme Director.

The ISR can take 3-6 months to complete, in some instances longer if repeated vaccination doses are required. For those students going on placement before being fully compliant, a document can be provided to reflect that the student is engaged in the programme and is awaiting a threshold immune status. This document advises of the student's risk status, and appropriate precautions, while awaiting full compliance.

When the student shows acceptable immunity to the above diseases and is cleared from risks for transmission of other infections, the medical practitioner should sign off the ISR form and the student should submit it, along with copies of test results, to the faculty contact person/Programme Director.

The deadline for submission of the completed ISR, or notification of delayed results is 1 May each year.

Students who lack immunity should be vaccinated (if appropriate) and then have repeat testing for antibody response after allowing time for this to occur. The ISR can then be completed when an antibody response is demonstrable.

1.3. Summary of guidelines: immunisation status testing

The following tables outline immunisations which should be reviewed by every student. Table 1 lists required immunisation status testing and follow-up action. Table 2 lists other recommended immunisations.

Table 1: Required immunity status assessment

Student group	Testing for	Results on ISR form	Further action	Comment
Year 1	Varicella Zoster virus antibody	+ve	None	
		-ve	Vaccinations (x2) with follow-up blood test required	If exposed, non-immune contacts may develop chicken pox and pose risks to vulnerable patients. Non- immune students' risk being stood down with consequent significant disruption to clinical training schedules.
	Measles/ Mumps/Rubella antibodies	+ve	None	
		-ve	MMR vaccinations – if no receipt of prior MMR then 2 doses at least 4 weeks apart) & follow up with further blood test. A single dose may be offered if prior evidence of receipt of 2 MMR and seronegative for measles or mumps.	See above for non-immune contact risk.
	Hepatitis B antibody	+ve	None	
		-ve	HBV vaccinations given at 0,1 and 6 months if no prior vaccination. If prior vaccination history then a single dose and check of Hep B serology is done 4 weeks later.	If non-immune, contacts are managed based on exposure (for example needlestick injury) and receipt of immunoglobulin may be required.
	Hepatitis B surface antigen	-ve	None	
		+ve	Refer to hepatologist for discussion re management	Refer to Programme Director for career advice.
	Hepatitis C	-ve	None	
		+ve	Refer to hepatologist for discussion re management	If further testing (HCV RNA) confirms HCV infection refer to Programme Director for career advice.
	HIV antibody	-ve	None	
		+ve	Refer to specialist infectious disease physician for discussion re management	Refer to Programme Director for career advice.
	Quantiferon TB	-ve	None	
	Gold test	+ve	Assess in conjunction with questionnaire – may need follow up with chest x-ray	Follow Public Health guidelines.

Year 1	Pertussis	Vaccination date	There is no reliable test for Pertussis immunity so evidence of vaccination at least in the last 4 years is required	If exposed, non-vaccinated contacts are very likely to become infected after exposure to patients with pertussis and then pose risks to vulnerable patients. Prophylactic antibiotics may be required and students risk being stood down after such exposures, with consequent significant disruption to clinical attachment schedules.
	Covid-19	Vaccination dates for all doses (2 doses and 1 booster)	In keeping with Health New Zealand | Te Whatu Ora policy, vaccination is expected. All students must declare vaccination status. Unvaccinated students must undergo risk assessment before clinical placements are permitted.	Number of vaccinations required is in keeping with the current regulations. Please indicate the vaccine that you were given. For domestic students this will typically be the Pfizer vaccine.

Table 2: Other immunisations to be considered

Target Group	Vaccination	Record on ISR	Further action	Comment
All students annually	Seasonal Influenza	No	Vaccination highly recommended	Recommended annually to protect themselves, patients and reduce community spread.
All students	Diphtheria Polio Tetanus	No	Vaccination highly recommended	Most students will have completed vaccination in early childhood and at age 11-12 years. Further doses are recommended at age 45 years and 65 years.
All students	Meningococcal disease (2 vaccines available to cover serogroups A, CW, Y and B)	No	MenQuadfi (conjugate meningococcal vaccine ACWY) Meningococcal B (Bexsero)	Recommended for all students. Funded for those in certain living situations. Bexsero is not the same as the NZ MenZB vaccine which was used between 2004 and 2008. MenB vaccination is still strongly recommended if received the NZ MenZ B vaccine in the past.
All students	HPV	No	Highly recommended for all students	Many students will have completed vaccination through School programme in NZ given at age 11-12 years.
All students	Hepatitis A		Highly recommended for all students	Recommended for certain laboratory workers (Hep A) and useful for healthcare workers - particularly if taking Electives or working in developing regions.
Some students	Typhoid Yellow Fever Chole	No		May be recommended in particular circumstances e.g. on Electives in developing countries.

2. Prevention of transmission of infectious diseases

The section provides background/rationale to FoS entry testing and immunisation requirements and to other infection-related clinical attachment health issues.

2.1. Risks of transmission from patients to students

As a clinical student, and later as a health professional, you will be exposed to infection, especially when you have direct contact with patients. The infections you may be exposed to include respiratory viruses, bacteria or viruses causing diarrhoea, bacteria, fungi or viruses causing skin diseases, and viruses present in patients' blood such as Hepatitis B virus, Hepatitis C virus or HIV.

2.2. Risks of transmission from students to patients

Similarly, you may be a potential source of infection for your patients. The infections you may potentially transmit to your patients include respiratory viruses such as cold viruses or influenza, bacteria colonising your skin such as Staphylococcus aureus, and viruses which may be present in your blood such as Hepatitis B virus, Hepatitis C virus or HIV.

The guidelines below are intended to help you minimise the risk of transmission of infection between you and your patients.

2.3. Standard precautions and isolation precautions

The FoS will require you to be familiar with the strategies used to minimise the risks of transmission of infectious diseases between health care workers and their patients.

Hand hygiene, gloves, masks, gowns, etc

Guidelines to minimise the transmission of infection between Health Care Workers and their patients are widely published and provide advice about appropriate measures to reduce exposure to blood or contaminated bodily secretion from a potentially infected person.

www.handhygiene.org.nz

The relevant advice contained in these guidelines includes that:

1. Hands should be cleaned using an alcohol-based hand-gel or with soap and water, before and after all patient contacts.
2. Gloves should be worn for touching mucous membranes or non-intact skin of all patients and for performing venepuncture and other vascular access procedures. Gloves should be changed after contact with each patient. All open lesions, i.e. fresh cuts, grazes or areas of moist eczema/dermatitis should be covered by non-permeable dressings.

2.4. Advice and information about vaccine preventable infections

Refer to Section **1.3 Summary of guidelines: immunisation status testing**. This section provides background information and some advice, to support these guidelines.

Measles, Mumps and Rubella

Measles, Mumps and Rubella continue to cause disease in New Zealand. While most adults will have acquired immunity to disease by vaccination or natural infection, all students will be tested for immunity to measles, mumps and rubella; those who are not immune must receive two doses of MMR (measles, mumps, rubella) vaccine given at least four weeks apart. Pregnancy should be avoided for four weeks after the MMR vaccination because of concern that the vaccine strain could cause fetal infection. Other contraindications to MMR vaccine are: anaphylactic reaction to Neomycin; febrile illness at the time when presenting for vaccination; active tuberculosis; treatment with immunosuppressive therapy; bone marrow and lymphatic system malignancies; blood disorders; primary immunodeficiency states.

Hepatitis B

Hepatitis B is relatively common in Māori, Pacific and Asian people in New Zealand. Most adults will have acquired immunity following childhood vaccination. However, some students may not have been vaccinated or the course of vaccine given may not have induced effective immune responses. All students will be tested for immunity to Hepatitis B; those who are not immune and not chronically infected must receive a course of Hepatitis B vaccinations with follow-up testing to ensure immunity has been achieved. Blood donations should be deferred for 24 hours following Hepatitis B immunisation.

Varicella

Some students will have been infected by Varicella virus during childhood. Many will have had an obvious episode of chickenpox at this time but in many the illness will have been subclinical. Some students may have already received varicella vaccination. Approximately 10% of students will be susceptible to Varicella infection. These students may acquire the infection from a person (e.g. a patient or other health care worker) and then may transmit it to a patient. This may have severe consequences if the patient is immunocompromised. Two doses of Varicella vaccine given six weeks apart induce immunity in most adults and are required by students who do not have Varicella antibodies on serotesting.

Tuberculosis

Tuberculosis is an uncommon disease in New Zealand. However, many medical students and other health workers will be exposed to infected patients and thus be placed at a significant risk of developing tuberculosis (TB). Students need to know their TB status.

The Quantiferon Gold TB test is used to determine a person's exposure or immunity to tuberculosis.

Students are not required to have the BCG vaccination. However, health workers sometimes request BCG vaccination if they anticipate that they will be working regularly with known tuberculosis patients.

BCG is a live attenuated (weakened) strain of Mycobacterium bovis and is closely related to Mycobacterium tuberculosis – the usual cause of tuberculosis. BCG vaccination can reduce the risk of developing tuberculosis but the benefit is greatest in infants who are at a high risk of infection (especially those living in poor countries with a high prevalence of TB). BCG vaccination of adults provides only modest protection against tuberculosis – some studies have even suggested that the vaccine may increase risk of tuberculosis. BCG vaccination commonly causes a shallow ulcer at the site of the injection, which may take weeks to heal.

Further information about tuberculosis and BCG vaccination is available in The Immunisation Handbook 2024, version 6, Chapter 23: Tuberculosis; available as an electronic publication of the NZ Ministry of Health at:

https://www.tewhatuora.govt.nz/for-the-health-sector/vaccine-information/immunisation-handbook-2024-version-1

Pertussis

Recently, Pertussis (Whooping Cough) has occurred in epidemics approximately every four years in New Zealand. Many adults will have acquired immunity to disease by vaccination or natural infection, however immunity following either disease or vaccination wanes within a decade.

Therefore, a history of vaccination within the last four years is required for all students starting their clinical attachments, irrespective of previous history of pertussis or vaccination.

Diphtheria

Diphtheria is extremely rare in New Zealand, but in third world countries may be contracted either by inhalation of infected droplets or by skin contact with infected material. Students who had a full course of diphtheria vaccinations in childhood are likely to have life-long protective immunity. Booster doses are recommended at age 11, 45 and 65 years. A course of three injections of diphtheria vaccine (low dose for adults) given at intervals of four weeks is recommended for persons who have not previously been immunised.

Tetanus

Tetanus is an uncommon disease in New Zealand. Students who had a full course of tetanus vaccinations in childhood are likely to have life-long protective immunity. Booster doses are recommended at ages 11, 45 and 65 years. A course of three injections of tetanus vaccine given at intervals of four weeks is recommended for persons who have not previously been immunised.

Poliomyelitis

Poliomyelitis is extremely rare in New Zealand, but in a small number of third world countries it may be contracted by consuming contaminated food or drinks. Students who had a full course of polio vaccinations in childhood, and who are neither in contact with patients with polio nor travellers to countries where polio is common, do not require further polio vaccinations. Two injections of inactivated polio vaccine given at an interval of four weeks, followed by a third dose at 6 months, is recommended for adults who have not previously been immunised.

2.5. Risk of transmission from students to patients

The FoS requires that you are tested for infection with HBV, and HCV. Students who recognise that they are at particular risk for acquisition of HIV infection (e.g. via sexual contact with at risk persons or via intravenous drug use) have a responsibility to also be tested for HIV. Students who are found to be infected with HBV, HCV or HIV must seek advice about practice precautions to prevent transmission of infection to their patients.

Hepatitis B

Hepatitis B infection is relatively common (approximate prevalence of 8%) in Māori, Pacific and Southeast Asian people aged over 30 years living in New Zealand. Most chronically infected persons have acquired the infection perinatally and are asymptomatic and unaware of their chronically infected status.

Hepatitis B virus (HBV) infection is transmitted from person to person in blood and blood contaminated secretions and body fluids. Blood and body fluids from some infected persons are highly contagious. Many examples of transmission of HBV infection from a health care worker to patients have been recognised. Most have involved dentists or surgeons who were exceptionally infectious. The dentists who transmitted infection to their patients had commonly not been wearing gloves during dental procedures, and the surgeons who transmitted infection to their patients most commonly did so during major procedures with a high risk of puncture of the surgeon's gloves during the operation. The estimated average risk of transmission of HBV infection with a needle stick injury when the injured person has not been vaccinated and the needle is contaminated by blood from an HBV infected person is approximately 15%.

Hepatitis C

Approximately 0.5% of the adult population in New Zealand has chronic Hepatitis C infection. This is usually an asymptomatic infection, and many infected patients will not be aware of it. Increased rates of infection are found in people who have received blood products before 1992 and in current or ex injecting drug users. Hepatitis C may be

transmitted by contact with infected blood e.g. a needle stick injury. The estimated average risk of transmission with a needle stick injury when the needle is contaminated by blood from an HCV infected person is approximately 3%.

HIV

Human Immunodeficiency Virus (HIV) infection in New Zealand is largely confined to men who have sex with men and to people from third world countries and their sexual partners. The prevalence of HIV infection in medical students and other health care workers is likely to be very low – probably less than 0.1%. A significant minority of HIV infected persons are unaware that they are infected, although they may recognise that their behaviour has placed them at risk to this infection.

HIV infection is transmitted in blood and blood contaminated secretions and body fluids. Transmission of HIV from a dentist with AIDS to three of his patients has been recognised. In contrast, follow-up of over 2,000 patients and HIV testing of 691 patients operated on by three surgeons with HIV infection or AIDS has failed to reveal any instance of transmission of infection from these surgeons to their patients.

HIV is much less contagious than HBV; the estimated average risk of transmission with a needle stick injury when the needle is contaminated by blood from an HIV infected person is approximately 0.3%.

Career implications of HBV, HCV or HIV infection

The identification of students who have HBV, HCV or HIV infection is an essential step to helping those students prevent transmission of these infections to their patients during the course of their careers as health care workers. However the process of identifying HBV, HCV or HIV infection in a student can potentially have significant adverse effects for the student. These adverse effects could include anxiety about their health, stigmatisation, and reduced career opportunities. The FoS will make every effort to mitigate the adverse effects that knowledge of infection with HBV, HCV or HIV may have for a student. Infected students are required to discuss their situation confidentially with the Programme Director as early as possible in their studies so that appropriate options can be explored and strategies developed.

Exposure prone procedures

Health care workers with a blood-borne virus infection must not perform any exposure prone procedures, unless they have received advice from an appropriate panel, which confirms the safety of them performing such procedures.

Exposure prone procedures are those invasive procedures where there is a risk that injury to the student may result in the exposure of the patient's open tissues to the blood of the student (bleed-back). These include procedures where the worker's gloved hands may be

in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

Procedures where the hands and fingertips of the student are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the student's gloved hands from sharp instruments and/or tissues, are considered not to be exposure prone provided routine infection control procedures are adhered to at all times.

Examples of non-exposure prone procedures include:

- Taking blood (venepuncture).
- Setting up and maintaining intravenous lines or central lines (provided any skin tunnelling procedure used for the latter is performed in a non-exposure prone manner).
- Minor surface suturing.
- The incision of external abscesses.
- Routine vaginal or rectal examinations.
- Simple endoscopic procedures.

2.6. Risk of transmission from patients to students

Students are at risk of becoming infected with HBV or HCV or HIV as the result of contact with blood or other contaminated secretions from infected patients. The risk of becoming infected by an accident involving blood from a patient with hepatitis B or hepatitis C or HIV infection is affected by the nature of the injury. For each of these viruses the greatest chance of transmission is by a deep injury that inoculates a large amount of blood into the injured person's tissues. For example, a deeply penetrating needlestick with a large-gauge hollow- bore needle containing infected blood is much more dangerous than an accident in which blood is spilt onto unbroken skin.

Successful vaccination against HBV provides absolute protection against infection with this virus, but there is no effective vaccine available against HCV or HIV.

Treatment with intravenous or intramuscular injection of anti-HBV immunoglobulin reduces the risk of infection with HBV if given soon after exposure to HBV infected blood or body fluids. This treatment is appropriate in persons who have not mounted an adequate immune response to HBV vaccination.

Treatment with anti-retroviral drugs significantly reduces the risk of infection if given soon after exposure to HIV infected blood or body fluids. This treatment is appropriate in persons who have suffered a significant injury involving exposure to blood or body fluids from a person with uncontrolled HIV infection.

There is no effective treatment to prevent infection with HCV after exposure to HCV infected

blood or body fluids.

Students who suffer an injury that involves exposure to blood or body fluids from a patient known or suspected to have HBV, HCV or HIV infection should promptly (within 1-2 hours) seek advice about management of this exposure either from the Occupational Health and Safety Department or from the Adult Infectious Disease team at the hospital where the accident occurred or from the hospital Emergency Department, or from the University Health & Counselling Service.

2.7. Key principles

1. All health care workers have ethical and legal duties to protect the health and safety of their patients. They also have the right to expect that their confidentiality will be respected and protected.
2. The duty of confidentiality is not absolute. Legally, the identity of infected individuals may be disclosed with their consent, or without their consent in exceptional circumstances, where it is considered necessary for the purpose of treatment, or prevention of spread of infection.
3. [Note that this accords with the New Zealand Health Practitioners Competence Assurance Act. 2003, Section 35 (1): "Whenever an authority that a health practitioner is registered with has reason to believe that the practice of the health practitioner may pose a risk of harm to the public, the authority must promptly give the following persons written notice of the circumstances that have given rise to that belief: The ACC, Director General of Health, Health and Disability Commissioner, and person who, to the knowledge of the authority, is the employer of the health practitioner.]
4. Health care workers with a blood-borne virus (Hepatitis B, Hepatitis C, or HIV) infection must not rely on their own assessment of the risk they pose to patients.
5. A health care worker who has any reason to believe they may have been exposed to a blood-borne virus, in whatever circumstances, must promptly seek and follow confidential professional advice on whether they should be tested for the virus. Failure to do so may breach the duty of care to patients.
6. Health care workers who are infected with blood-borne viruses must promptly seek appropriate expert medical and occupational health advice. Those who perform or who are expected to perform exposure prone procedures must obtain further expert advice about modification or limitation to their work practices to avoid exposure prone procedures.

3. Infectious diseases and overseas travel

Students travelling to developing countries where there may be increased risk of infection with diseases of poverty should seek consultation, before travel, to determine risks of infection followed by provision of advice, vaccination and prophylaxis as appropriate. This consultation, advice and treatment may be provided by the University Health & Counselling Service Grafton or by the student's family doctor or travel medicine specialist.

Students returning from countries were tuberculosis is endemic should visit the University Health & Counselling Service Grafton or their family doctor or travel medicine specialist on their return, to discuss any follow-up testing required.

Malaria, typhoid, hepatitis A, meningococcal infection, cholera etc.

Students travelling to countries where there is an increased risk of acquiring these infections should seek advice from the University Health & Counselling Service Grafton, their own General Practitioner, or an infectious disease physician or microbiologist regarding prophylaxis. Students expecting to work in areas with a high prevalence of HIV infection may seek a "starter pack" of anti-retroviral drugs to use in the event of a significant injury.

4. Methicillin Resistant Staphylococcus aureus

4.1. Background

Approximately 25% of the normal population are colonised in the anterior nares with Staphylococcus aureus. Approximately 10% of isolates of Staphylococcus aureus are resistant to methicillin and related antibiotics such as flucloxacillin. These resistant isolates are known as MRSA. The prevalence of colonisation, and disease, due to MRSA, is increased in some population groups and in the patients in some hospitals. Many hospitals in New Zealand have concerns about the introduction of MRSA into their environment by health care workers who have transferred from other hospitals where MRSA patient colonisation rates are high. These hospitals may request that newly arrived staff members or students have nasal swabs collected to screen for MRSA colonisation and have a clear result before the staff member commences clinical duties.

Students need to anticipate this possibility as they move from one hospital to another and seek updated hospital specific information in advance to avoid loss of clinical access time.

4.2. MRSA Testing

In line with Health New Zealand | Te Whatu Ora Occupational Health Policy, students are no longer routinely required to undergo swabbing for MRSA carriage. There is a shift of emphasis from MRSA carriage to likelihood of MRSA transmission. There will also be more emphasis on hand washing. Students are to undergo screening administered by the

relevant teaching department on an annual basis. If a student has no positive answer to any of the 5 screening questions, they can be given a clearance certificate by the teaching department. If they answer positive to any questions (i.e. are identified as having risk factors for TRANSMITTING infection) they are to be directed to the University Health & Counselling Service, where they will be swabbed and treated if found to be carrying MRSA. It is anticipated that only about 5/100 students should require swabs to be taken. It is anticipated that only about 5/100 students should require swabs to be taken. Any University Health & Counselling Service and/or laboratory costs are to be met by the student. If treatment is required, any treatment costs are the student's responsibility.

4.3. Guidelines

1. All students involved in clinical environments are required to complete an assessment for the transmission risk of Staphylococcus aureus (whether methicillin sensitive S. aureus - MSSA or methicillin resistant S. aureus - MRSA) at least annually.
2. The assessment is an online survey containing questions developed by the FMHS working party on Immunisation and MRSA. The questions relate to identifying those health conditions which would increase the risk of transmission if colonised with S. aureus (SA).
3. The survey is conducted annually by the relevant teaching department and monitored for compliance. Students who do not complete the survey will be referred to the Programme Director. Non-compliance may be considered a Fitness to Practise issue.
4. Students who answer YES to any question will be referred to the University Health & Counselling Service for follow up assessment, appropriate swabbing, and if necessary, treatment and re-testing. Colonisation by methicillin resistant Staphylococcus aureus will be tested for.
5. The Programme Director will issue dated clearance certificates in the form of PDF documents. This electronic certificate will be held on file separate from academic files.
6. Students are encouraged to present their clearance certificates when starting clinical attachments at each new health provider/Health New Zealand | Te Whatu Ora sites. Almost all host Health New Zealand | Te Whatu Ora sites have indicated acceptance of these certificates in place of swab results.
7. Notwithstanding any agreements indicated in item 6, FoS respects the right of institutions to request MRSA swabs prior to allowing a student patient contact and it is the student's responsibility to check requirements (at least three weeks prior to starting an attachment) to avoid losing patient contact time pending the outcome of swabbing.
8. Students who have been required to be swabbed (as in item 7) or students who suspect they may be at risk of transmission (regardless of their certified status) may self-refer to the University Health & Counselling Services at any time for assessment. This includes

those who are concerned about an especial risk of MRSA contact either in New Zealand or overseas.

9. The cost of swab testing (when requested by University Health & Counselling Service), and any subsequent treatment costs, are to be met by the student.

APPENDIX: Document History

Version	Change details	Date Issued:
1	Initial FMHS policy published	2019
2	2020 FMHS policy – COVID added	2020
3	2021 FMHS policy – COVID guidance updated	2021
4	FMHS policy – COVID vaccination details updated	2023
5	FMHS policy – 2024 update	2024
6	FoS Guidelines (adapted from FMHS v5.5), Nov 2024	2024