School of Health Technology and Management
Clinical Practicum
Student Responsibilities

These guidelines are to be used in addition to those established by each program/department.

All students are responsible for conducting themselves in a professional manner during any educational experience conducted at a clinical affiliate and for demonstrating respect toward its personnel, patients and their families. This includes being enthusiastic, mature, motivated to learn and accepting of responsibility.

**Physical Examination and Immunization Records**

All SHTM students are required to submit a completed Health History and Examination Form to the Student Health Service prior to the first day of classes. This form includes a health history, physical exam, PPD, documentation of a Tdap immunization within the last 5 years, and documentation of titers for measles, mumps, rubella, varicella and hepatitis B. Students must also sign the meningitis form online via SOLAR. If a student has a history of a positive PPD, documentation of a negative chest x-ray and/or treatment is required.

State law requires that all students have their health assessment and PPD updated annually. **Any student not in compliance will not be allowed to attend class or participate in any clinical activities.**

**HIPAA**

All students must complete the required HIPAA training. **All information concerning patients is confidential and must not be discussed with anyone who is not authorized or does not require the information for care of that patient.**

**Rules and Regulations of the Clinical Facility**

Though students are not employees of the clinical site, nevertheless, they are subject to all rules and regulations of the clinical facility as well as those of the School of Health Technology and Management (SHTM). **Rules and regulations will be specified by the clinical faculty and given to the student at the start of the clinical experience. The student is required to become familiar with them and strictly abide by them.**

Unexcused tardiness or absence; unavailability; inappropriate behavior, conduct or dress; or failure to comply with university or clinical facility rules and regulations may result in
immediate disciplinary action by the clinical faculty, director of clinical education, or program director/department chair.

The clinical site may request additional health clearance, drug screening, criminal background check or an interview with the student before accepting the student for the clinical rotation.

**IDENTIFICATION**

While on clinical rotation, all students are to wear proper SHTM identification as follows:

a. SHTM emblem sewn on the left shoulder of your white coat. (You will be provided with one patch before going on clinical rotation. Additional patches may be purchased for $2.00 in the Dean’s office.)

b. A name tag and/or ID badge (provided by SHTM or the clinical site) identifying you as a student.

**PROPER ATTIRE CODE**

The uniform or proper attire used during clinical practice will be in accordance with the policy established by your program and SHTM.

a. The student shall be neat, clean and presentable at all times.

b. Students who do not wear the appropriate uniform or proper attire will be asked to leave the clinical site and the program will be notified. Any time missed must be made up.

**ATTENDANCE/ABSENCE**

Each student is to complete all assigned clinical time. Each student is expected to be present and ready to begin his/her clinical practicum promptly at the assigned starting time each day and to remain until the assigned ending time. There will be no exceptions!

In case of illness or tardiness, it is the student’s responsibility to notify the clinical facility at least one hour prior to the assigned starting time. The student should then contact their SHTM professional program for further instructions regarding the make up of that time. Repeated tardiness or unexcused absences will result in a lowering of the final grade (or failure of the clinical course). Students who have clinical time to make up may be required to have prior written permission from their program. If at the end of a rotation a student has not made up all the missed time, an Incomplete grade (I) will be submitted. This Incomplete grade will convert to an “F” at the appropriate time and in accordance with the SHTM policies if not completed within the designated time.
**STUDENT PERFORMANCE**

All students are expected to be responsive and enthusiastic in their performance. They are to follow directions, be attentive to patients, ask questions and participate actively in all learning experiences.

All students are expected to seek out independent learning experiences, as well as those assigned. Students are expected to utilize all clinical time effectively and should be familiar with all objectives prior to the start of each clinical day.

**HEALTH INSURANCE**

All students pay a required “student health service fee” during registration for courses. This fee entitles students to be seen by a physician in Student Health Service without charge. Students are responsible for fees that are incurred for lab work, medications, and immunizations related to their medical care. In addition, all Stony Brook full-time students are required to purchase mandatory health insurance, or document equivalent coverage to receive a waiver (effective fall 2005).
STATEMENT ON RISKS TO STUDENTS

The School of Health Technology and Management (SHTM) is engaged in the education and training of students for entry into different health professions. The learning experiences which must be provided to students of the school may unavoidably create certain risks which arise from essential laboratory, classroom and clinical activities. These risks are comparable to those which exist for currently practicing health professionals.

In the various types of learning experiences which take place within the school, and at its affiliated clinical training sites, the student may be exposed to safety and health hazards which can be minimized (prevented) by adherence to the safety rules and regulations which have been established by each program. Potential hazards are controlled and monitored by competent faculty supervision, and conscientious observance of universal precautions and safety procedures. Carelessness in risk situations can lead to accidents with resultant injury or illness.

Within the educational experiences conducted by the school, the following risks may exist:

a. exposure to infectious materials including body substances, lab specimens, contaminated equipment and supplies, contaminated environmental surfaces, contaminated air or lab animals
b. exposure to radioactive materials
c. burns from chemicals, open flames, heated liquids or electrical equipment
d. physical injury from improperly operated equipment or improper body mechanics
e. electrical shock from equipment
f. lacerations or injury from improperly handled equipment
g. aggravation of students’ preexisting conditions secondary to educational exercises or activities of a strenuous nature
h. skin irritations due to exposure to materials to which the student may be sensitive.

In an effort to reduce incidents of students’ exposure to environmental hazards and infectious diseases, information regarding safety and exposure to infectious agents and hazardous substances will be provided prior to the first class meeting for each course or prior to clinical activities. Students will be educated about the principles of proper body mechanics and infection control, including standard precautions, bloodborne pathogens, appropriate first aid and exposure response procedures. Students who are concerned about their participation or believe they may be placed at unusual risk because of medical conditions or physical limitations are advised to consult with their program director/department chair and/or course instructor prior to participating in any learning exercise which may create such a risk. (Please refer to the Americans with Disabilities Act document in this orientation handbook, as relevant).
**STANDARD PRECAUTIONS**

In order to reduce the risk of transmission of bloodborne pathogens and to reduce exposure to infectious diseases and environmental hazards, the Centers for Disease Control (CDC) recommends the use of “Standard Precautions” when dealing with all patients by treating all blood and potentially infectious material (semen, vaginal secretions, synovial, pleural, peritoneal, pericardial, cerebrospinal, and amniotic fluids) with appropriate precautions. These precautions include:

a. **Handwashing**
   - Wash hands prior to and immediately after examining/treating every patient
   - Hands must be washed as soon as possible after touching blood, body fluids, excretions and contaminated objects even if gloves have been worn
   - Hands must be washed between patients and after removing gloves and other protective equipment

b. **Gloves**
   - must be worn when:
     - touching blood, body fluids, mucous membranes, nonintact skin and contaminated objects
     - performing venipuncture or vascular access procedures
     - processing specimens
     - performing invasive procedures.
   - must be changed between tasks if contaminated even when caring for the same patient.
   - must be removed promptly after use and new gloves must be donned before caring for another patient.

c. **Mask, Eye Protection, Face Shield** - must be worn during patient care activities that may generate splashes of blood, body fluids, secretions, excretions or bone chips.

d. **Gowns** – must be worn during patient care activities that may generate splashes of blood, body fluids, secretions or excretions to protect skin and clothing. Soiled gowns must be removed as soon as possible followed by prompt handwashing.

e. **Dispose of all biohazard material, including blood, body fluids, and microbiological culture, as infectious.**

f. **Never pipette by mouth.**

g. **Disinfect work surfaces after a spill and when work is complete.**
   - Appropriate disinfectants include 35% isopropyl alcohol and 10% chlorine bleach.

h. **Eliminate the use of needles/sharps whenever possible. Use medical devices with safety features.**
i. Use sharps in a safe, controlled environment whenever possible, with a sharps container nearby. Use safe techniques when using, handling, cleaning or disposing of sharp instruments and devices. Never recap used needles, do not remove used needles from disposable syringes by hand and do not bend, break or otherwise manipulate used needles by hand. Place all used sharps in appropriate puncture-resistant containers.

j. Use mouthpieces, resuscitation bags or other ventilation devices when mouth-to-mouth resuscitation is required.

**IMMUNIZATION/DISEASE SURVEILLANCE**

Preventive strategies for infections known to be transmitted in health care settings include immunizations for vaccine preventable diseases. Students entering SHTM must show immunity to measles, mumps, rubella, varicella and hepatitis (unless Hepatitis B vaccine declination statement is signed), and have received tetanus /diptheria toxoid within the past 10 years. Students must receive a PPD within 6 months prior to the start of classes, and yearly thereafter if negative. If a student has a history of a positive PPD, documentation of a negative chest x-ray and/or treatment is required prior to entering SHTM.

Each student will have an annual assessment, including a PPD, before the start of the second (and third, if applicable) year(s) of their respective programs. If a student has a newly recognized positive PPD (a new converter) they must be evaluated by the Student Health Service.

**TUBERCULOSIS (TB) EXPOSURE**

Adequate infection control measures (masks and isolation precautions) should be strictly followed in an effort to minimize the risk of exposure to an infectious patient. If appropriate precautions have not been followed, students who have been exposed to a patient with active TB will require post-exposure PPD skin testing. The student should receive a baseline PPD skin test at the clinical site as soon as possible after the exposure, unless the student has a documented negative PPD within the preceding 3 months. The student must notify the appropriate individual in his/her professional program at SHTM if he/she has been exposed to TB. A School of Health Technology and Management Incident Report must also be submitted to the program within 48 hours of occurrence. The student will then be referred to the Occupational Medicine Clinic for repeat testing which must be performed 12 weeks after the exposure. Students with previously positive PPDs who have been exposed to an infectious patient should be referred to the Occupational Medicine clinic where they will be evaluated and followed for active TB by a complete symptom review. If the student remains asymptomatic, no further testing is required.
**Bloodborne Pathogen Exposures**

Health care personnel are at risk for exposure to bloodborne pathogens including, but not limited to, hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). These exposures can occur through needlesticks or cuts from sharp objects contaminated with an infected patient’s blood or visibly bloody fluid or potentially infectious fluid (semen, vaginal secretions, synovial, pleural, peritoneal, pericardial, cerebrospinal, and amniotic fluids) or through contact of mucous membranes or nonintact skin with an infected patient’s blood or visibly bloody fluid or potentially infectious fluid. In the laboratory any direct contact to concentrated virus is also considered an exposure and as such requires clinical evaluation.

Factors that influence the risk of exposure include the pathogen involved, the type of exposure, the amount of blood involved in the exposure and the amount of virus in the patient’s blood at the time of the exposure. According to the CDC, the frequency of transmission of HBV can range from 1% to 30% depending on the source patient’s “e antigen” result which, if positive, correlates with high infectivity. If exposed to HCV the risk of infection is 1.8%. When a percutaneous injury involves blood from an HIV infected source the risk of HIV transmission is roughly 0.3%. After a mucous membrane exposure the average risk of seroconversion is approximately 0.1%. Most exposures do not result in infection. The CDC publishes a brochure, “Exposure to Blood: What Healthcare Personnel Need to Know”. This is an excellent resource that you should read before your clinical experiences. It can be accessed at http://www.cdc.gov/HAI/pdfs/bbp/Exp_to_Blood.pdf. Effective management of educational exposures to blood borne pathogens requires coordination among multiple parties, SHTM, clinical affiliates and the Stony Brook University Medical Center Occupational Medicine Clinic. Students must be trained in the prevention of injuries and in the management of injuries when they occur. Upon arrival at a clinical site students must become familiar with the site specific protocols for the initial management of blood and body fluid exposures. Post exposure follow-up will be provided by the Stony Brook University Medical Center Occupational Medicine Clinic. Exposure prevention remains the primary strategy for reducing blood and body fluid exposures.

**General Care After Bloodborne Exposure**

1. Perform basic first aid immediately
   a. wash the area of injury with soap and water
   b. flush splashes to nose, mouth or skin with water
   c. irrigate eyes with clean water or sterile irrigants

Use of caustic products (bleach) or squeezing the puncture site is not advised. Discarded needles/sharps are not tested for bloodborne pathogens.
2. After performing basic first aid, report the exposure immediately to your supervisor/preceptor and report to the Emergency Department or Employee Health Service (as directed by your supervisor). **Prompt reporting is essential; if treatment is recommended it must be started as soon as possible after the exposure.**

3. The student **must** also notify the appropriate individual in his/her professional program at SHTM. A School of Health Technology and Management Incident Report must also be submitted to the program within 48 hours of occurrence.

4. The student must follow up in 72 hours with the Occupational Medicine Clinic for further postexposure testing, follow-up, and counseling.

   Occupational Medicine Clinic  
   2700 Nesconset Highway (Route 347)  
   Building #9  
   Stony Brook, NY 11794   (631) 444-6250

**HEPATITIS B VIRUS (HBV) EXPOSURE AND POST-EXPOSURE PROPHYLAXIS (PEP)**

Percutaneous (needlestick) injuries are the most efficient mode of transmission of HBV, however, at room temperature HBV can survive in dried blood on surfaces for at least 7 days. Persons who have been adequately immunized are at virtually no risk for infection, as evidenced by the 95% reduction in the number of occupational infections since the Hepatitis B vaccine became available in 1982. In susceptible individuals (those who have not been vaccinated or who did not develop antibodies after immunization) the risk of infection after a percutaneous exposure to HBV infected blood ranges from 1-30%.

**HEPATITIS B VIRUS (HBV) PEP**

Hepatitis B immune globulin (HBIG) and/or hepatitis B vaccine may be recommended depending on the source patient’s infection status and your immune status. For students who have not been vaccinated, the CDC currently recommends hepatitis B vaccination for all exposures regardless of the source patient’s hepatitis status. (see table 7)

**HEPATITIS C VIRUS (HCV) EXPOSURE AND POST-EXPOSURE PROPHYLAXIS (PEP)**

Hepatitis C is not transmitted efficiently through occupational/educational blood exposures in the health care setting. If exposed to HCV, the average risk of transmission is 1.8%. HCV can survive outside the body and still transmit infection for 16 hours, but not longer than 4 days.

**HEPATITIS C VIRUS (HCV) PEP**

Currently no PEP exists for hepatitis C, recommendations for postexposure management are in place to achieve early identification of chronic disease, and if present, referral for
evaluation of treatment options. Postexposure management includes baseline testing for HCV antibodies and liver function tests, repeated at 4-6 months or at any time if symptoms develop (abdominal pain, nausea/vomiting, jaundice, malaise, fever). (see table 8)

**HUMAN IMMUNODEFICIENCY VIRUS (HIV) EXPOSURE AND POST-EXPOSURE PROPHYLAXIS (PEP)**

The average risk of acquiring HIV infection after a needlestick or other sharp injury that involves HIV infected blood is 0.3%; the risk after mucous membrane exposure is 0.1%. Factors that might affect the risk of HIV transmission after exposure include:
- deep injury
- visible blood on device
- procedure involving needle placed directly in a vein or artery
- terminal illness in source patient

**HUMAN IMMUNODEFICIENCY VIRUS (HIV) PEP**

An individual assessment by the Emergency Medicine or Employee Health Practitioner will be made regarding the degree of risk associated with each exposure. For example, prophylaxis may not be recommended to students who sustain exposures that are not thought to be significant (i.e., if an accidental needle stick occurs with a piggy-back intravenous solution that did not contain blood). Exposure to saliva, tears, sweat, or non-bloody urine or feces does not require PEP. (see table 2)

Students who sustain a significant exposure to material that may be infected with HIV may benefit from the prompt initiation (within 1-2 hours) of antiretroviral therapy to interrupt viral transmission. First dose antiretroviral medication will be provided by the clinical site with subsequent follow up provided by the Occupational Medicine Clinic at the student’s own expense, however, the Stony Brook University mandatory health insurance provides coverage for these expenses.

Students should be tested for HIV antibody at the time of the exposure and then again at 6 weeks, 12 weeks and 6 months. Students who elect to start PEP should have baseline (at the time of the exposure) complete blood counts and liver and kidney function testing, with repeat testing performed 2 weeks later.

Students should seek medical care from Occupational Medicine if they experience any sudden symptoms of flu like illness (fever, rash, muscle aches, malaise or swollen glands) during the weeks following an exposure. These symptoms may suggest a drug reaction or HIV or other infection.

Students are advised to follow recommendations for preventing transmission of HIV during the follow up period, especially the first 6-12 weeks. These include the correct and consistent use of condoms during sexual activity; donating blood, semen or organs; and refraining from breast feeding.
School of Health Technology and Management
Blood and Body Fluid Exposure Procedure

1. Perform basic first aid immediately
   - wash the area of injury with soap and water
   - flush splashes to nose, mouth or skin with water
   - irrigate eyes with clean water or sterile irrigants
   Use of caustic products (bleach) or squeezing the puncture site is not advised. Discarded needles/sharps are not tested for bloodborne pathogens.
2. After performing basic first aid, report the exposure immediately to your supervisor/preceptor and report to the Emergency Department or Employee Health Service (as directed by your supervisor). **Prompt reporting is essential; if treatment is recommended it must be started as soon as possible after the exposure.**
3. The student must also notify the appropriate individual in his/her program. An accident report must also be submitted to the program within 48 hours of occurrence.
4. The student must follow up in 72 hours with the Occupational Medicine Clinic for further postexposure testing, follow-up, and counseling.*
   - Occupational Medicine Clinic
   - 2700 Nesconset Highway (Route 347) Building #9
   - Stony Brook, NY 11794
   - (631) 444-6250

*If out of area, consult with your faculty

**Bibliography**


Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities. MMWR Morb Mortal Wkly Rep, October 28, 1994 / 43(RR13);1-132.


New York State Department of Health AIDS Institute: [www.hivguidelines.org](http://www.hivguidelines.org) accessed 5/26/2011

Revised 4/12
Table 2
Exposures for which PEP is indicated

- Break in the skin by a sharp object (including both hollow-bore and cutting needles or broken glassware) that is contaminated with blood, visibly bloody fluid, or other potentially infectious material, or that has been in the source patient’s blood vessel.
- Bite from an HIV-infected patient with visible bleeding in the mouth that causes bleeding in the HCW.
- Splash of blood, visibly bloody fluid, or other potentially infectious material to a mucosal surface (mouth, nose, or eyes).
- A non-intact skin (e.g., dermatitis, chapped skin, abrasion, or open wound) exposure to blood, visibly bloody fluid, or other potentially infectious material.

Table 7
Recommended Post-Exposure Prophylaxis for Hepatitis B Virus

<table>
<thead>
<tr>
<th>Vaccination and/or antibody response status of exposed patient</th>
<th>Treatment when source patient is:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HBsAg positive</td>
</tr>
<tr>
<td>Unvaccinated/ non-immune</td>
<td>HBIG(^b) × 1; initiate HB vaccine series</td>
</tr>
<tr>
<td>Previously vaccinated, known responder(^d)</td>
<td>No treatment</td>
</tr>
<tr>
<td>Previously vaccinated, known non-responder(^d)</td>
<td>HBIG(^b) × 1 and initiate revaccination(^e) or HBIG(^b) × 2</td>
</tr>
<tr>
<td>Previously vaccinated, antibody response unknown</td>
<td>Single vaccine booster dose</td>
</tr>
<tr>
<td>If still undergoing vaccination</td>
<td>HBIG(^b) × 1; complete series</td>
</tr>
</tbody>
</table>

HBsAg, hepatitis B surface antigen; HBIG, hepatitis B immune globulin; anti-HBs, antibody to hepatitis B surface antigen.

\(^a\) persons who have previously been infected with HBV are immune to re-infection and do not require PEP.

\(^b\) Dose 0.06 mL/kg intramuscularly.

\(^c\) Vaccinated with full three-dose series.

\(^d\) Based on information available at presentation. Responder is defined as person with previously documented adequate levels of serum antibody to HBsAg (serum anti-HBs >10 mIU/mL); non-responder is a person with previously documented inadequate response to vaccination (serum anti HBs <10 mIU/mL). It is not recommended that decision-making be delayed while testing for anti-HBs at presentation.

\(^e\) The option of giving one dose of HBIG and re-initiating the vaccine series is preferred for non-responders who have not completed a second three-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

\(^f\) High-risk is defined as sources who engage in needle-sharing or high-risk sexual behaviors, and those born in geographic areas with HBsAg prevalence of ≥2%.\(^f\)

New York State Department of Health AIDS Institute: www.hivguidelines.org
<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source patient is HCV-antibody negative</td>
<td>No further testing or follow-up is necessary</td>
</tr>
<tr>
<td></td>
<td>for source patient or the exposed HCW</td>
</tr>
<tr>
<td>Source patient is unavailable or refuses testing</td>
<td>Exposed HCW: Follow-up HCV antibody at 3</td>
</tr>
<tr>
<td></td>
<td>and 6 months</td>
</tr>
<tr>
<td>Source patient is HCV-antibody positive and HCV RNA</td>
<td>Manage the exposed HCW as if the source</td>
</tr>
<tr>
<td>negative</td>
<td>patient has chronic hepatitis C</td>
</tr>
<tr>
<td></td>
<td>(see Section 2: Post-Exposure Follow-Up)</td>
</tr>
<tr>
<td>Source patient is positive for both HCV</td>
<td>Source patient: Counsel and manage as</td>
</tr>
<tr>
<td>antibody and HCV RNA and</td>
<td>chronic hepatitis C regardless of status of</td>
</tr>
<tr>
<td>Exposed HCW is HCV-antibody negative</td>
<td>exposed person</td>
</tr>
<tr>
<td>Exposed HCW tests positive for both HCV</td>
<td>Exposed HCW: Follow up as outlined in Section 2:</td>
</tr>
<tr>
<td>antibody and HCV RNA</td>
<td>Post-Exposure Follow-Up</td>
</tr>
<tr>
<td></td>
<td>Counsel and manage as chronic hepatitis C</td>
</tr>
</tbody>
</table>

*a* Refer to Appendix G for information about HCV tests and how to interpret results.

*b* If at any time the serum ALT level is elevated in the exposed HCW, the clinician should test for HCV RNA to assess for acute HCV infection.

*c* A single negative HCV RNA result does not exclude active infection.

New York State Department of Health AIDS Institute: www.hivguidelines.org