Student Orientation Packet – 2016
Clinical Student

EMERGENCY CONTACT INFORMATION

GENERAL INFORMATION

Name		
Address		
City, State, Zip Code		
Telephone Numbers:	Home Phone:	Cell Phone:
Company/School		
Supervisor/Instructor	Name:	Phone:

EMERGENCY INFORMATION

Notify/Relationship	Contact Number
Notify/Relationship	Contact Number

INSURANCE/MEDICAL CONTACT INFORMATION

Medical Insurance	Medical Record #
Policy #	Contact Number
Physician	Contact Number
Where non-emergent care is to be provided	

MEDICAL INFORMATION

Important Medical History:	
Critical Allergies	
Any additional information	

Attestation of orientation for Clinical Student

School:_____

Name:_____

Sign and return this form and a completed orientation exam prior to starting your first shift.

By signing below, I _____ attest that I have reviewed the Clinical Student Orientation Packet in its entirety and take responsibility for the information contained therein. If I have any questions regarding the material in the orientation packet, I will seek clarification from the person in charge of my assigned area prior to starting my first shift at PIH HEALTH.

_____ _____

Signature Date

PRIVACY, INFORMATION SECURITY AND CONFIDENTIALITY

Acknowledgement of Responsibility

I understand and acknowledge that in the course of my employment or involvement with Presbyterian Intercommunity Hospital, Inc., a California nonprofit public benefit corporation dba PIH Health Hospital – Whittier and/or any of its related entities, collectively referred to as ("Organization"), there will be times when I will see, hear, or otherwise have access to confidential and private information such as patient health information, whose privacy and security I must maintain. To that end, I understand and acknowledge that:

- I agree to preserve and protect the privacy, confidentiality and security of all confidential information relating to the Organization, its patients, activities and affiliates, in accordance with applicable state and federal laws, including but not limited to the Health Information Portability and Accountability Act (HIPAA), and the Organization's policies.
- I will only access, use or disclose confidential information only in the performance of my duties for the Organization, when required or permitted by law, and disclose information only to persons who have the right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.
- The Organization is committed to protecting patient privacy and keeping patient information confidential and secure. I support this obligation during the course of my employment or involvement with the Organization. How I treat, protect, and secure confidential information applies even when I am not at the Organization.
- I recognize that posting, transferring, or reproducing patient health information on the internet such as on a social media or networking site or on any electronic or mobile device or via electronic communication methods (e.g. email, text, or instant messaging) without appropriate authorization is not allowed and may compromise the privacy and security of that information and subject me to disciplinary and/or legal action.
- If I am provided a user name / log in and password to access any of the Organization's electronic medical record, billing and financial, or other computer or information systems, I understand that it is my responsibility to follow safe computing guidelines. To this end, I agree not to share my user name / log in and/or password with any other person. I am responsible for any potential breach of confidentiality or privacy resulting from access made to the Organization's electronic information systems (including mobile devices) using my user name / log in and password. If I believe someone else has used my user name / log in or password, I will immediately report the use to the appropriate information technology department and request a new password. My user name / log in and password constitutes my signature and I will be responsible for all entries made under my user name / log in. I agree to always log off shared workstations and lock personal workstation if left unattended.
- I understand that my access to any of the Organization's electronic information systems is subject to audit in accordance with the Organization's policies.
- Under state and federal laws and regulations and the Organization's policies governing a patient's right to privacy, unlawful or unauthorized access to, or use or disclose of, patients' confidential patient information may subject me to disciplinary action up to and including immediate termination from my employment/professional relationship with the Organization, civil fines for which I will be personally responsible, and criminal sanctions.
- I agree to report to the Organization's management, the HIPAA Privacy and Data Security Officer any instance where I suspect that the Organization's privacy or security policies are being violated or where the security or privacy of the Organization's confidential or patient information may be compromised.

I have read, understand and acknowledge all of the above **PRIVACY, INFORMATION SECURITY AND CONFIDENTIALITY; Acknowledgement of Responsibility**

_____	_____	_____
Signature	Print Name	Date

☐ Employee; ID #:_____ ☐ Student ☐ Medical Staff observer ☐ Contract Staff ☐ Volunteer ☐ Other:

Please return this form with attestation and test

CLINICAL STUDENT

CONSENT FOR RELEASE OF INFORMATION

_____ _____

Name (Last, First, MI) **Date of Birth**

The University may not disclose information contained in employee's records without the employee's written consent except under certain conditions. The employee's record may be released to a third party by providing a written authorization or consent.

Consent for Release of Information:

I hereby **give my consent** for the following information to be released to PIH HEALTH (upon the hospital's request) specifically for the calendar year: _____.

1) Background Check
2) Immunization Records
3) TB Test Results
4) Drug Screen Results
5) Physical Examination by Licensed Provider

_____ _____

Signature Date

Photocopies of this authorization may be made and used as duplicate originals. This authorization shall remain valid for as long as this Agreement remains in effect and/or University provides services to Hospital, whichever is longer.

STUDENT ORIENTATION EXAM
Clinical Staff

Name_____

Agency _____

Assigned unit_____

1. The mission of PIH Health Hospital includes providing high quality healthcare, demonstrating compassion, respect, and dignity in caring for all patients.
   True _____ False _____

2. All employees commit to providing customer service that promotes a positive patient *experience*.
   True _____ False _____

3. What circumstances are reportable by law:
   a. Suspected Elder Abuse
   b. Alcohol & Tobacco use
   c. Financial Exploitation/Abuse
   d. A & C

4. The *number one* thing an employee can do to prevent the spread of microorganisms is:
   a. Wear Gloves
   b. Wash hands (or use waterless hand gel) between patient contact, after using the restroom, and before and after eating
   c. Cover your mouth when sneezing
   d. Washing the telephone receiver after each use

5. Match the correct Code description to the Code:

_____	Code Decon	A. Begin Assessment/Potential for victims
_____	Code Blue	B. Medical Emergency Pediatric
_____	Code Red	C. Triggered by drugs commonly used in Anesthesia
_____	Code Triage External	D. Medical Emergency Adult
_____	Code Pink	E. Unannounced survey
_____	Code Orange	F. Child/Pediatric Patient Abduction
_____	Code Yellow	G. Infant Abduction
_____	Code White	H. Patient with new signs/symptoms of Stroke
_____	Code Triage Internal	I. External Disaster
_____	Code Purple	J. Internal Disaster
_____	Code Silver	K. Hazardous Material Spill/Release
_____	Code Gray	L. Person with a Weapon &/or hostage situation
_____	PALS Code Blue	M. Medical Emergency Neonate/Infant
_____	Code Triage Watch	N. Fire
_____	Code Gold	O. Combative Person
_____	Code STEMI	P. Impending Heart Attack/ Patient Arriving in the ED
_____	Stroke Team	Q. Patient Decontamination
_____	Code Hyperthermia	R. Bomb Threat

6. Only the nursing staff personnel are responsible for identifying situations that might put a patient at risk for falls.
   True _____ False _____

7. Which of the following is Protected Health Information (PHI) under HIPAA?
   a. the patient's address
   b. the patient's allergies
   c. the patient's medical record number
   d. all of the above

8. Which of the following types of information does the HIPAA's privacy rule protect?
   a. patient information in an electronic form
   b. patient information communicated orally
   c. patient information in paper form
   d. all of the above

9. Under what circumstances are you free to repeat PHI to others that you hear on the job?
   a. after you no longer work for PIH HEALTH
   b. after the patient's dies
   c. only if you know that the patient won't mind
   d. when your job requires it

10. Some examples of service excellence are:
    a. help keep work area clean and safe
    b. keep uniform clean and appropriate for job duties
    c. wear your name badge above the waist
    d. introduce yourself to the patient/family
    e. all of the above

11. In case of fire, your FIRST step should be to
    a. Call the operator
    b. Get a fire extinguisher
    c. Rescue anyone in immediate danger
    d. Pull the alarm

12. In the event of a medical emergency, the number to call is
    a. 0
    b. 1111
    c. 12999

13. If you have a concern or question that you cannot answer related to operations, you should follow the
    a. Chain of Custody
    b. Chain of Command
    c. Incident Command System
    d.

14. At PIH HEALTH, we believe that our care and communications should be sensitive to specific needs of patients of different ages and different cultures.
    True _____ False_____

15. Match the correct Wristband Color to correct patient-specific risk factor or special need.

_____	Yellow	A. Do not use this extremity for blood pressure or blood draw
_____	Red	B. "Do Not Resuscitate"
_____	Purple	C. Allergies
_____	White	D. Fall Risk
_____	Black	E. Patient Identification

16. Correct identification of the patient requires using which two forms of identification:
    a. name and medical record number for inpatients
    b. account number and medical record number
    c. name and account number
    d. name and birth date for outpatients
    e. A &D

17. The patient at high risk for falls can *best* be identified by:
    a. the wearing of an additional arm wristband that is bright red in color
    b. being in the bed location closest to the door
    c. the patient's diagnosis
    d. the wearing of an additional arm wristband that is yellow in color

18. If you suspect a medical staff member or allied health professional may be providing medical care under the influence of alcohol and/or drugs, the following steps should be taken:
    a. Immediately notify your manager or supervisor who, in turn contacts the Chief Nursing Officer. The Chief Nursing Officer reports the incident to the Chief of Staff or Medical Executive Committee designee for appropriate action.
    b. Notify the police.
    c. Call the Department of Health and Human Services

19. Development of obesity is complex and involves social, behavioral, cultural, physiological, metabolic and genetic factors:
    True _____ False _____

20. Weight bias related to weight seen in Healthcare may be:
    a. Reluctance to seek preventative care due to embarrassment
    b. Delaying or cancelling of appointments
    c. Stigmatization by Physicians and healthcare workers
    d. All of the above

21. When a co-worker talks negatively about an obese patient in your unit you. Your response to that comment will be:
    a. Tell your manager / instructor
    b. Make no comments and leave

c. Pull co-worker aside and discuss that all people deserve respect and nobody deserves unkind remarks
d. None of the above

PIH HEALTH -WHITTIER, CALIFORNIA
HIPAA GLOBAL TRAINING
POST TEST

Name_____

Agency_____

Assigned Unit_____

1. What is a "covered entity" under the HIPAA Privacy Rule?
   a. Only hospitals
   b. Hospitals and doctor offices
   c. Most providers, clearinghouses, and health plans

2. When you see or hear patient health information while on the job, but you are not directly involved in the patient care, the information is confidential and cannot be shared with others.
   _____ True _____ False

3. You are allowed to repeat patient health information that you hear on the job when:
   a. The patient dies
   b. It is needed to do your job
   c. You believe the patient won't mind
   d. You no longer work at the hospital

4. Protected health information can be:
   a. Written or verbal
   b. Information we create or that we receive from another provider
   c. Displayed on a computer screen, faxed, or given over a telephone
   d. a, b, and c

5. When you disclose information, it is shared with an outside entity.
   _____ True _____ False

6. Criminal penalties for wrongfully and knowingly disclosing protected health information carry large fines and jail time.
   _____ True _____ False

7. You notice a vendor looking at a computer screen with protected health information on it. Because the vender is not an employee of the hospital, this is not a violation.
   _____ True _____ False

8. You have knowledge of a violation or potential violation of PIH's privacy policies. To whom should you report it?

   _____

9. A patient can be denied treatment if he or she has not signed an acknowledgment of receipt of our *Notice of Patient Privacy Practices* even though a good-faith effort to get the signature has been made.
   _____ True
   _____ False

10. The HIPAA Privacy Rule protects the patient's fundamental right to confidentiality and privacy.
    _____ True _____ False

eMD User Identification Code Receipt

As a/an □ Contract Staff □ Student □ Volunteer □ Instructor at Presbyterian Intercommunity Hospital, or any of its affiliates, I understand that the confidentiality and protection of hospital and patient information is legally mandated and of the utmost importance.
I, the undersigned, acknowledge receipt of my User Identification Code for eMD and understand that:

1. My User Identification Code is the legal equivalent to my signature.
2. I understand that disclosure of my User Identification Code to anyone is a breach of confidentiality.
3. I will not attempt to learn another employee's User Identification Code.
4. I will not attempt to access information in the system by using a User Identification Code other than my own.
5. I will not attempt to access any unauthorized information.
6. I am responsible for all entries of orders, information, and data entered into the information system under my User Identification Code.
7. It is my responsibility and obligation to notify Information Services immediately if I have reason to believe that the confidentiality of my User Identification Code has been broken.
8. Any disclosure of patient and hospital information will be subject to disciplinary action in line with hospital policy.
9. I am responsible for working within my scope of practice.

I have read the above information and understand that any violation or compromise of the confidentiality of the Presbyterian Intercommunity Hospital Information System or the information contained therein will subject me to disciplinary action.

I further understand that my User Identification Code will be deleted from the system as soon as I terminate my services at Presbyterian Intercommunity Hospital or transfer to a position which changes my need for computer access. Should I be re-instated at Presbyterian Intercommunity Hospital or transfer to a position which requires a different user code, a new User Identification Code will be issued.

_____	_____	_____	_____
Signature	Printed Name	ID Number	Date
_____	_____	_____	_____
Witness Signature	Printed Name	ID Number	Date

Name_____

Agency_____

Assigned Unit_____

RETURN TO HUMAN RESOURCES/ NURSING OFFICE
For floats, keep form in unit file for reference

1. Assign preceptor
2. Complete unit/department specific orientation (contract and floats)
3. Complete required hospital wide competencies* (not necessary for floats)
4. Complete required unit specific competencies

UNIT/DEPARTMENT SPECIFIC ORIENTATION – Clinical Student

I acknowledge that I have been oriented to the following specific information.

Signature:_____ **Date:**_____

Employee to initial when completed	
	Department Overview: • Location of Departmental/Hospital Policies on Intranet • Review of unit specific policies and procedures as appropriate • Identify unit/department chain of command
	Physical Set-up/Work Environment • Office equipment review / Identify location of supplies and forms • Review physical set-up of unit/department and review telephone system, beeper, VOCERA
	Safety Issues • Identify location of fire exits and extinguishers and review fire and disaster plan
	Workflow • Identify shift responsibilities and assignment including assigned resource person/buddy • Review documentation responsibilities and review admission/discharge processes (clinical only)
	Human Resources Items • Meal breaks; identification badge visible and above waist; dress code

_____ _____

Signature Manager/Designee Date

Competency Validation Record – Clinical Student

Each Competency Assessment Sheet to be filed with Nursing Administration/Human Resources in Contract Personnel File.
Competencies must be assessed prior to care delivery. If competence not demonstrated, personnel may not deliver that component of care.

Competency	Preceptor Signature	Date Performed

I acknowledge that I have read & completed the competency criteria support document.

_____ _____

Employee Signature Evaluator Signature/ Initials

PIH HEALTH HOSPITAL
WHITTIER, CALIFORNIA

Name_____

Student_____

EDUCATION DEPARTMENT

Assigned Unit_____

COMPETENCY ASSESSMENT:

RESTRAINTS (If Competency is not applicable, do not complete)

Assessment Code:
1 = Performs skill independently & completely
2 = Performs skill but requires supervision
3 = Can verbalize theory or how to perform skill, but has had minimal opportunity to practice skill

Method of Evaluation
D = Return Demonstration
O = Clinical Observation
V = Verbal Feedback

PRE-ASSESSMENT	Assessment Code	Evaluator Initials	Method of Evaluation
• Finds and reads Policy No. 100.87200.604			D O V
Nonviolent, Non-Self Destructive			
• Defines non-violent, non-self-destructive restraint use			D O V
• Identifies required nonviolent, non-self-destructive restraint documentation - MD to order the Nonviolent order in eMD - RN to document clinical Justification for use upon new order - RN to document on the Nonviolent Restraint Flowsheet/Parameter			D O V
- Describes timeframe for obtaining an initial restraint order as soon as possible but no longer than 1 hour from initiation of restraints			D O V
- Describes timeframe for an in-person evaluation as within 24 hours of initiation of restraints			D O V
- Describes time frame for a restraint renewal order as until patient no longer meets the rationale (clinical justification)			D O V
• Defines criteria for release as (all MUST be met) - No longer pulling on tubes or other lines - Follows direction to stop behavior - Complying with safety instructions			 D O V D O V D O V
• Describes frequency of RN assessment as every 2 hours			D O V
• Describes frequency of RN documentation as every 2 hours			D O V
• Defines the content of RN assessment / documentation as - level of consciousness - behavior / condition - type of restraint / site - circulation and range of motion in the extremities - nutrition and hydration - hygiene and elimination			 D O V D O V D O V D O V D O V D O V
Violent , Self-Destructive			
• Defines violent, self- destructive restraint use			D O V
• Describes required violent, self-destructive restraint documentation - MD to order the Violent order in eMD - RN to document the Restraint Assessment as specified by patient age. - RN to document on the Violent Restraint Flowsheet/Parameter			D O V
• Describes timeframe for obtaining an initial order as soon as possible but no longer than 1 hour from initiation of restraints			D O V
• Describes timeframe for renewal of order as every: - 4 hours for patients ages 18 years and older - 2 hours for patients ages 9-17 - 1hour for patients under age 9			D O V D O V D O V
• Describes timeframe for an in-person evaluation as 1 hour from initiation of restraints to be done by MD, LIP, Clinical Director, or House Supervisor			D O V

• Defines criteria for release as (all MUST be met) - No longer exhibits violent self-destructive behavior - Calm and in control - Follows direction to stop behavior			 D O V D O V D O V
• Describes frequency of Monitoring as every 15 minutes			D O V
• Describes frequency of RN assessment as every 2 hours			D O V
• Defines content of RN assessment / documentation as: - vital signs as clinically warranted - level of consciousness - behavior / condition - type of restraint / site - circulation and range of motion in the extremities - nutrition and hydration - hygiene and elimination			 D O V D O V D O V D O V D O V D O V D O V
• Verbalizes process for delegation of restraint application to assistive personnel			D O V
• Verbalizes process for restraint delegation follow-up with assistive personnel			D O V
Restraint Application Clinical Staff / Ancillary Support Staff			
Roll Belt			
• Demonstrates correct application of restraint of the roll belt per mfg. instructions			D O V
• Demonstrates correct technique for securing the roll belt			D O V
• Demonstrates correct technique for releasing the roll belt buckles			D O V
Vest (Bed) Restraint			
• Demonstrates correct application of vest restraint per mfg. instruction			D O V
• Demonstrates correct technique for securing vest ties			D O V
• Demonstrates correct technique for quick release ties			D O V
Extremity Restraint			
• Demonstrates correct application of restraint to extremity per mfg instruction			D O V
• Demonstrates correct technique of securing extremity restraint			D O V
• Demonstrates correct technique for quick release of extremity restraint			D O V
Finger Control Mitt Restraints			
• Verbalizes that a Mitt becomes a restraint when - pinning or attaching to the bedding - used in conjunction with a wrist restraint - applied so as to immobilize hand or fingers			 D O V D O V D O V
• Demonstrates application of Mitt per manufacturer instruction			D O V
Torso (Chair) Restraint			
• Demonstrates correct application of the Torso Support per mfg instruction			D O V
• Verbalizes process for choosing correct restraint size			D O V
• Verbalizes patient instruction as to sit with hips against the chair back			D O V
• Demonstrates wrapping chest strap around patient torso			D O V
• Demonstrates securely hooking chest straps together behind chair back			D O V
• Demonstrates bringing shoulder straps over patient shoulders and chair back and crossing in an “X” to secure to chest strap			D O V
• Demonstrates checking for restraint fit using the flat of the hand			D O V

I acknowledge that I have read & completed the competency criteria support document.

_____ _____

Signature **Evaluator Signature/ Initial**

PIH HEALTH HOSPITAL
WHITTIER, CALIFORNIA

EDUCATION DEPARTMENT

Name_____

Agency_____

Assigned Unit_____

COMPETENCY ASSESSMENT:

GAIT BELTS (If Competency is not applicable, do not complete)

Assessment Code:
1 = Performs skill independently & completely
2 = Performs skill but requires supervision
3 = Can verbalize theory or how to perform skill, but has had minimal opportunity to practice skill

Method of Evaluation
D = Return Demonstration
O = Clinical Observation
V = Verbal Feedback

Gait Belt Competency			
	Assessment Code	Evaluator Initials	Method of Evaluation
• Demonstrates appropriate application of gait belt			D O V
• Verbalizes indications for use of gait belt			D O V
• Demonstrates appropriate positioning and guarding techniques for utilization of gait belt			D O V
• Demonstrates or verbalizes the appropriate infection control technique with gait belt			D O V

I acknowledge that I have read and completed the competency criteria support document.

_____ _____

Employee Signature Evaluator Signature/Initials

RETURN TO HUMAN RESOURCES/NURSING OFFICE

Name_____

Agency_____

Assigned Unit_____

Evaluation of Clinical Student

Complete at completion of first work day:

Standard	Outstanding	Proficient	Unacceptable	Comments
General Appearance				
Communication Skills				
Organization and Flexibility				
Documentation Skills				
Customer Service Skills/ Patient Satisfaction				
Overall Performance				

☐ Recommended to Return ☐ Not Recommended to Return

Comments:

_____

_____

_____

_____

_____ _____

PIH HEALTH Manager/Designee Signature Date

CLINICAL STUDENT REQUIREMENT GRID

COLLEGE: **STUDENT YEAR (circle one):**
INSTRUCTOR NAME: **START & END DATE:**
INSTRUCTOR CONTACT INFO: **Objectives posted in unit:**

Assigned Unit: **Student Names**	**Drug Screen 9 Panel/Date**	**Background Check /Date**	**TB Test Date**	**Immunization & Physical**	**Flu Vaccine Date & Copy of validation card or declination**	**Orientation Packet Forms Signed**	**HIPAA Exam**	**STUDENT CONTACT INFORMATION**	**APPLICABLE COMPETENCIES ATTACHED**
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
Instructor Name:									

I confirm that the above shaded student requirements are current and on file in our college/university dept.

_____ _____
INSTRUCTOR SIGNATURE DATE