

Student Orientation Packet – 2016

Non Clinical

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 Non Clinical Student

School: _____

Student 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 Non 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

NON CLINICAL STUDENT CONSENT FOR RELEASE OF INFORMATION

Name (Last, First, MI)

Date of Birth

The School may not disclose information contained in student's records without the student'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 Agency provides services to Hospital, whichever is longer.



STUDENT ORIENTATION EXAM

Non Clinical

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

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. 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:
- 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.
 - Notify the police.
 - Call the Department of Health and Human Services
16. Development of obesity is complex and involves social, behavioral, cultural, physiological, metabolic and genetic factors:
True _____ False _____
17. Weight bias related to weight seen in Healthcare may be:
- Reluctance to seek preventative care due to embarrassment
 - Delaying or cancelling of appointments
 - Stigmatization by Physicians and healthcare workers
 - All of the above
18. When a co-worker talks negatively about an obese patient in your unit you. Your response to that comment will be:
- Tell your manager / instructor
 - Make no comments and leave
 - Pull co-worker aside and discuss that all people deserve respect and nobody deserves unkind remarks
 - 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 vendor 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
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_____ Witness Signature	_____ Printed Name	_____ ID Number	_____ Date
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**RETURN TO
EDUCATION
DEPARTMENT**

Name _____

School _____

Assigned Unit _____

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 - Non Clinical Student

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

Signature: _____ Date: _____

Student to initial when completed	
	Department Overview: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Office equipment review / Identify location of supplies and forms Review physical set-up of unit/department and review telephone system, beeper, VOCERA
	Safety Issues <ul style="list-style-type: none"> Identify location of fire exits and extinguishers and review fire and disaster plan
	Workflow <ul style="list-style-type: none"> Identify shift responsibilities and assignment including assigned resource person/buddy Review documentation responsibilities and review admission/discharge processes (clinical only)
	Human Resources Items <ul style="list-style-type: none"> Meal breaks; identification badge visible and above waist; dress code

Signature Manager/Designee

Date

Competency Validation Record – Non Clinical Student

Each Competency Assessment Sheet to be filed with Education Department.

Competencies must be assessed prior to care delivery. If competence not demonstrated, personnel may not deliver that component of care.

Competency	Evidence (Example: Peer to Peer)	Preceptor Signature	Date Performed

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

Signature Student

Evaluator Signature/Initial



PIH HEALTH HOSPITAL
WHITTIER, CALIFORNIA

EDUCATION DEPARTMENT

**RETURN
TO EDUCATION OFFICE**

Name _____

School: _____

Assigned Unit _____

Name _____

Agency _____

Assigned Unit _____

Evaluation of Non 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



NON CLINICAL STUDENT REQUIREMENT GRID

COLLEGE:

INSTRUCTOR NAME:

INSTRUCTOR CONTACT INFO:

STUDENT YEAR (circle one):

START & END DATE:

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
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

