

Infirmiry Health Clinical Form

FACILITY: _____

School of Nursing: _____

Instructor: _____ Contact number: _____

Dates students will be on the unit: _____ - _____

Unit(s) students will be on: _____ Maximum # of students: _____

Days of the week: _____ Clinical hours: _____

Students' current clinical level: _____

Clinical focus: _____

New skills to be performed this semester: _____

Current theory topics: _____

Skills that students/instructors should not perform:

- Administer prn narcotics or controlled medications
- Administer blood or blood products
- Administer medications during an emergency code
- Administer any hazardous drugs of any route
- Clinical Students do not documents in the EMR
- Do not taker or enter physicians orders
- Do not sign as a witness to patients consent

Infirmary Health Rotation Checklist

(For instructor use only; checklist does not need to be sent to Infirmary Health facility contact person)

ALL REQUIRED PAPERWORK AND EDUCATION REQUIREMENTS (must be completed and turned in to the Infirmary Health contact person every semester at least 2 weeks prior to clinical start date in order to obtain an appointment to get name badges and parking decals).

- _____ 1. Infirmary Health Student Information Form (Excel spreadsheet)
- _____ 2. I Heard, Read and I Understood
 - One form for each student in clinical group
 - One form for instructor
- _____ 3. Instructor Compliance Statement for each instructor
- _____ 4. LifeCare/Epic Access Request Form
- _____ 5. Clinical Rotation Schedule
- _____ 6. Clinical Form
- _____ 7. Medication Dispensing System Education (instructors only)
- _____ 8. Obtain ID badges and parking permits at Employee Service Center
- _____ 9. Complete Instructor and Student Evaluations at the end of clinical rotation

Infirmiry Health Facilities - Contact Information

Listed below are the contact persons for nursing clinical assignments at each of the Infirmiry Health facilities:

Infirmiry LTAC Hospital

Stefanie Willis-Turner
Nursing School Partnership and Programs Director
Office: 251-435-7410
Fax: 251-435-7431
E-mail: Stefanie.Willis@InfirmiryHealth.org

J.L. Bedsole Rotary Rehab

Stefanie Willis-Turner
Nursing School Partnership and Programs Director
Office: 251-435-7410
Fax: 251-435-7431
E-mail: Stefanie.Willis@InfirmiryHealth.org

Mobile Infirmiry

Stefanie Willis-Turner
Nursing School Partnership and Programs Director
Office: 251-435-7410
Fax: 251-435-7431
E-mail: Stefanie.Willis@InfirmiryHealth.org

North Baldwin Infirmiry

Tiare Graves
Director of Education
Office: 251-580-1766
E-mail: Tiare.Graves@InfirmiryHealth.org

Thomas Hospital

Phyllis Tate
Clinical Education and Diabetes Center Director
Office: 251-279-1702
Fax: 251-279-1701
E-mail: Phyllis.Tate@InfirmiryHealth.org

Infirmiry Health Student Evaluation of Clinical/Practium Experience

Name (optional): _____ College/School of Nursing: _____

Course#: _____ Unit: _____ Quarter/Semester & Year: _____

In our efforts to continuously improve the quality of student clinical experiences, please answer the following questions about your experience participating in this clinical rotation at an Infirmiry Health facility.

	Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Staff made me feel welcome					
2	Staff was open to questions					
3	Assistance was given as needed to access supplies and medications					
4	Nurses helped me to understand the patients and their needs					
5	Nurses were good role models for patient care					
If you were a practicum student please complete questions 6-9 and continue. If you were NOT a practicum student please skip to question 10.						
6	My preceptor planned patient care assignments in consideration of my abilities and course objectives					
7	My preceptor served as a positive role model					
8	My preceptor had an up to date nursing knowledge base					
9	My preceptor helped me to organize my nursing care activities and set priorities					
10	Please identify by name, staff who you felt were positive role models. How were they positive role models?					
11	Were there other activities on the unit that impacted your learning opportunities or experiences? Please describe.					
12	Would you recommend the unit as a future learning site for students? Why or why not?					

Thank you for your time and thoughtful responses. Please submit the completed form to the hospital clinical coordinator.

Infirmiry Health Instructor Evaluation of Clinical Experience

FACILITY: _____

Name (optional): _____ College/School of Nursing: _____

Course#: _____ Unit: _____ Quarter/Semester & Year: _____

Have you had a prior clinical experience at IHS: Yes No Staff Nurse/Manager? Instructor?

Have you had a previous experience on this unit: Yes No Staff Nurse/Manager Instructor?

In our efforts to continuously improve the quality of student clinical experiences, please answer the following questions regarding your role as a nursing instructor this quarter/semester at an IHS facility.

	Question	Agree	Neutral	Disagree	N/A
1	I didn't need any more orientation; I've had students on this unit before				
2	I was assisted in getting access in the hospital (ID badge, parking permit, EPIC LifeCare, Medication dispensing system)				
3	I met with the nurse manager or clinical coordinator to discuss expectations and working relationships with students				
4	Staff made me feel welcome and was helpful				
5	I felt comfortable asking questions				
6	The students and I had a place to put our belongings, and a place to meet and talk				
7	Unit personnel worked cooperatively with us				
8	Nurses were helpful in selecting patient assignments for students				
9	Nursing staff were supportive in sharing patient information and involving students in patient care				
10	Learning opportunities on the unit matched the needs of the students				
11	Please identify by name, staff who you felt were positive role models for the students				
12	Were there any other activities on the unit that impacted your students' learning opportunities or experiences? Please describe				
13	Do you have any recommendations that would be helpful for future instructors/faculty?				
14	Would you recommend this unit as a future learning site for students? Why or why not?				

Thank you for your time and thoughtful responses. Please submit the completed form to the hospital clinical coordinator.



Omnicell Rx Security End User

Last Name

First Name

NI#

Unit

Position: ____ Nursing Instructor

Instructions: Please complete the top portion including: Last name, First name, E#, Unit and position. You're NI# is going to be identified as your primary access code for the Omnicell Rx system. You will also have a pre assigned P.I.N. The first time you access Omnicell Rx you must change your P.I.N. to something only you know.

Note: This P.I.N. is confidential. No one will be able to look it up for you.

Please read the statement below and sign at the bottom to verify that you have read and understand the following statement:

I understand that my access code for Omnicell Rx system is my NI# and in combination with my P.I.N. and/or fingerprint will be my electronic signature for all transactions in the system. It will be used to track all of my transactions in the system and will be permanently attached to those transactions with a time stamp and date. These records will be maintained and archived as per the policies of Infirmiry Health system and/or the specific facility. Records will be available for inspection by the Drug Enforcement Administration (DEA) and the Department of Professional Regulation (DPR), as is presently done with my handwritten signature for controlled substance records.

I also understand that to maintain the integrity of my electronic signature, I must not give this password to any other individual.

Signature

Date

Requestor Signature (IH Clinical Coordinator)

Date

Scan and submit via email to:

MOBILE INFIRMARY: Stefanie.Willis@InfirmiryHealth.org

THOMAS HOSPITAL: Phyllis.Tate@InfirmiryHealth.org

NORTH BALDWIN INFIRMARY: Tiare.Graves@InfirmiryHealth.org

Infirmiry Health Clinical Rotation Requests

FACILITY:

Each clinical instructor should complete the following information when requesting a clinical rotation at any Infirmiry Health Facility: J.L. Bedsole Rotary Rehab, Mobile Infirmiry, North Baldwin Infirmiry, Thomas Hospital or Infirmiry Long Term Acute Care Hospital. (ONE FORM PER UNIT)

Date of Request

Clinical First Day – Clinical Last Day

School/University

Course Name/Number

Requestor Name and Phone

Instructor Name and Phone

1. _____

1. _____

2. _____

2. _____

Requested Days of the Weeks (two choices)

Preferred Time of Day on Unit (two choices)

1. _____

Total number of students per day

Max 8 for Medical Surgical

Max 2 for Speciality Care Areas

2. _____

Unit and Hospital Requested (two choices)

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Clinical Rotation

School: _____ Clinical Coordinator _____

Clinical Instructor _____ Course _____ Month _____ Year _____

Units/Departments Utilized _____

Document the month, date and unit location of each student in the spaces provided.

Student's Name	Student's Phone	Dates	6/2/08	6/9/08	6/16/08	6/23/08	6/30/08	7/4/08	7/14/08	7/21/08	7/28/08			
Suzy Nurse	555-4554	Clinical Units	4W	OR	4W	4W	4W	4W	4W	4W	4W	4W	4W	4W
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