INFIRMARY HEALTH

# Undergraduate Nursing Students Orientation Forms

- Student Evaluation of Clinical/Practicum Experience
- Instructor Evaluation of Clinical Experience
- Omnicell Rx Security End User
- Practicum Request
- Clinical Rotation Requests
- I Heard and Read Checklist
- Instructor Compliance
- Clinical Rotation - Optional

FACILITY: _____

# Infirmary 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 Infirmary 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.<br>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.

# Infirmary 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 Infirmary 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@InfirmaryHealth.org

**THOMAS HOSPITAL:** Phyllis.Tate@InfirmaryHealth.org

**NORTH BALDWIN INFIRMARY:** Tiare.Graves@InfirmaryHealth.org

# Infirmary Health
# Practicum Request

**The school practicum clinical coordinator should complete ONE form for all practicum rotation request per semester for any Infirmary Health Facility: Infirmary LTAC Hospital, J.L. Bedsole Rotary Rehab, Mobile Infirmary, North Baldwin Infirmary or Thomas 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

Requestor Email

Instructor Email

| STUDENT NAME | STUDENT EMAIL | REQUIRED CLINICAL HOURS | UNIT REQUESTED | PRECEPTOR REQUESTED |
|---|---|---|---|---|
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# Infirmary Health
# Clinical Rotation Requests

**FACILITY:** _____

Each clinical instructor should complete the following information when requesting a clinical rotation at any Infirmary Health Facility: J.L. Bedsole Rotary Rehab, Mobile Infirmary, North Baldwin Infirmary, Thomas Hospital or Infirmary 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. _____

2. _____
Requested Days of the Weeks (two choices)

1. _____

2. _____
Preferred Time of Day on Unit (two choices)

_____
Total number of students per day
Max 8 for Medical Surgical
Max 2 for Speciality Care Areas

1. _____

2. _____
Unit and Hospital Requested (two choices)

**Infirmary LTAC Hospital**
Stefanie Willis-Turner
Nursing School Partnership and Programs Director
Office: 251-435-7410
Fax: 251-435-7431
E-mail: Stefanie.Willis@InfirmaryHealth.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@InfirmaryHealth.org

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

**North Baldwin Infirmary**
Tiare Graves
Director of Education
Office: 251-580-1766
E-mail: Tiare.Graves@InfirmaryHealth.org

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

**I Heard and Read**

**FACILITY:** _____

During the course of the Infirmary Health student/instructor orientation,

| I Heard and Read a presentation on: | | I Understood the presentation |
|---|---|---|
| ☐ | Mission, Vision and Values | ☐ |
| ☐ | Corporate Compliance/Fraud & Abuse | ☐ |
| ☐ | Patient Rights and Organizational Ethics | ☐ |
| ☐ | Confidentiality of Patient Information/HIPPA/HITECH | ☐ |
| ☐ | Infection Control | ☐ |
| ☐ | Safety and Security/Safety Codes/Back Safety | ☐ |
| ☐ | Quality | ☐ |
| ☐ | Student/Instructor-Specific Information | ☐ |
| ☐ | Facility Specific Procedures | ☐ |
| ☐ | Instructor Student Orientation Manual | ☐ |

I acknowledge that I have received and understood education on the Infirmary Health Business and Professional Standards of Conduct. I agree to abide by the standards and understand that adherence to them is a condition of my affiliation with Infirmary Health. In addition, I understand that I am obligated to report any violations of non-compliance with these standards.

Signature _____ Date_____

I have been made aware that there is information available in my department regarding the present and potential risks of hazardous materials and wastes routinely handled and used therein; that such information addresses precautions for the handling and use of such materials; potential risks associated with them; appropriate procedures that are to be followed in the event of spills and leaks; and emergency aid and/or first aid treatment in the event of an improper exposure or overexposure to them.

Signature _____ Date_____

Pledge of Confidentiality

I understand and agree with, that in my association with Infirmary Health, I am required to maintain the confidentiality of system, employee, and patient in accordance with System policies and all applicable federal and state laws and regulations including, without limitation, HIPAA, as the same may be amended from time to time. I will not attempt to obtain data or information by any illegal, unethical, or unauthorized means. I have the opportunity to review the complete Maintenance of Confidentiality Policy that is available in the Infirmary Health Personnel Policy Manual. Any breach of confidentiality may result in disciplinary actions up to and including termination. I further understand and acknowledge that any unauthorized access and/or disclosure of patient information (PHI) may leave me subject to civil and criminal penalties in accordance with applicable law and regulations.

Signature _____ Date_____

I am a: ☐ Student ☐ Instructor
Name (please print) _____

School/University _____

Contact number _____

# Instructor Compliance

FACILITY: _____

I have reviewed the required information for Instructor Orientation to Infirmary Health. I understand that if I have questions I am to call the Infirmary Health contact person:

**Infirmary LTAC Hospital** – Stefanie Willis-Turner | 251-435-7410
**J.L. Bedsole Rotary Rehab** – Stefanie Willis-Turner | 251-435-7410
**Mobile Infirmary** – Stefanie Willis-Turner | 251-435-7410
**North Baldwin Infirmary** – Tiare Groves | 251-580-1766
**Thomas Hospital** – Phyllis Tate | 251-279-1702

School/University _____ Date _____

Instructor _____

I, _____
Dean or designee (print name)

validate that _____
Instructor (print name)

is competent to provide clinical supervision for students.

_____
Signature

_____
Date

**NOTE:** This form must be completed and on file with the Infirmary Health facility for each instructor utilizing Infirmary LTAC Hospital/J.L. Bedsole Rotary Rehab/Mobile Infirmary/North Baldwin Infirmary/ Thomas Hospital as a clinical site.

# Clinical Rotation - Optional

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 | 4W | 4W |
| | | Clinical Units | | | | | | | | | | | | | | |
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| | | Clinical Units | | | | | | | | | | | | | | |

# Submit Undergraduate Nursing Students Orientation Forms

- Submit forms to Mobile Infirmary & Infirmary LTACH
- Submit forms to North Baldwin Infirmary
- Submit forms to Thomas Hospital