

Infirmiry Health Clinical Form

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: _____

Prior clinical settings including types of patient care: _____

Skills that students may NEVER perform:

Take verbal orders

Hang blood/blood products

Administer medication without clinical instructor's verification

Hang hazardous drugs

Additional: _____

Infirmary Health Rotation Checklist

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

Dates of clinical rotation: _____

Day(s) of the week: _____

School/University: _____

Program coordinator: _____

Instructor(s): _____

Unit(s): _____

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

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					
	Example:					
2	Staff was open to questions					
	Example:					
3	Assistance was given as needed to access supplies and medications					
4	Nurses helped me to understand the patients and their needs					
	Example:					
5	Nurses were good role models for patient care					
	Example:					
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

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 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	Students were offered off-unit learning opportunities such as going to diagnostic tests, etc. with their patient				
12	How can orientation be improved?				
13	Please identify by name, staff who you felt were positive role models for the students				
14	Were there any other activities on the unit that impacted your students' learning opportunities or experiences? Please describe				
15	Do you have any recommendations that would be helpful for future instructors/faculty?				
16	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

Infirmary Health Clinical Rotation Requests

Each clinical instructor should complete the following information when requesting a clinical rotation at any Infirmary Health Facility: 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. _____

1. _____

2. _____

2. _____

Requested Days of the Weeks (two choices)

Preferred Time of Day on Unit (two choices)

Total number of students per day

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

Mobile Infirmary

Stefanie Willis-Turner
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North Baldwin Infirmary

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

Thomas Hospital

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E-mail: Phyllis.Tate@InfirmaryHealth.org

I Heard and Read

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

I Heard and Read a presentation on:

I Understood the presentation

- | | | |
|--------------------------|---|--------------------------|
| <input type="checkbox"/> | Mission, Vision and Values | <input type="checkbox"/> |
| <input type="checkbox"/> | Corporate Compliance/Fraud & Abuse | <input type="checkbox"/> |
| <input type="checkbox"/> | Patient Rights and Organizational Ethics | <input type="checkbox"/> |
| <input type="checkbox"/> | Confidentiality of Patient Information/HIPPA/HITECH | <input type="checkbox"/> |
| <input type="checkbox"/> | Infection Control | <input type="checkbox"/> |
| <input type="checkbox"/> | Safety and Security/Safety Codes/Back Safety | <input type="checkbox"/> |
| <input type="checkbox"/> | Quality | <input type="checkbox"/> |
| <input type="checkbox"/> | Student/Instructor-Specific Information | <input type="checkbox"/> |
| <input type="checkbox"/> | Facility Specific Procedures | <input type="checkbox"/> |

I acknowledge that I have received and understood education on the Infirmiry 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 Infirmiry 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 Infirmiry 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 Infirmiry 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

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

Infirmiry LTAC Hospital – Stefanie Willis-Turner | 251-435-7410

Mobile Infirmiry – Stefanie Willis-Turner | 251-435-7410

North Baldwin Infirmiry – 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 Infirmiry Health facility for each instructor utilizing Infirmiry LTAC Hospital/Mobile Infirmiry/North Baldwin Infirmiry/Thomas Hospital as a clinical site.

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
		Clinical Units												
		Clinical Units												
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