CMC
Conway Medical Center
VOLUNTEER SERVICES

PLEASE COMPLETE ALL OF THE
ORIENTATION DOCUMENTS
RETURN TO Director of Volunteer Services

NEW VOLUNTEER ORIENTATION AGREEMENT

Upon completion of the Volunteer Services Orientation documents, I agree to uphold the policies and procedures of the CMC Volunteer Services. I acknowledge I have reviewed the orientation presentation, the Volunteer Handbook, the hospital General Information Handbook and Policy & Procedures Manuals.

I agree to hold in strict confidence privileged information concerning CMC and its patients, employees and other volunteers.

I understand the requirements of HIPAA and will abide by those mandates as I perform my volunteer duties.

I understand that I must abide by the uniform code and have my nametag visible at all times. The nametag is your identification in the hospital setting as a volunteer in good faith. This nametag must be surrendered upon leaving the volunteer organization.

I understand that I reflect the entire volunteer organization in my performance of my task, in my commitment to the task, and in my adherence to schedules in my service area.

I understand that there is an annual mandatory training event and annual TB screening in the fall of each year – this is a requirement of the hospital and its regulatory agencies.

NAME_____

DATE_____

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Confidentiality and Security Agreement Form #23-HR

I understand that Conway Medical Center and its affiliate organizations, (hereinafter "CMC") in which or for whom I work, volunteer or provide services, or with whom the entity *(e.g.,* physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information, CMC, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of its patients' health information. Additionally, CMC must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information "Confidential Information").

In the course of my employment/assignment or association with CMC, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with CMC's Privacy and Security Policies, which are available from CMC. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

- I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
- I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
- I will not discuss Confidential Information where others can overhear the conversation.
- I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
- I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with CMC.
- Upon termination of any relationship with CMC, I will immediately return any documents or media containing confidential Information to CMC.
- I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with CMC.
- I will act in the best interest of CMC and in accordance with its Code of Conduct at all times during my relationship with CMC.
- I understand that violation of this Agreement may result in the disciplinary action, corrective action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within CMC, in accordance with CMC's policies.
- I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
- I understand that I should have no expectation of privacy when using the CMC information systems. CMC may access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
- I will practice good workstation security measures such as locking up diskettes when not in use, using hospital approved screen savers with activated passwords appropriately, and position screens away from the public view.
- I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved standards.

Confidentiality and Security Agreement Form #23-HR

- I will:
  a. Use only my officially assigned User-ID and password.
  b. Use only approved licensed software.
  c. Use a device with virus protection software.
  d. Contact the Information Technology department if my password is accidentally revealed to request a new password.

- I will never:
  a. Share/disclose user- IDs or passwords.
  b. Use tools or techniques to break/exploit security measures.
  c. Connect to unauthorized networks through the systems or devices.
  d. Install unauthorized software on hospital computer systems.

- I will notify my manager or appropriate Information Technology person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy, and security policies, or any other incident that could have any adverse impact on Confidential Information.

- The following statements are additional requirements for physicians using CMC systems containing patient identifiable health information (e.g., Meditech):

- I will only access software systems to review patient records when I have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to CMC at the time of each access that I have the requisite patient consent to do so, and CMC may rely on that representation in granting such access to me.

- I will only access patient information to the extent it is reasonable and necessary for me to treat a patient. The information that I review will be kept confidential, and I will only review so much of a patient's medical record as is necessary for me to render appropriate treatment. If I am given access to a patient's medical record due to a consult, emergency situation, or an on-call situation at which time I am not the patient's primary attending physician, I will only access that patient's information to the extent it is needed for me to render appropriate medical treatment. Under no circumstances will I access a patient's information without a patient's verbal or written consent or for whom I am not rendering medical treatment.

- I will ensure that only appropriate personnel in my office will access the CMC's software systems and Confidential Information and that I will annually train such personnel on issues related to patient confidentiality and access.

- I will accept full responsibility for the actions of my employees who may access the CMC's software systems and Confidential Information.

By signing this document, I acknowledge that I have read this agreement and I agree to comply with all terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician/Volunteer Signature	Facility Name	Date
Employee/Consultant/Vendor/Office Staff/Physician/Volunteer Printed Name	Business Entity Name	

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SERVICE AGREEMENT
EXCELLENCE IN CUSTOMER SERVICE

As a volunteer of Conway Medical Center, I agree to adhere to the Mission, Vision, Value Statements and Customer Service Standards as defined in Conway Medical Center's Excellence in Customer Service Policy. I am committed to excellence in Customer Service and to exceeding the expectations of my customer.

Specifically, I agree to the following:

- I understand the organization exists only because of our customers. They are not an interruption of my day, they are the purpose of it.
- I will seek to exceed the expectations of the customers I serve.
- My activities will be guided by my commitment to the Conway Medical Center's Mission, Vision & Values, and the organizational ethics policy.
- I will greet customers promptly, with a smile, welcoming tone and by making eye contact.
- I will answer the phone quickly, in a welcoming tone and helpful manner. I will identify myself clearly by department and name.
- I will communicate with customers in a positive manner – I will tell the customer what I <u>can</u> do, not what I can't do.
- I will listen attentively and be responsive to customer needs on a timely basis.
- I will function as a "team member", respecting and supporting my co-workers.
- I will treat every customer with courtesy and respect.
- I will take necessary precautions to provide customers with privacy and confidentiality.
- I will take necessary precautions to provide customers with a safe and secure environment.
- I will seek to ensure that all customer complaints are appropriately addressed.
- I will be professional in both behavior and appearance.

Signed: _____Date: _____

Print Name: _____ Department: Volunteer Services

NAME:_____

PLEASE SHARE THE FOLLOWING INFORMATION TO HELP IN OUR PLANNING:

SKILLS / TALENTS / COMMITTEE INTERSTS:

CARPENTRY _____

CHAIR A COMMITTEE _____

CLERICAL SKILLS _____

COMPUTER SKILLS _____

COOKING/BAKING _____

DECORATING _____

JEWELRY MAKING _____

NEEDLEWORK _____

ORGANIZE AN EVENT _____

PAINTING _____

PHOTOGRAPHY _____

SERVE ON A COMMITTEE _____

SHORT TERM PROJECTS _____

TELEPHONE _____

THEATRICAL INTERESTS _____

OTHER _____

Safety Responsibility Policy
Personal Statement of Accountability to Safety

Safety is one of our most important priorities at CMC. Red Rules, Behavior Based Expectations, and Error Prevention Techniques are tools we use to ensure the safety of our patients, visitors, volunteers and employees.

By complying with established red rules, following behavioral expectations, and utilizing prevention tools and techniques, I make a conscious decision to help ensure the safety of patients and employees, and I am helping to create a culture of safety at CMC.

Conway Medical Center Red Rules
1. I will always wash my hands or use hand sanitizer before and after every patient contact.
2. I will verify patient identity using two identifiers prior to any action or procedure.
3. I will verify and accurately label all specimen containers prior to leaving the collection site. (n/a)
4. For all Nursing Personnel: I will ensure that bed alarms are activated on all patients whose Fall Risk Assessment indicates the need for bed alarm activation. (n/a)
5. For all Personnel participating in invasive procedures: I will perform surgical counts in accordance with policy on any procedure in which a foreign body could be retained. (n/a)
6. For all Personnel participating in invasive procedures: I will participate in a time out before every procedure begins, using validation of correct patient, correct procedure, correct site by the procedural team which should include at a minimum the physician, circulator/nurse, and anesthesia care provider. (n/a)

Conway Medical Center Behavior Based Expectations/Error Prevention Techniques	
Employees	
1. Communicate Effectively	1. Identify Self, Department & Purpose 2. Use Repeat-Backs and Read-Backs with Clarifying Questions 3. Use SBAR (Situation, Background, Assessment, Request/Recommendation) for Reports and Handoffs
2. Take "Time-Out" for Detail	1. Use **S.T.A.R. (Stop, Think, Act, Review)**
3. Commit to Safety	1. Adhere to Red Rules, Policies and Procedures 2. Practice Peer Checking and Peer Coaching using ARC – A-Ask a question R – Request change C – Concern (Voice a concern) 3. STOP when Unsure & seek clarification and assistance 4. **Raise the Red Flag**

My Personal Safety Commitment:

1. I have received training and education on Red Rules, Behavior Based Expectations, and Error Prevention techniques.
2. I will comply exactly and at all times with the Red Rules.
3. If compliance with a Red Rule is not possible, I shall STOP any action until any uncertainty can be resolved.
4. I will employ error prevention techniques as a part of my daily work.

I understand that compliance problems with Red Rules shall be managed in accordance with CMC's Safety Responsibility Policy. No less than a written reprimand shall be given for Red Rule non-compliance.

_____ _____
Volunteer Signature Date

_____ _____
Manager Signature Date

VOLUNTEER ORIENTATION POST-TEST (circle the correct Answer)

NAME_____DATE_____ SCORE_____(PASS >80)

Elevators may be used during a Facility Alert Fire	**TRUE**	**FALSE**
Conway Medical Center and all their facilities are nicotine-free campuses	**TRUE**	**FALSE**
The best way to control the spread of infection is proper Hand Washing	**TRUE**	**FALSE**
A Volunteer may give out information concerning a Patient's medical condition	**TRUE**	**FALSE**
A volunteer's primary responsibility during a disaster is to protect themselves.	**TRUE**	**FALSE**
If I spot a fire, I am to report it immediately, if able	**TRUE**	**FALSE**
Proper wheelchair procedures are important for the safety of patient and volunteer	**TRUE**	**FALSE**
A volunteer can give out medications to patients with permission of the nursing staff	**TRUE**	**FALSE**
I must knock and identify myself before entering a patient's room	**TRUE**	**FALSE**
As a Volunteer, I am making a commitment to the hospital	**TRUE**	**FALSE**
I must wear my ID badge at all times while serving as a Volunteer	**TRUE**	**FALSE**
If I am injured while on duty, I am to report it to the Director of Volunteers or a supervisor immediately. A SREO will be filed.	**TRUE**	**FALSE**
Report any unsafe electrical conditions to your supervisor or to the Maintenance department	**TRUE**	**FALSE**
PPE stands for Personal Protective Equipment	**TRUE**	**FALSE**
If you are on the nursing floors as a volunteer it is your responsibility to follow the NO PASS ZONE guidelines	**TRUE**	**FALSE**
The Corporate Compliance Hot Line is available 24/7	**TRUE**	**FALSE**
Interpreter Services are available upon request	**TRUE**	**FALSE**
The Volunteer Services Rally Point is out the main lobby doors to the parking lot on left closest to Singleton Ridge Rd	**TRUE**	**FALSE**

CONFIDENTIALITY REMINDER

Conway Medical Center Volunteers have access to information, which is often highly confidential, and/or of a sensitive nature. As Volunteers, you may be subject to inquiries from other Volunteers or Personnel from outside the Medical Center, but you must NOT divulge this information to anyone unless such information is normally communicated as part of the Volunteer's work assignment *in accordance with hospital policy.* The release of confidential information to unauthorized individuals, or attempting to gain access to such information for personal reasons, is grounds for dismissal from the Volunteer Services and CMC Hospital Auxiliary programs.

MATCH THE FOLLOWING SAFETY TERMS

a.) FACILITY ALERT FIRE	_____SDS
b.) EVACUATION BOARDS	_____ AVOID, DENY, DEFEND
c.) MEDICAL EMERGENCY	_____ MISSING CHILD/INFANT – EVERYONE SEARCH
d.) SECURITY ALERT MISSING INFANT/CHILD	_____HANDLED BY STAFF VERTICAL & HORIZONTAL
e.) NO PASS ZONE	_____BOMB THREAT
f.) SAFETY DATA SHEET	_____MEDICAL ALERT CODE BLUE
g.) HOT ZONE	_____ 5555
h.) FACILITY ALERT - CODE ORANGE	_____MISSING PSYCH PATIENT
i.) SECURITY ALERT CODE WHITE	_____ CONTAMINATED AREA
j.) SECURITY ALERT – ACTIVE SHOOTER	_____ FIRE – EXIT TO RALLY POINT
k.) DIAL FOR EMERGENCY	_____DO NOT PASS A CALL LIGHT

VOLUNTEER NAME_____DATE_____

HIPAA Awareness Training Quiz

1. The compliance deadline for HIPAA was _____.

2. PHI stands for: P_____ H_____ I_____.

3. The following information can be used to identify patients:
   A) Address
   B) License Plate Number
   C) Account Number
   D) All of the above

4. Without prior authorization, patient information can ONLY be shared if it pertains to:
   T_____P_____O_____

5. Wrongful disclosure of health information carries fines and can involve jail time.
   True ___ False ___

6. Under HIPAA, patients can choose to NOT be listed in the patient directory.
   True ___ False ___

7. Placing patient information in a wastebasket is OK as long as it is behind a desk.
   True ___ False ___

8. Reporting HIPAA violations is everyone's responsibility.
   True ___ False ___

I have completed the HIPAA orientation packet. I accept the "I Am HIPAA Wise" oath by agreeing to follow *CONWAY MEDICAL CENTER* privacy and confidentiality policies.

Volunteer SIGNATURE **Date**

UNIFORM REQUEST

PRINT NAME _____

PLEASE IDENTIFY THE SIZE & STYLE YOU DESIRE.

YOUR INITIAL UNIFORM IS ISSUED AT NO COST.
ADDITIONAL UNIFORMS MAY BE PURCHASED AT THE COST of $20 unless you are ordering an XXL or larger than the cost is $22. Checks may be made payable to CMC or cash payment accepted.

MEN –

POLO (GOLF SHIRT)	S___	M___	L____	XL____	XXL____
JACKETS LONG SLEEVE	S___	M___	L____	XL____	XXL____

LADIES –

POLO (GOLF SHIRT)	S_____	M___	L____	XL____	XXL____
VEST	S_____	M___	L____	XL____	XXL____
JACKETS	S_____	M___	L____	XL____	XXL____

RECOMMENDATION: SOAK IN WARM WATER & SALT TO SET COLOR. WASH SEPERATELY.

POLO SHIRTS, VESTS, JACKETS ARE MONOGRAMED AND DO NOT REQUIRE THE AHA PATCH.

IF YOU ARE A MEMBER OF THE AUXILIARY, THE AUXILIARY PATCH IS TO BE CENTERED AND SEWN ON ONE INCH ABOVE THE MONOGRAM ON THE FRONT OF UNIFORM.

REVISED 1/2020

CMC
CONWAY MEDICAL CENTER

Our volunteers are an important part of what makes Conway Medical Center a special place. The Hospital Administration is always looking for ways to thank you for your service and dedication to our hospital. We would like to offer our volunteers access to the Employee Fitness Area at the Rehabilitation Center. Follow the steps below to register. Once you register you will be able to use the fitness area between the hours of 5 am and 10 pm 7 days a week including holidays.

There are a few things you have to do to gain access to the area and start your exercise regimen:

1. Check with your Doctor to make sure exercise should be a part of your "I want to stay healthy" routine.
2. Stop by the HR department in the Administration Building to get your Volunteer Badge coded so Security can program access to the employee entrance on your badge.
3. While in HR complete and sign the User Agreement and get a copy for future reference. The User Agreement explains the terms you agree to when using the exercise area. And don't forget to give us an email address so we can let you know when you can start using the area and keep you informed about any changes and updates.
4. Check your email for the confirmation that you have access to the fitness area.
5. Put "go to the gym" on your schedule.

Should you have any questions about the fitness area please call Nancy Seeds in HR at 843-347-8112 any afternoon.

Again, Thank you for your service to Conway Medical Center.

Please check that you have read, understand and agree to each item and have made a copy for future reference.

O I warrant and represent that I have no physical or mental disability, impairment, or ailment which prevents me from engaging in active passive exercise, or that may be detrimental to my health, safety or physical condition if I do so engage or participate in active or passive exercise (collectively "impairment").

0 I agree the organization shall not be liable for any injury arising out of any condition I may have which does not rise to the level of impairment.

0 I will be aware of my medical history and physical limitations at all times and will consult with a physician prior to engaging in exercise or continuing to exercise if a medical condition appears to be developing.

0 I agree I am personally liable for any property damage and/or personal injury I cause and I am obligated to pay for any costs involved upon presentation of a statement thereof.

0 I agree the organization shall not be liable for any injuries, death or damages I may suffer due to any cause, including but not limited to the negligence of the released parties, arising out of or in any way connected to may use of the facility and/or its equipment. I indirectly and on behalf of my personal representatives, heirs, administrators, assigns and successors to hereby expressly forever release and discharge the organization its successors and assigns, as well as its officers, agents and employees from all such claims, demands, actions, or cause of action.

0 I will wear appropriate exercise attire and athletic footwear and will not bring food or alcohol into the area.

0 I understand I won't be paid while using the fitness area as work time", and I am not covered by workers compensation insurance.

0 I will respect the individual privacy of others utilizing the facility and won't videotape, take pictures or otherwise record activity.

0 I understand the equipment in the facility is shared with Cardiac Rehab department patients and I may be asked to switch equipment to allow for patient treatment needs to be met.

0 understand I am permitted to use the locker room facilities and I will lock all valuables with my own lock and bring my own towel. (the organization is not responsible for lost or stolen items.)

0 I understand there is only one authorized entrance and exit to the employee fitness area where I will utilize my company identification badge (ID) to trigger my facility access and use.

0 I understand the employee fitness area is for daily employee and physician/provider access and traditional volunteers only and is not available to family members, guests, or other organizational affiliates to use or enter at any time and that the facility is monitored by CMC Security.

0 I will never share or loan my ID badge or otherwise in any way facilitate the access of others.

0 I understand it is my responsibility to re-rack weights, return accessories to their proper locations and generally clean up after myself by wiping down equipment after each use with the cleaning supplies located at the cardiac rehab desk and that misuse of the equipment will not be tolerated.

0 I understand the area is unsupervised and I will use the equipment at my own risk with no instruction or assistance.

0 I agree to only access the fitness area and no other parts of the facility, such as meeting rooms, offices, etc. for any reason at any time.

0 I I understand the cardio pulmonary rehabilitation patients have priority of use of the equipment.

Suspension/termination of Use Privilege – I understand the use of the organization's fitness area is a benefit and privilege and not an entitlement. Management has the right to suspend and/or terminate use access for failure to follow the rules noted above or behavior which may be inconsistent with the operation of the area.

By signing this document, I am representing that I understand and intend to be bound by all of these terms and conditions.

Printed name_____ Signature_____ ID badge#__

Email address we can use to communicate start date and center updates_____