Scope of CMC Embrace Hospice Volunteer Role

Title: CMC Embrace Hospice Volunteer

Reports to: Volunteer Coordinator/Director, Case Manager, Office Manager, Nursing Supervisor

Role Summary: CMC Volunteer Services has been established to provide qualified, well-trained service delivery volunteer personnel to augment, complement, enhance and extend the activities of the salaried staff; to increase the efficiency and effectiveness of human and physical resources; to provide quality services to benefit patients, visitors and staff. The structured volunteer program provides adult volunteers.

The scope of the volunteer role with Hospice functions under the supervision of the Volunteer Services Coordinator/Director or designee and under the specific supervision of the care team when assigned to a patient. The volunteer will provide practical assistance and support to patients/families as indicated by the plan of care and as defined by their specific volunteer role and as trained during orientation, as requested by the interdisciplinary team members.

Minimum Qualification Requirements: Completion of CMC Embrace Hospice orientation training and acceptance into CMC/Embrace Hospice volunteer program.

Duties and Responsibilities:

- Carry out defined volunteer role as indicated in the Plan of Care, as developed by patient/family and the Interdisciplinary Group (IDG)
- Share information with members of the IDG and Volunteer Director/designee when involved with a patient/family.
- Maintain a record of all patient contacts/service hours and record on Volunteer/Patient related Volunteer Visit Documentation forms; submit following a contact/service with patient/family.
- Record education and supportive supervision hours by filling out sign-in sheets at these events.
- Be available for volunteer service approximately four hours weekly.
- Be able to attend education and supportive supervision meetings.
- Specific position description must be signed and placed within the volunteer file.

Physical Requirements: Ability to effectively communicate verbally and in writing. Physical requirements are outlined by the specific position description.

I have read and understand this Scope of Volunteer Role, and agree to abide by it:

_____ _____ _____

Print Name ***Signature*** ***Date***

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

CONWAY MEDICAL CENTER EMBRACE HOSPICE
VOLUNTEER AGREEMENT

CMC/Embrace Hospice welcomes the Volunteer. Hospice agrees to remain accessible and supportive to the Volunteer throughout their service to Hospice and people it serves.

I, _____, hereby agree to accept the responsibilities of a volunteer with Conway Medical Center / Embrace Hospice. I understand that my commitment is of vital importance to the continuity of the Hospice Program and thus recognize the need to inform the Volunteer Director / Coordinator of any inability to meet my commitment or any change in my volunteer status at the earliest possible date; including if any change occurs in his/her address, telephone number or availability.

The Volunteer understands his/her role as it pertains to Hospice patients, family members, and staff as a result of completing the Volunteer Training Program, including how to access CMC / Embrace Policies and Procedures.

I understand that any patient/family information to which I have access, regardless of how obtained, is privileged and shall be held in strict confidence. Patient/family information will be shared only with appropriate Hospice personnel. The Volunteer understands the confidentiality policy and that all patient information is kept confidential. I understand the requirements of HIPAA and will abide by those mandates as I perform my volunteer duties.

If assigned as a patient/family Bereavement Support; Community Education/Marketing, Patient Care, Receptionist, Volunteer Veteran Ambassador or Spiritual Care volunteer, I will submit any required documentation on a timely basis. I will keep the Nursing Supervisor informed of my observations of the patient/family.

The Volunteer understands that documentation of volunteer time and patient contacts is required by the State of South Carolina and that all required paperwork must be submitted according to policy.

Regardless of my assignment, I will be punctual and conscientious in performing my volunteer duties in order to uphold the quality of our Hospice services; bring personal volunteer issues or grievances to the attention of the Volunteer Director / Coordinator; promote the Hospice concept in my community. The Volunteer understands that he/she may accept or decline an assignment, or withdraw services from that assignment at any time, with explanation to the Volunteer Director / Coordinator. The staff will respect the Volunteer's decision.

I will continue to expand my skills and knowledge as a volunteer by attending requested meetings and in-service training opportunities. The Volunteer understands the need to participate in in-services and is the requirement of annual training.

I understand the person I am to contact for assistance/direction is the CMC Embrace Hospice Nursing Supervisor at 843-353-6228 or designee. In the event that the CMC Embrace Hospice Nursing Supervisor is not available I will contact Assistant Administrator for assistance.

I have read and the Volunteer Agreement and been given an opportunity to ask questions related to the volunteer role and agree to terms as stated.

_____ _____

Volunteer Signature Date

_____ _____

Volunteer Coordinator Date

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EMBRACE HOSPICE

SERVICE AGREEMENT
EXCELLENCE IN CUSTOMER SERVICE

As a team member of Conway Medical Center / Embrace Hospice, I agree to adhere to the Mission, Vision, Value Statements and Customer Service Standards as outlined in the CMC General Information Handbook. I am committed to excellence in Customer Service and to exceeding the expectations of my customer.

The mission of CMC Embrace Hospice is to be the leader in end of life care throughout the communities' we serve. We strive to enhance the quality of life of our patients and families by providing spiritual guidance and quality focused care while emphasizing patient choice and dignity.

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 / Embrace Hospice Mission, Vision & Values, and the organizational ethics.
- 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

CMC | VOLUNTEER SERVICES
CONWAY MEDICAL CENTER

EMBRACE HOSPICE

Confidentiality and Security Agreement Form VOL-23-HR-2-FRM

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/volunteer 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 / volunteering, 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 / volunteer 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.

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

Confidentiality and Security Agreement Form VOL-23-HR-2-FRM

- 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 staff 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	

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

OSHA CLASSIFICATION SYSTEM

The Occupational Safety and Hazard Administration (OSHA) requires that all employees (paid or not) be assigned to an OSHA Category Classification. The Classification System relates to evaluating potential exposure to blood and blood-borne pathogens.

Category 3 of the OSHA guidelines applies to Volunteers. It states:

"Tasks that involve no exposure to blood or body fluids, or tissues. Category 1 tasks are not a condition of employment.

The normal work routine of this position involves no exposure to blood, body fluids or tissues. Persons who perform these duties are not called upon as part of their employment to be potentially exposed in some other way. Tasks that involve handling of instruments or utensils, use of public or shared bathroom facilities or telephones and personal contacts, such as handshaking are Category 3 tasks. All individuals performing procedures or tasks for Hospice shall have documented evidence that they are aware of which category their duties shall place them in. This documentation shall include clear understanding of the proper use of personal protective clothing and equipment and where this clothing and equipment is maintained for their use, if they are Category 1 or Category 2. All employees shall receive training in Universal Precautions and barrier protection techniques."

I, _____, understand that the duties that are required of me in my role of Volunteer place me in Category 3, and I will not have to perform duties that will require the use of personal protective clothing or equipment. I have received education and training in Universal Precautions and modes of transmission of blood-borne viruses.

_____ _____

Volunteer Signature Date

I have reviewed the job tasks of this position with (Orientation Instructor Name) and verify this classification to be correct.

_____ _____

Signature/Title of Hospice Official *Date*

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CONWAY MEDICAL CENTER

EMBRACE HOSPICE

CMC/ EMBRACE HOSPICE
NOTIFICATION / ACKNOWLEDGEMENT
EDUCATION REGARDING ABUSE POLICIES

Volunteer:_____

I, the undersigned, acknowledge that I will receive education and will need to understand the abuse policies, and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits any form of abuse. Disciplinary actions will be taken against those who are found to have committed abuse.

I understand that it is my responsibility to abide by all rules contained in the facility policies. I also understand I will be educated on how to report incidents of abuse as set forth in the abuse policies, including retaliating against any employee or volunteer exercising his or her rights under these policies.

I clearly understand where I may find written hard copies of CMC / Embrace Hospice Policies and Procedures.

_____ _____

Volunteer Signature Date

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

VOLUNTEER ORIENTATION POST-TEST
MATCH THE FOLLOWING ORIENTATION SAFETY TERMS

A. WHEN SOMEONE IS ON FIRE	_____ FIRE EXTINGUISHER USE
B. IT IS A PATIENTS RIGHT	_____ MINIMIZE PAIN & SUFFERING
C. EVERYONE HAS A DUTY TO:	_____ MEDICAL DEVICE PROTECTED UNDER SAFE MEDICAL DEVICE ACT
D. TUBE FEEDING PUMP / WALKER	_____ STOP, DROP, ROLL
E. HOSPICE GOAL	_____ TO BE TREATED WITH RESPECT
F. PERSONAL SAFTEY	_____ REPORT ABUSE OR NEGLECT
G. P.A.S.S. PULL, AIM, SQUEEZE, SWEEP	_____ IS MY RESPONSIBLITY

VOLUNTEER SIGNATURE_____DATE_____

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

VOLUNTEER ORIENTATION POST-TEST (circle the correct Answer)

NAME_____DATE_____ SCORE_____(PASS >80)

Conway Medical Center / Embrace Hospice and all their facilities are nicotine-free campuses except a patient designated area at Hospice House.	TRUE	FALSE
The best way to control the spread of infection is proper Hand Washing	TRUE	FALSE
A Volunteer is free to give out information concerning a patient's medical condition to their friends	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 should bring any questions regarding medications to the immediate attention of the nursing staff attending to the patient.	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 volunteer program.	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. An injury report will be filed.	TRUE	FALSE
Report any unsafe electrical conditions to your supervisor.	TRUE	FALSE
It is important for a volunteer to know the location of the closest fire extinguisher.	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	TRUE	FALSE

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

CONFIDENTIALITY REMINDER

CMC / Embrace Hospice 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 entities 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 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 programs.

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 / EMBRACE HOSPICE* privacy and confidentiality policies.

Volunteer SIGNATURE Date

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

HANDBOOK ACKNOWLEDGMENT

I hereby acknowledge that I have reviewed the CMC General Information Handbook and the CMC Embrace Volunteer Handbook and understand that I am responsible for becoming familiar with its contents. I understand it is my responsibility to follow the organizational policies and to get clarification on any items that I do not understand. I agree to contact the Volunteer Services Department with any questions that may arise.

I understand the organization reserves the right to make changes at any time and that this information is provided on an advisory basis. I understand that the CMC General Information Handbook and CMC Embrace Volunteer Services Handbook is a confidential document and will be treated as such.

I further understand that volunteering is at will for an indefinite period of time unless terminated at any time by the organization or myself.

By signing below, I fully understand and agree to this acknowledgment.

_____

Print Name

_____ _____

Signature Date

UNIFORM REQUEST

We expect all volunteers to use good judgment in choosing dress and appearance and to present a neat, well-groomed appearance and a courteous disposition. See dress code procedure for details. Details are also enclosed in the orientation presentation.

PRINT NAME _____

PLEASE IDENTIFY THE SIZE & STYLE YOU DESIRE.

YOUR INITIAL UNIFORM IS ISSUED AT NO COST – SELECT ONE.

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 – SELECT ONE

POLO (GOLF SHIRT) **S___ M___ L____ XL____ XXL____**

JACKETS LONG SLEEVE **S___ M___ L____ XL____ XXL____**

LADIES – SELECT ONE

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.

REVIEWED 10/2022

CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

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

Please review the following in order to gain access to the fitness area and begin your exercise regimen:

1. Check with your Doctor to make sure exercise should be a part of your "I want to stay Healthy" routine. NOTE: There is no supervision in this arena while you are exercising. Patients have priority on all equipment.
2. Complete and sign the User Agreement enclosed to receive access to the Fitness Area. The User Agreement explains the terms you agree to when using the exercise area.
3. Check your email for the confirmation that you have access to the fitness area.
4. Put "Go to the gym" on your schedule!

Should you have any questions about the fitness area, please call Human Resources at (843) 347 – 8112 anytime Monday – Friday 8am – 4:30pm.

Thank you for your service to Conway Medical Center and dedication to our core values of excellence, compassion, healing, teamwork, stewardship, innovation, and integrity!

Conway Medical Center Fitness Area User Agreement HR -50

ONLY if you wish to have access to the Fitness Area. 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 IDbadge 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_____ IDbadge#_____

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