

El Camino College
Emergency Medical Technician (EMT)



Clinical Experience Manual

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EL CAMINO COLLEGE EMT PROGRAM CLINICAL EXPERIENCE MANUAL

GOALS AND OBJECTIVES

I. DEFINITIONS

- Clinical rotation – The overall hands-on experience in a health care facility and field setting. This rotation allows the EMT student to relate to real-world experiences described in textbooks and the classroom.
- Health facilities – Includes various medical units in acute care hospitals, emergency departments, clinics, urgent care centers, convalescent hospitals, skilled nursing facilities, etc.
- Field rotation – Ambulance providers that respond to 9-1-1 calls and provide emergency or interfacility transportation. This allows the student to experience what it is like to be a member of an ambulance.

II. CLINICAL GOALS

The goal of the clinical experience for the EMT student is to observe and participate in as many EMS related activities that may be available. This is the time to refine skills, develop professional relationships with healthcare colleagues, develop critical thinking skills, and actively seek out learning experiences.

- Student **MUST** adhere to the Los Angeles County Prehospital Code of Ethics (Reference 1301, page 3), and EMT Scope of Practice (Reference 802.1, page 4) throughout clinical rotations.
- Student **MUST** notify the training program of any injury or exposure as soon as possible (pages 5-6).
- Student **MUST** maintain a professional demeanor at all times and adhere to all policies in this manual and additional policies and requirements listed on the ECC EMT course syllabus and webpage (page 10).
- Student **MUST** adhere to the El Camino College EMT Uniform Agreement (page 11).
- Student **MUST** confirm they meet the standards set in the EMT Student Physical Clearance (page 12).
- All Providence and McCormick policies shall apply to the student during clinicals (pages 13-22).

III. REQUIREMENTS

Student is eligible for their clinical experience when they have successfully completed: an approved CPR program, ECC EMT lectures including: assessment, workforce safety and wellness, vital signs and accompanied skills instruction, and all Castle Branch ECC EMT background and document upload requirements (pages 7-18).

IV. MINIMUM CLINICAL REQUIREMENTS

Complete a minimum of 24 hours of clinical experience including:

- **12 hours on an ambulance ride along with McCormick Ambulance Station 8-**
11184 California Avenue, Lynwood, CA. All shifts are scheduled from 0700-1900 HRS.
 - Student **MUST** arrive early in full uniform (no beards, tattoos, jewelry, etc.) and check in with EMT.
 - Student **MUST** bring all three signed McCormick agreements with them (pages 19-22).
 - Student **MUST** bring ECC Clinical Packet, 10 printed and stapled LA Co EMS PCRs, and valid ID card.
- **12 hours at Providence Little Company of Mary Medical Center Emergency Department-**
4101 Torrance Boulevard, Torrance, CA. Shifts are scheduled from either 0700-1900 or 1100-2300 HRS.
 - Student **MUST** arrive early in full uniform and check in with the Emergency Department.
 - Student **MUST** upload all four Providence signed agreements on Castle Branch (pages 13-18).
 - Student **MUST** bring ECC Clinical Packet, 10 printed and stapled LA Co EMS PCRs, and valid ID card.

V. EL CAMINO COLLEGE EMT CLINICAL PACKET

The El Camino College EMT Clinical Packet **MUST** be 100% complete prior to submission for course completion.

- Student is required to completely fill out the **Patient Summary Form** and attach **10 LA Co EMS PCRs**.
- Student **MUST** print out 10 LA Co EMS PCRs from the ECC EMT webpage prior to clinical rotations.
- Student **MUST** have both preceptor and student evaluations signed, dated, and completed.

VI. ATTENDANCE

Tardiness reflects that the student lacks self-motivation and professional behavior and may result in disciplinary action. Tardiness is not tolerated during the clinical rotation. In the event of unavoidable tardiness/absence, the student must contact the assigned area or station and the ECC EMT program.

VII. INJURY OR COMMUNICABLE DISEASE EXPOSURE

Safety **MUST** always be our first consideration. Hygiene combined with body substance isolation and proper safety protocols are discussed in ECC EMT lectures, assessed in skills tests, and referenced in Los Angeles County EMSA documents. The following documents are available on the ECC EMT webpage and **MUST** be read and acknowledged prior to clinical experience: **LA County EMT Clinical Manual, LA County Communicable Disease Exposure and Testing, Providence LCM Infection Prevention Handbook, and Providence LCM Code of Conduct.**

- If the student is injured while in an assigned healthcare facility, the student must comply with all healthcare facility and training program policies.
- If the student is injured while on an ambulance or in the station, the student must comply with all ambulance provider and training program policies.
- Student must complete/submit all required paperwork to the clinical rotation site/training program.

VIII. PATIENT INTERACTION

Clinical is the only time that a student is able to practice actual patient interactions before certification and entering “the real-world workforce”. The more interaction the student has the more confidence he/she gains in caring for patients. **All patient information is confidential and must follow HIPAA guidelines.**

IX. STAFF INTERACTIONS

Clinical allows the student to gain further understanding of the roles and responsibilities of medical professionals involved in healthcare, the EMS System, and the importance of developing a good working relationship with various healthcare facilities and potential co-workers. The student shall:

- Seek out learning activities to enhance the clinical experience.
- Never hesitate to ask questions regarding patient care.
- Observe and learn different ways of doing procedures.
- Do not participate if poor practices are encountered.
- Do not argue with staff but ask for clarification as to why a procedure was done.
- Keep voice level down in the clinical area.
- Keep cell phones on silent and other electrical devices off, use only in designated areas during breaks.

X. CLINICAL EXPERIENCE

The clinical experience is designed to integrate didactic and practical knowledge. The clinical experience allows students to observe various aspects of the EMS System, put into practice the skills and medical information learned, and employ therapeutic communication techniques. Not all objectives will be accomplished by every student due to the varied experiences available. **Students must refer to the ECC EMT webpage to download, print, read and understand the LA County EMT Clinical Experience Manual and objectives listed below:**

- **Los Angeles County EMSA Core Clinical Experience Objectives**
 1. Roles, Responsibilities, and Professionalism
 2. Safety and Wellness
 3. Therapeutic Communication
 4. Documentation and Record Keeping
 5. Clinical Behavior and Psychomotor Skills



LOS ANGELES COUNTY PREHOSPITAL CODE OF ETHICS



The Emergency Medical Services (EMS) System consists of health care professionals that include EMT's, paramedics, nurses, physicians, educators, and administrators. This Code defines our ethical responsibilities and beliefs in the following principles for guiding practice...

RESPECT

- Recognize, acknowledge, listen, and encourage all members of the health care team
- Uphold and maintain patient confidentiality and privacy
- Honor the patient's rights and autonomy to make decisions regarding their medical care

CARING

- Provide professional, compassionate, and competent care to all patients
- Advocate for the patient's care needs
- Participate and support the advancement of the EMS system through education, training, and continuous quality improvement
- Support prehospital care research to validate, improve and promote evidence-based practice

FAIRNESS

- Provide competent medical care to all persons with compassion and respect for human dignity regardless of nationality, race, creed, religion, sex, status, or financial considerations
- Ensure justice by treating all individuals equally and fairly
- Encourage and support impartiality in the delivery of patient care. Decisions should be absent of bias, prejudice or benefit one person over another for improper reasons but based on objective criteria

INTEGRITY

- Promote honesty, truthfulness, and consistency in action and practice by all members of the health care team
- Demonstrate responsibility and accountability by maintaining licensure/certification, operating within one's scope of practice, and providing thorough documentation
- Inspire fidelity by adhering to professional code(s) of ethics, following policies and procedures, ensuring team members are respectful, competent and capable of performing duties, and honoring agreements with patients and colleagues
- Maintain trustworthiness and excellence in the delivery of patient care and medical practice

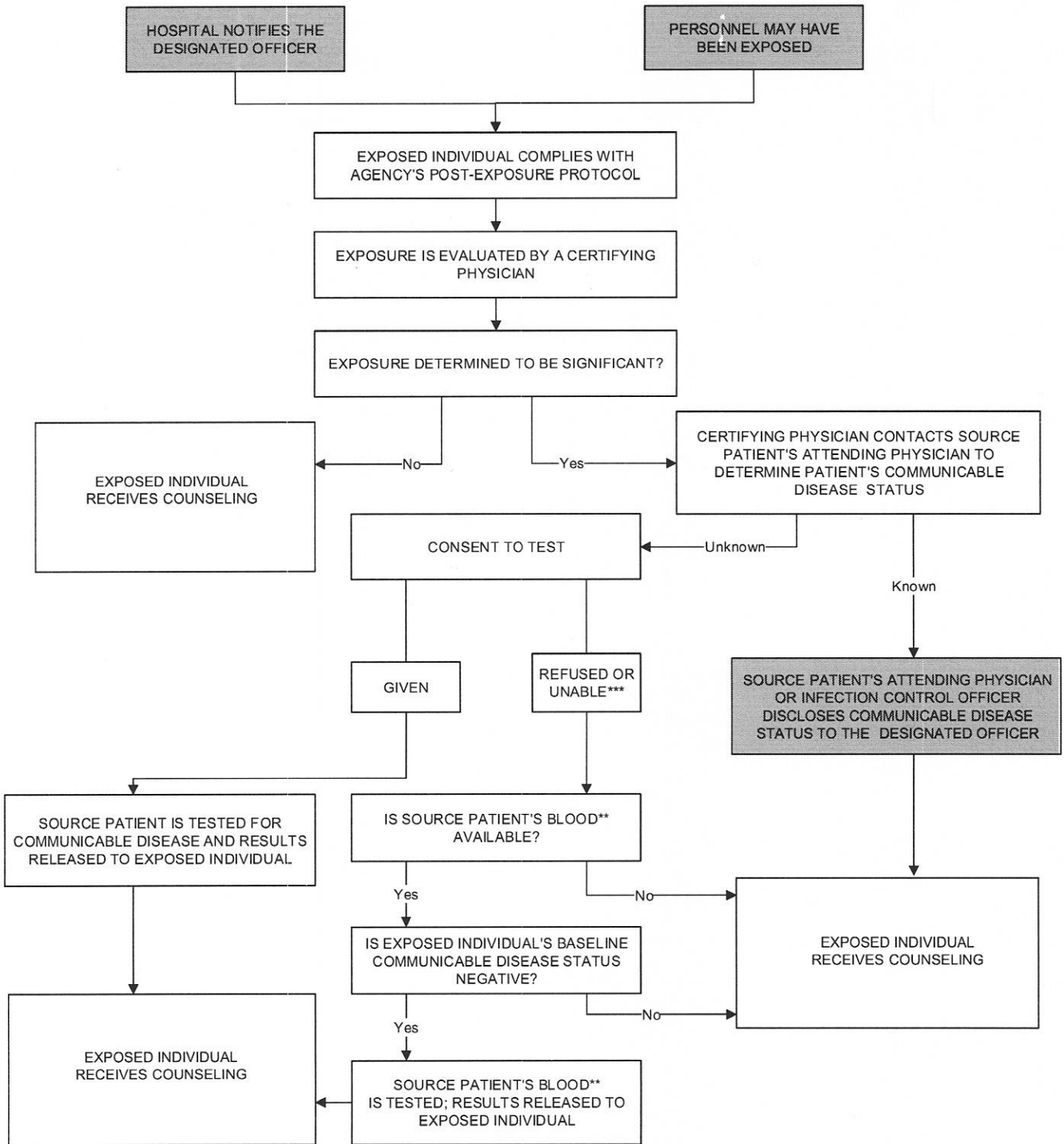
Revised date: 9-1-2013

PATIENT ASSESSMENT	TRAUMA CARE
<ol style="list-style-type: none"> 1. Evaluate the ill or injured patient 2. Obtain diagnostic signs to include, but not limited to: <ol style="list-style-type: none"> a. respiratory rate b. pulse rate c. skin signs d. blood pressure e. level of consciousness f. pupil status g. pain h. pulse oximetry (if available) 	<ol style="list-style-type: none"> 1. Provide initial prehospital emergency trauma care including, but not limited to: <ol style="list-style-type: none"> a. tourniquets for bleeding control b. hemostatic dressings <i>(State EMSA approved dressings only)</i> c. extremity splints d. traction splints 2. Use spinal motion restriction devices
RESCUE AND EMERGENCY MEDICAL CARE	ASSIST PATIENTS WITH PRESCRIBED EMERGENCY MEDICATIONS
<ol style="list-style-type: none"> 1. Provide basic emergency care 2. Perform cardiopulmonary resuscitation (CPR) 3. Utilize mechanical adjuncts for basic CPR <i>(requires EMS Agency approval)</i> 4. Use a Public Access Automated External Defibrillator (AED) <i>(carrying an AED requires EMS Agency approval as an AED Service Provider)</i> 5. Administer oral glucose or sugar for suspected hypoglycemia 6. Apply mechanical patient restraints <i>(per Reference No. 838)</i> 7. Use various types of stretchers 8. Perform field triage 9. Extricate entrapped persons 10. Set up for ALS procedures under paramedic direction 	<ol style="list-style-type: none"> 1. Assist patients with the administration of their physician-prescribed emergency devices and medications to include but not limited to: <ol style="list-style-type: none"> a. Sublingual nitroglycerin b. Aspirin c. Bronchodilator inhaler or nebulizer d. Epinephrine device (autoinjector) e. Patient-operated medication pump
AIRWAY MANAGEMENT AND OXYGEN ADMINISTRATION	PATIENT TRANSPORT AND MONITORING BY AN APPROVED EMS PROVIDER
<ol style="list-style-type: none"> 1. Use the following airway adjuncts: <ol style="list-style-type: none"> a. oropharyngeal airway b. nasopharyngeal airway c. suction devices 2. Administer oxygen using delivery devices including, but not limited to: <ol style="list-style-type: none"> a. nasal cannula b. mask – nonrebreather, partial rebreather, simple c. blow-by d. humidifier 3. Use the following manual/mechanical ventilating devices: <ol style="list-style-type: none"> a. bag-mask ventilation (BMV) device b. continuous positive airway pressure (CPAP) <i>(requires EMS Agency approval)</i> 4. Ventilate advanced airway adjuncts via bag-device: <ol style="list-style-type: none"> a. endotracheal tube b. perilyngeal airway device (King LTS-D) c. tracheostomy tube or stoma 5. Suction: <ol style="list-style-type: none"> a. oropharynx b. nasopharynx c. tracheostomy tube or stoma 	<ol style="list-style-type: none"> 1. Transport and monitor patients in the prehospital setting and/or during an inter-facility transfer by an approved EMS Provider <i>(Fire Department or a licensed Los Angeles County Ambulance Provider)</i> 2. Transport patients with one or more of the following medical devices: <ol style="list-style-type: none"> a. nasogastric (NG) b. orogastric tube (OG) c. gastrostomy tube (GT) d. saline/heparin lock e. foley catheter f. tracheostomy tube g. ventricular assist device (VAD) h. surgical drain(s) i. medication patches j. indwelling vascular lines <ol style="list-style-type: none"> i. pre-existing vascular access device (PVAD) ii. peripherally inserted central catheter (PICC) k. patient-operated medication pump 3. Monitor, maintain at a preset rate or turn off if necessary, the following intravenous (IV) fluids: <ol style="list-style-type: none"> a. glucose solutions b. isotonic balanced salt solutions (normal saline) c. ringer's lactate
	ADDITIONAL THERAPIES REQUIRING APPROVAL BY THE LA COUNTY EMS AGENCY
	<p>EMS Providers <i>(Fire Department or a licensed Los Angeles County Ambulance Provider)</i> may apply for approval of select additional therapies and medications</p> <p>Authority: California Code of Regulations, Title 22, Section 100063</p>

Effective: 3-01-86
 Revised: 04-01-18
 Supersedes: 12-01-17

**SUBJECT: COMMUNICABLE DISEASE EXPOSURE
 AND TESTING FLOWCHART**

(EMT, PARAMEDIC, MICN)
 REFERENCE NO. 836.1



* California law prohibits an exposed individual from attempting to directly obtain informed consent for communicable disease testing from a source patient
 ** Or other patient sample available for testing
 *** If source patient is deceased, any available blood or patient sample may be tested without consent

EFFECTIVE: 04-01-04
 REVISED: 07-01-18
 SUPERSEDES: 06-01-08

SUBJECT: **COMMUNICABLE DISEASE EXPOSURE
 AND NOTIFICATION REPORT FORM**

REFERENCE NO. 836.2



COMMUNICABLE DISEASE EXPOSURE AND NOTIFICATION REPORT FORM



**EMERGENCY MEDICAL
 SERVICES AGENCY**
 LOS ANGELES COUNTY

Section 1797.188 (b)(1) of the Health and Safety Code requires the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services as being afflicted with a reportable disease or condition, and that the reportable communicable disease or condition may have been transmitted during the provision of care, shall immediately notify the designated officer of the prehospital emergency medical care person.

INSTRUCTIONS: COMPLETE THE FORM AND KEEP IT IN THE EMPLOYEES FILE

NAME OF EXPOSED PERSONNEL	EMPLOYEE NO.	EMT CERTIFICATION NUMBER
CALIFORNIA STATE LICENSE NO. (if paramedic)	LOCAL ACCREDITATION NUMBER (if paramedic)	EMS REPORT FORM SEQUENCE NUMBER
EMS PROVIDER NAME	STATION TELEPHONE NUMBER	DESIGNATED OFFICER NAME & EMAIL
BATTALION	STATION	SHIFT
PATIENT'S NAME	HEALTH FACILITY	INCIDENT DATE / TIME
CHECK PERSONNEL PROTECTIVE EQUIPMENT USED:		
<input type="checkbox"/> GLOVES <input type="checkbox"/> EYE PROTECTION <input type="checkbox"/> GOWN <input type="checkbox"/> MASK <input type="checkbox"/> NONE		
<input type="checkbox"/> OTHER: _____		
CHECK TYPE OF EXPOSURE:		
<input type="checkbox"/> Blood/Body fluid splash to eyes <input type="checkbox"/> Blood/Body fluid splash to mouth <input type="checkbox"/> Blood/Body fluid to open skin, i.e., cuts, scrapes, etc. <input type="checkbox"/> Needle stick <input type="checkbox"/> Bite <input type="checkbox"/> Coughing or sneezing of unmasked patient (excluding common cold/flu)		
<input type="checkbox"/> OTHER: _____		
RECEIVED BY		
EMPLOYEE SIGNATURE		DATE

Castle Branch ECC EMT Upload Requirements

Clinical Requirements:	EC90
Measles, Mumps, and Rubella (MMR)	<p>One of the following is required:</p> <ul style="list-style-type: none"> - 2 vaccinations -OR- - A positive antibody titer for all three components (Measles, Mumps, and Rubella) <p>If any titer is negative or equivocal, new alerts will be created for you to submit documentation of a repeat series of 2 vaccinations.</p>
Varicella (Chicken Pox)	<p>One of the following is required:</p> <ul style="list-style-type: none"> - 2 vaccinations -OR- - A positive antibody titer <p>If the titer is negative or equivocal, new alerts will be created for you to repeat series.</p>
Tuberculosis (TB)	<p>One of the following is required:</p> <ul style="list-style-type: none"> - 1 step TB Skin Test -OR- - Blood Test (lab report or physician verification of results required) -OR- <p><i>If positive results or previously known positive results, provide:</i></p> <ul style="list-style-type: none"> - A clear Chest X-Ray (lab report or physician verification of results required)
Tetanus, Diphtheria & Pertussis (Tdap)	Please upload documentation of a Tdap booster within the past 10 years to this requirement.
Photo Identification	<p>One of the following is required:</p> <ul style="list-style-type: none"> - El Camino College ID card -OR- - Valid state issued ID card from any state in the U.S.A. -OR- - Valid state issued Drivers License from any state in the U.S.A. -OR- - Valid Passport from the U.S.A.
Student Information Sheet	Please submit a copy of the Student Information Sheet (available for download) to this requirement.
Course Commitment	Please submit a copy of the Course Commitment (available for download) and upload to the requirement.
Uniform Policy Agreement	Please submit a copy of the Uniform Policy Agreement (available for download) and upload to the requirement.
El Camino EMT Physical Clearance	Please submit a copy of the El Camino EMT Physical Clearance (available for download) and upload to the requirement.
Providence Acceptable Use Agreement	Please submit a copy of the Acceptable Use Agreement (available for download) and upload to the requirement.
Providence Commitment to Code of Conduct	Please submit a copy of the Providence Commitment to Code of Conduct (available for download) and upload to the requirement.
Providence Confidentiality Agreement	Please submit a copy of the Providence Confidentiality Agreement (available for download) and upload to the requirement.
Providence HAI Prevention	Please submit a copy of page 8 of the LCM Infection Prevention Handbook (available for download) and upload to the requirement.
CPR Certification	<p>One of the following BLS CPR/AED certification is required:</p> <ul style="list-style-type: none"> - American Heart Association course -OR- - American Red Cross course
ICS - 100 Certificate	Please upload your Incident Command System (ICS) certificate to this requirement.
NIMS - 700 Certificate	Please upload your National Incident Management Systems (NIMS) certificate to this requirement.

**El Camino College EMT
Immunization Form**



Name: _____ Section #: _____ Year: _____

Date of Birth: _____ Phone: _____

Vaccine Name	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result <u>(Must include lab report)</u>
1. MMR (Measles, Mumps, Rubella) (2 doses on or after 12 months of age)			
2. Varicella (Chickenpox)			
3. Tdap (Adacel/Boostrix)		--NOT APPLICABLE--	

4. Tuberculosis Screening					<i>Must have completed testing within 12 months of matriculation.</i>	
TB Skin Test by TST (Mantoux)	Date Placed	Date Read	MM	Result: Neg Pos		
OR Interferon-based Assay (QFT or Tspot)	Date	Result	Submit copy of lab report in English			
Chest X-ray (Only if positive TST or Lab Test)	Date	Result	Submit copy of x-ray report in English			

Full Name and Address of Facility <small>(Written OR Stamped)</small>	Physician or Authorized Signature	Date

El Camino College EMT

Student Information

Course Section: _____ Semester: _____ Year: _____

Student ID: _____ SSN (last 4): _____

Full Name: _____

Address: _____

Phone: _____ e-mail: _____

Background:

Motivation(s):

Desire(s):

El Camino College EMT Course Commitment

____ I have read and understand the points outlined in the course syllabus.
(initials)

____ I agree to ALL the terms and requirements outlined in the course syllabus.

____ I understand that students are responsible for ALL the material in the textbook and sills workbook and that some of this material may not be covered in class. I recognize that I will be required to study this material on my own in order to gain all the information necessary to pass this class.

____ I agree to conduct myself in a professional manner while in class, on campus, in the field and at any other time in which I am representing El Camino College.

____ I understand and agree that cheating and/or professional misconduct of any kind will not be tolerated and may result in immediate dismissal.

I have read and fully understand the conditions and requirements set fourth in the EMT course syllabus. Furthermore, I agree to be bound by this statement for the entire duration of my enrollment in the El Camino College EMT program. I understand that failure to complete and/or comply with any of the conditions set forth in the course syllabus may result in a non-passing grade and/or my termination from the course. Also, if I am unable to maintain the necessary minimum scores required for certification, I may be required to retake the course in order to receive a Course Completion Certificate from El Camino College.

Signature: _____ Date: _____

Printed Name: _____

EL CAMINO COLLEGE EMT UNIFORM AGREEMENT

- I understand that the uniform for this course consists of black leather or leather-like work boot, black leather, non-woven belt, navy blue work pant, white program T-shirt, a white program uniform shirt, a wristwatch and my El Camino student ID name badge.
- I understand that if I wish to purchase a navy blue program uniform jacket and/or a navy blue uniform program baseball cap, I may do so.
- I understand that the above two items outline the ONLY approved program uniform attire.
- I understand that ONLY approved program uniform attire can be worn while in class, outside of class on breaks or class functions, during my hospital and ambulance rotations, during Open Lab and any other class related function where the uniform is appropriate.
- I understand that ONLY a complete uniform is acceptable for this class.
- I understand that NON-Approved attire shall not be worn during course related functions.
- I understand that I may be asked to leave class if I am not in the correct uniform and that I will not be given credit for the day's hours.
- I understand that the ONLY permitted jewelry is a wedding ring and/or reasonably sized stud earrings (one in each ear, no larger than a pencil eraser).
- I understand that ALL visible tattoos must be covered at all times.
- I agree that I will purchase a long sleeve uniform shirt if it is necessary to cover otherwise visible tattoos.
- I agree that it is not the job of program staff to ensure that I am in the proper uniform at all times.
- I understand that uniforms should look presentable at all times, including a neatly pressed, clean shirt that is tucked in with a visible El Camino student name tag.
- I understand that male students should be clean shaven or have their beard neatly groomed.
- I understand that ALL students with long hair should have their hair pulled back at all times.
- I understand that a uniform being cleaned or laundered is not an acceptable reason to be out of uniform.
- I understand that a visible name tag and properly tucked in uniform shirt are required to be in compliance with this uniform policy.
- I understand that if I am not in my proper uniform for the duration of the class I will not receive hours.
- I understand and agree to all terms of the El Camino College EMT Uniform Agreement.
- I understand that it is my responsibility to ensure that I have, and am in, the proper uniform at all times.

Student's Printed Name: _____

Student's Signature: _____

Date: _____



EL CAMINO COMMUNITY COLLEGE DISTRICT

16007 Crenshaw Boulevard Torrance, California 90506-0001
Telephone (310) 532-3670 or 1-866-ELCAMINO

EMT - STUDENT PHYSICAL CLEARANCE STATEMENT

Student Name (PRINT): _____ **Student Phone #:** _____

Date of birth: _____ **Date:** _____ **Student ID #:** _____

EMT is a physically demanding class and profession. Students must be in good physical condition to handle the demands of this course. By signing this form you confirm your ability to participate in this course without limitation.

PHYSICAL REQUIREMENTS - The student must demonstrate a high degree of manual dexterity and physical flexibility and have the ability to preform repetitive tasks. The student should also have the ability to:

- lift and move patients with the assistance of others
- carry standard equipment used in the prehospital care setting
- walk reasonable distances (up to several miles a day)
- reach above shoulder level
- hear and speak on the phone
- work with chemicals and detergents
- tolerate exposure to dust and/or fumes
- preform CPR
- bend
- kneel
- squat
- grip
- sit for long periods of time
- stand for extended periods of time
- distinguish colors
- adapt to shift work

Comments: _____

Student Signature: _____ **Date:** _____

**Providence Little Company of Mary Medical Center Torrance
Orientation Reference Sheet**

<p><u>MISSION STATEMENT</u> As People of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.</p> <p><u>CORE VALUES</u> <i>Respect</i> <i>Compassion</i> <i>Justice</i> <i>Excellence</i> <i>Stewardship</i></p> <p><u>VISION STATEMENT</u> Together, as people of Providence, we answer the call of every person we serve: Know me, care for me, ease my way.</p>	<p><u>PROVIDENCE INTEGRITY REPORTING</u> <i>(for any actions that appear illegal, unethical, or in conflict with Providence policy)</i></p> <p>Integrity Hotline: (888) 294-8455 Confidential and anonymous Regional Compliance Officer: Arnold Krauss (818) 847-3140</p> <p><u>Examples of Issues to Report:</u> Theft and fraud; billing and coding; bribes and kickbacks; falsification of records; gifts and entertainment; Code of Conduct violations; privacy of employee / patient records; any other issues or concerns where you are unable to get a reasonable resolution.</p>
<p><u>PATIENT CONFIDENTIALITY</u></p> <p>It is the responsibility of all individuals with access to any information pertaining to patients, employees, or the business of any Providence Health System facility or entity to safeguard that information to prevent inappropriate or unauthorized use of disclosure of that information.</p>	<p><u>RESTRAINTS</u></p> <p><u>Non-Violent / Non-Self-Destructive Behavior:</u> Type of physical restraint ordered by physician. Restraint order MUST not exceed one (1) calendar day. Patient care staff will assess and treat patient according to restraint guidelines.</p> <p><u>Violent / Self-Destructive Behavior:</u> Type of physical restraint used for behavioral reason. Behavioral restraint order MUST not exceed four (4) hours (<i>adults ≥ 18 yrs</i>), two (2) hours (<i>9-17 yrs</i>), one (1) hour (<i>< 9 yrs</i>) and a physician MUST assess patient (<i>face to face</i>) within one (1) hour of applying the restraint.</p> <ul style="list-style-type: none"> ◆ Refer to Restraint Policies located in the Online Policy and Procedure Library. ◆ Documentation MUST be completed in the medical record for any patient in restraints. <p><u>Law Enforcement Restraint Devices:</u> Handcuffs, ankle shackles, leg irons, and other chain-type restraint devices applied by law enforcement officials for custody, detention, and public safety reasons are not governed by hospital policy. The law enforcement officers who maintain custody and direct supervision of their prisoner (<i>the hospital patient</i>) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient.</p>
<p><u>SMOKING POLICY</u></p> <ul style="list-style-type: none"> ◆ This is a non-smoking facility. ◆ Smoking is permitted only in designated outdoor areas. 	<p><u>MANDATORY REPORTING</u></p> <p>All reports of abuse and exploitation, including reports of abuse and exploitation occurring in the hospital, MUST be reported to the Director/Manager, Charge RN, and Nursing Supervisor immediately.</p>
<p><u>CHAIN OF COMMAND</u></p> <p>Contact the following for problems/concerns/adverse events:</p> <ul style="list-style-type: none"> • Department/Unit Appointed Resource is . . . _____ • Department Supervisor/Charge Nurse is . . . _____ • Department Manager is . . . _____ • After hours and weekends contact House Supervisor by dialing "0". 	<p><u>RAPID RESPONSE TEAM (RRT)</u></p> <p>Dial 34777</p> <p><u>THE JOINT COMMISSION (TJC)</u></p> <p>Call (800) 994-6610 for concerns or complaints.</p> <p><u>SAFETY MANAGEMENT</u></p> <ul style="list-style-type: none"> • Ask supervisor for unit-specific safety work practices and concerns. • If unsure of procedures, ASK FOR HELP. • Contact the Facilities Safety Officer through Security: Dial 37233

**Providence Little Company of Mary Medical Center Torrance
 Safety Program Guidelines**

<p><u>LIFE SAFETY (FIRE)</u></p> <ul style="list-style-type: none"> • Four Step Plan (<i>R-A-C-E</i>) <ul style="list-style-type: none"> R - rescue from immediate area of danger A - alert Dial 34777 C - contain fire E - extinguish fire or evacuate area • Fire extinguisher use (<i>check for the location of the closet extinguisher in the area</i>) <ul style="list-style-type: none"> P - pull pin A - aim nozzle at bottom of fire S - squeeze handle S - sweep from side to side • Evacuation route <ul style="list-style-type: none"> Ask unit supervisor for evacuation route map. 	<p><u>EMPLOYEE HEALTH & SAFETY</u></p> <p>For injuries sustained while on duty:</p> <ul style="list-style-type: none"> • Report immediately to supervisor. • Complete an Employee Injury Packet. • Bring completed packet to Occupational Health & Safety (<i>OHS</i>) M-F, 7:30a – 4:00p. If after hours, weekends, or holiday, take to House Supervisor for assessment and treatment direction. • Follow-up with OHS next business morning. <p>For blood/body fluid exposure:</p> <ul style="list-style-type: none"> • Report immediately to supervisor and to OHS (<i>House Supervisor when closed</i>). • Bring patient source information with you. • Bring information on exact type of sharp you were injured with (<i>if needlestick or sharps injury</i>) brand, device name, gauge. 																																										
<p><u>MEDICAL EQUIPMENT MANAGEMENT</u> <i>(Biomedical Services)</i></p> <ul style="list-style-type: none"> • Reporting medical equipment problems, Dial 31349 • Tag equipment “DEFECTIVE, DO NOT USE” • If unfamiliar with equipment operation, ASK FOR HELP BEFORE USING EQUIPMENT ON PATIENTS. • Complete an Unusual Occurrence Report (<i>UOR</i>) to Risk Management if patient/staff injury was involved. 	<p><u>HAZARDOUS MATERIALS & WASTE</u></p> <ul style="list-style-type: none"> • For chemical spills summon hazardous response team Dial 34777 • Material Safety Data Sheets (<i>MSDS</i>): Access Max Com via intranet link. • Whenever in doubt, ask supervisor for assistance before handling unfamiliar chemicals. • MSDS MUST be provided to the department manager when chemicals, cleaning agents, etc., are brought into the medical center premises for any reason. 																																										
<p><u>SECURITY MANAGEMENT</u></p> <ul style="list-style-type: none"> • To summon – Dial 37233 (3-SAFE) • Call for escort to parking area after hours. • Report all suspicious circumstances to Security. • Wear photo ID when on duty. 	<p><u>EMERGENCY PREPAREDNESS</u></p> <ul style="list-style-type: none"> • Code Triage = Internal & External disasters • Employee Labor Pool = Staff available for reassignment Report to Cafeteria • Incident Command Center = Responsible for overall operations & Facilities Building Report to Facilities Building • Unit role in a disaster = Reference Disaster Manual 																																										
<p><u>UTILITIES MANAGEMENT</u> <i>(Plant Operations)</i></p> <ul style="list-style-type: none"> • Utility failures (<i>medical gas, electricity, plumbing, heating, A/C, vacuum system, etc.</i>) • The Medical Gas shut off valves may be closed upon approval of Respiratory Therapy and/or Unit charge Nurse if located in the OR, the Operating Room Supervisor. • To report problems refer to Disaster Manual for response plan or Dial 31349 	<p><u>CODES</u></p> <table> <tr><td>Code Red</td><td>=</td><td>Fire / Smoke</td></tr> <tr><td>Code Blue</td><td>=</td><td>Medical Emergency (<i>Adult</i>)</td></tr> <tr><td>Code White</td><td>=</td><td>Medical Emergency (<i>Child</i>)</td></tr> <tr><td>Code Gray</td><td>=</td><td>Combative Person</td></tr> <tr><td>Code Silver</td><td>=</td><td>Combative with Weapon</td></tr> <tr><td>Code Pink</td><td>=</td><td>Infant Abduction</td></tr> <tr><td>Code Purple</td><td>=</td><td>Missing Child</td></tr> <tr><td>Code Triage</td><td>=</td><td>Disaster Response</td></tr> <tr><td>Code Orange</td><td>=</td><td>HazMat Spill</td></tr> <tr><td>Code Yellow</td><td>=</td><td>Bomb Threat</td></tr> <tr><td>RRT</td><td>=</td><td>Rapid Response Team</td></tr> <tr><td>EDRT</td><td>=</td><td>Emergency Dept Response Team</td></tr> <tr><td>AMI</td><td>=</td><td>Acute Myocardial Infraction</td></tr> <tr><td>Employee Pool</td><td>=</td><td>Cafeteria</td></tr> </table> <p>Dial 34777</p>	Code Red	=	Fire / Smoke	Code Blue	=	Medical Emergency (<i>Adult</i>)	Code White	=	Medical Emergency (<i>Child</i>)	Code Gray	=	Combative Person	Code Silver	=	Combative with Weapon	Code Pink	=	Infant Abduction	Code Purple	=	Missing Child	Code Triage	=	Disaster Response	Code Orange	=	HazMat Spill	Code Yellow	=	Bomb Threat	RRT	=	Rapid Response Team	EDRT	=	Emergency Dept Response Team	AMI	=	Acute Myocardial Infraction	Employee Pool	=	Cafeteria
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<p><u>INFECTION PREVENTION</u></p> <ul style="list-style-type: none"> • Use Standard Precautions for all patient contact. • Personal protective equipment is available in all patient care areas. • Hands should be washed between patient contacts. • Please refer to Infection Control Manual for additional information as needed. 																																											

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ACCEPTABLE USE AGREEMENT

This Acceptable Use Agreement applies to Providence Health & Services (PH&S) employees, volunteers, trainees, and all others doing business with Providence.

Compliance with this agreement is a condition of continued employment or association with PH&S according to the Acceptable Use of Information Systems security policy found in the system policy manual.

The Acceptable Use of Information Systems policy describes the appropriate use of Providence information and technology resources including data, systems, networks and devices including but not limited to desktop computers, laptops, PDAs, fax machines and copiers and is intended to promote and protect the confidentiality, integrity, and availability of PH&S information and technology.

I am aware and agree, unless further described herein:

- Internet usage, communications and transactions are not private. All computer activity is recorded and can be traced to a specific user ID.
- Information and technology associated with or belonging to PH&S must be protected by taking appropriate measures such as keeping passwords private, encrypting all computers and devices, and locking all portable devices. Additional information and online training on how to protect information and technology is provided by Providence.
- Information and technology is for business use and must not be used for purposes which may interfere or are in conflict with the PH&S mission and/or policies. Any use of PH&S information or technology for a purpose not specifically authorized by PH&S is prohibited.
- PH&S reserves the right to limit or restrict the use of information or technology to meet the business and service obligations of the organization.

Although information and technology resources are for business use, limited personal use may be permitted with the following restrictions:

- Usage must be reasonable, lawful and ethical and cannot be offensive or disrespectful to co-workers or others in the work or patient care environment.
- Usage must not interfere or be in conflict with PH&S responsibilities or productivity.

IMPORTANT: In addition to termination, non-compliance could result in further action, including civil or criminal prosecution. Violation of these requirements by a third party contracted with PH&S may result in termination of the representative's contractual arrangement with PH&S for default and may further result in such representative being subject to civil or criminal laws, as applicable.

By signing this document, I acknowledge that I have read, understand, and agree to abide by the Providence Health & Services Acceptable Use Agreement. This agreement does not limit my right to use my own general knowledge and experience, whether or not gained while employed by PH&S, or my right to use information which is known to the general public through no fault of my own.

Signature: _____ Date: ___/___/___

Printed Name: _____ Position: EMT STUDENT

Department: EMERGENCY DEPARTMENT Work Location/Facility Site: LCM TORRANCE

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Employee#:

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ACKNOWLEDGMENT OF COMMITMENT TO THE CODE OF CONDUCT

These standards in the Providence Code of Conduct do not, nor were they intended to, cover every situation you may encounter. They provide only broad guidance that is defined in greater detail by the various policies, standards, procedures and guidelines of Providence, your region and your facility.

Providence is committed to the standards outlined in this Code of Conduct. Your commitment is critical to the success of this Integrity and Compliance Program. Failure to do so is grounds for disciplinary action, up to and including termination, in accordance with your personnel policies and/or collective bargaining agreement if applicable.

As with any policy, compliance with the Providence Code of Conduct is a condition for, but not a guarantee of, continued employment.



I acknowledge that I have received my copy of the Providence Code of Conduct.

I understand that I am responsible for becoming familiar with the information contained in the Code and that this Code does not include all of the specific policies of Providence.

I further understand that any clarification of the contents of this handbook will be provided during compliance education sessions or, upon my request, by my supervisor, the local or regional compliance office or the System Integrity office.

Name (Please Print)

Signature

LCM

Date

Ministry/Facility and Department

03-Code of Conduct



Confidentiality Agreement

It is the responsibility of all individuals with access to any information pertaining to patients, employees, or the business of any Providence Health & Services (PH&S) facility or entity to safeguard that information to prevent inappropriate or unauthorized use or disclosure of that information.

Confidential information includes, but is not limited to, medical records; employee records; computer records; information relating to marketing, purchasing, and financial status; insurance coverage; managed care and payor contracts; human resource policies and procedures including compensation rates and formulas; information gained from service on hospital or medical staff committees; information gained from patients from families and friends of patients, other employees, external agencies, media, or medical staff; and anything marked "confidential".

I, _____, understand that it is my obligation to maintain the privacy and confidentiality of information in order to protect patients, families, and members of this organization from inappropriate uses or disclosures of confidential information.

I understand that I must safeguard all confidential information, regardless of the form that information takes, both orally communicated information and information recorded in any form.

for whom I am providing services, or that are directly relevant to the performance of my job responsibilities, and that access of any other patient's information is a violation of that patient's privacy and PHS Southern California Region policy.

I understand that my computer user identification code(s) and password(s) are the basis for my electronic signature and that I am prohibited from disclosing my access code(s) to any other person, or using any other person's code(s) to gain access to any computer system.

I understand that I must adhere to standard information and physical security practices in order to effectively safeguard the privacy and confidentiality of information and that failure to do so is a violation of PH&S Southern California Region policy.

I understand that I have a professional responsibility to report to the Privacy Officer any violations of patients' privacy or confidentiality that I observe or are reported to me.

I understand that willful or malicious uses or disclosures of confidential information, or uses or disclosures of information made for personal gain, are a violation of PH&S policy and subject to disciplinary action, up to and including termination.

By my signature below, I acknowledge my agreement with, and understanding of, the statements in this Confidentiality Agreement. This Confidentiality Agreement shall remain in full force and effect after termination of employment.

Signed: _____ Date: _____

Providence Little Company of Mary Medical Center
HAI Prevention Strategies Handbook Acknowledgement

This signed acknowledgement page will be kept under employee competency file by registry per employee. Your signature below acknowledges that you have received, read and understand the information presented in the HAI Prevention Strategies Handbook.

Name: _____
(Please Print your Name)

Signature: _____

Date: _____

Ambulance Ride Along Tips

- ✓ Be “Rescue Ready” at all times meaning have your equipment and uniform prepared! Do not wear jewelry or expose tattoos. You will be responding to actual 911 calls and the public won’t know the difference between an EMT and a student, they are expecting a professional to help them:
 - Shine your boots
 - Iron your shirt and pants
 - Keep your shirt tucked in and boots tied
 - Ensure your wrist watch is on and working
 - Show up clean shaven and/or with your hair up
 - Equipment needed: B/P cuff, Notepad, Pen, Penlight, Sharpie, and Stethoscope
- ✓ Show up at least 20-30 minutes early. **“If you are early you are on time, if you are on time you are late, if you are late you are fired!”** Allow time for traffic or accidents, map the station address a few days before your ride along to ensure you know how to get there (including alternate routes).
- ✓ The ambulance crew may bring their own food or buy food along the way. It is advised that you prepare healthy snacks and a sack lunch, including plenty of water.
- ✓ Although not required, bringing a treat for the station makes a great first impression- especially if you intend to apply with the company in the near future...
- ✓ Bring study material, you may have some time when the ambulance you are assigned to is waiting for a call. This is a great opportunity to study for your upcoming module and ask clarifying questions.
- ✓ Be humble, do not sit down at the station and kick your feet up. Instead offer to help with station/ambulance duties such as checking and restocking equipment and washing the ambulance. Be your best self while striving for excellence to show them you want to be a part of the team.
- ✓ Always remember to use BSI on every call, and don’t forget SAFETY FIRST!
- ✓ Always be respectful to the EMS/Fire crews, law enforcement, patients, hospital staff and essentially everyone you encounter while in uniform, or life for that matter. If you do not know their name, then address them as “Sir” or “Ma’am.” Also use the words “Yes”, “No” and “Copy that” when replying.
- ✓ Treat others how you want to be treated. Be polite and respectful of everyone and everything around you at all times. Remember the ICARE Values: Integrity, Compassion, Accountability, Respect, Empathy.
- ✓ Turn your phone off and do not pull it out until you finish your shift. This will keep you from distractions throughout the day and prevent you from potentially violating HIPPA guidelines.
- ✓ Be ready to receive constructive criticism, it will only make you a better EMT. Good ambulance preceptors will brief and debrief with you as needed throughout the shift and provide active feedback.

Student Ride-Along Overview

WESTMED/McCORMICK Ambulance is pleased to be able to offer you the opportunity to ride-along as a third person. We hope you will have a great learning experience. We do ask that you observe our rules and be courteous at all times.

[REDACTED]

The calendar shows all of the shifts available to students. [REDACTED]

Find the shift you want and [REDACTED] and communicate your desired shift(s).
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

It's a good idea to request several shifts at one time in the order of preference. That way if your first choice has been taken, you may get your second, third, or fourth etc.

Report to your assigned station at least 15 minutes early.

It is not unusual for an ambulance crew to receive a call just before their shift actually starts. If they get a call before you arrive, there is no telling when they will return to the station to pick you up.

THE FOLLOWING REQUIREMENTS MUST BE STRICTLY ADHERED TO. FAILURE TO MEET THE FOLLOWING REQUIREMENTS FOR YOUR RIDE-A-LONG WILL RESULT IN YOU BEING SENT HOME:

- All students must report to their assigned station with a completed McCormick Ambulance ride along waiver.
- All students must report to their assigned station with a completed McCormick Ambulance ride-a-long HIPAA agreement
- All students must have 2 forms of identification previously copied and attached to the waiver and HIPAA agreement. A California driver license or I.D. and a student I.D. from your school are acceptable.
- All students must be dressed in professional attire. White button up shirt, navy blue/black slacks and black shoes. Please bring a black ball point pen and a wrist watch.
- BE ON TIME! If you are late, you will not be allowed to ride-a-long that day.

RIDE-ALONG NAME	DATE
SIGNATURE	

Form E-111 Rev 2 (11/06) M

Student Waiver of Liability and Hold Harmless Agreement

1. In consideration for receiving permission to come upon company property, ride along in an ambulance and participate in this educational class (hereafter jointly referred to as the "activity"), I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE Westmed Ambulance, Inc., Westmed Ambulance, Inc. dba McCormick Ambulance, Mariposa Commercial Properties, LLC, and all other affiliated companies, officers, property owners, agents, servants, or employees (hereinafter referred to as releasees) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or any of the property belonging to me, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in such activity, or while in, on or upon the premises or property where the activity is being conducted. This release includes, but is not limited to, all injuries and damages sustain while entering or exiting RELEASEES' vehicles, or while seated or situated in, around, or on any vehicle owned or operated by RELEASEES, or outside the vehicle while at the scene of any location to which RELEASEES' vehicle has responded to, or transported to, or parked at, or been situated at, or otherwise. I make this general release freely and with the full opportunity to seek the benefit of independent legal advice, and I am fully aware of and herby waive the benefit of the provisions of Civil Code section 1542, which provides:

A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS, WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM MUST HAVE MATERIALLY AFFECTED HIS SETTLEMENT WITH THE DEBTOR.

2. I am fully aware of the unusual risks involved and hazards connected with this activity. I hereby elect to voluntarily participate in said activity with full knowledge that said activity may be hazardous to me and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that my be sustained by me; or any loss or damage of property owned by me, as a result of being engaged in such activity, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES OR OTHERWISE. I acknowledge that riding in a vehicle owned by RELEASEE may be dangerous and MAY RESULT IN BODILY INJURY, DEATH, AND/OR EXPOSURE TO AIRBORNE OR BLOOD BORNE PATHOGENS.

Exposure to airborne or blood borne pathogens may result in the transmission of AIDS, hepatitis, tuberculosis, or other infectious diseases. The individual agrees that they will follow all precautionary measures and instructions given by RELEASEES' employee. I further agree that I WILL REMAIN SEATBELTED AT ALL TIMES WHILE IN THE RELEASEES' VEHICLES even if not verbal, instructed to do so.

3. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEES from any loss, liability, damage or costs, including court costs and attorney fees, that they may incur due to my participation in said activity, WHETHER CAUSED BY NEGLIGENCE OF RELEASEES OR OTHERWISE.

4. I agree that if any provisions of this agreement are subsequently held to be illegal, unenforceable or void, this agreement shall continue in full force and effect without said provision or portion of provision.

5. It is my express intent that this Waiver of Liability and Hold Harmless Agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of California.

6. IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Student Waiver of Liability and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete consideration fully intending to be bound by same.

RIDE-ALONG NAME	DATE
SIGNATURE	
WITNESS SIGNATURE	BADGE #

CREW USE ONLY: (A student lacking any of the following will not be permitted to ride-along.)

California ID or California Drivers License Initial: _____

Student Identification Initial: _____

Student Waiver of Liability and Hold Harmless Agreement signed, dated and witnessed. Initial: _____

Student Ride-Along HIPAA Acknowledgement

WESTMED/McCORMICK Ambulance is pleased to be able to offer you the opportunity to ride-along as a third person. We hope you will have a great learning experience. We do ask that you observe our rules and be courteous at all times.

McCormick Ambulance Service is committed to protecting our employees, the patients we serve and the company from illegal or damaging actions by individual and the improper release of protected health information and other confidential or proprietary information.

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. McCormick Ambulance Service prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment or health care operation. Discussions of "Protected Health Information" (PHI) within the organization should be limited to, exchange of patient information needed for the treatment of the patient, billing and other essential health care operations, peer review, internal audits and quality assurance activities.

I recognize that unauthorized release of confidential information may make me subject to a civil action under the provisions of the Welfare and Institutions Code. I hereby agree not to divulge any information for records concerning any client/patient without prior authorization in accordance with the "Health Insurance Portability Act" of 1996 (HIPAA) and McCormick Ambulance Policy 2015.3

RIDE-ALONG NAME	DATE
SIGNATURE	