Prairie Lakes Healthcare System
401 9th Ave NW
Watertown, South Dakota 57201
Phone 605.882.7710
Fax 605.882.7720
www.prairielakes.com

Dear Participant,

Thank you for sharing your interest in Prairie Lakes Hospital's Job Shadowing/Observation Program. The goal of our program is to provide experiential learning opportunities to help you learn about health careers, as well as learning about the skills different occupations require. Program participants will have the opportunity to see, first hand, the healthcare workplace and the day to day work of professionals in the health care field during the shadowing experience. Participants will not be permitted to take part in hands-on patient care. There are a few key facts about the program that you need to know:

1. Eligibility Students must be High School juniors or seniors, or older to be eligible to participate. The minimum age to participate in the program is 16 years of age.

2. Shadowing Time - The Job Shadowing/Observation Program allows a student to shadow in one area, unit or department for a total of up to 8 hours (hours/length of observation may vary depending upon various departments).

For students who have not already identified a hospital employee to shadow:
Each shadowing schedule is based on a matching process between the student's initial request and working out the best opportunities avail- able.

3. Pre-requisites for Participation in the Program—Prior to beginning a shadowing experience applicants must fill out the attached packet which includes completion of:

- A Job Shadowing/Observation Application Form, with three areas of interest outlined by student and student's information.
- A HIPAA (Health Insurance Portability and Accountability Act) Test, after reading and understanding the associated materials completes the test which is enclosed in the packet.
- A signed Confidentiality Statement, which is enclosed in the packet.

Prairie Lakes Hospital's Job Shadowing/Observation Program does not arrange physician shadowing opportunities, but if a student has arranged to shadow a physician the same pre-requisites apply.

It is extremely important that you understand confidentiality as you will be observing patient care and procedure; listening to conversations regarding patient care and treatment; and possibly reading printed documents or computer printouts. You will sign a Confidentiality Statement before your shadowing experience. You will not be able to shadow without having signed the Confidentiality Statement.

Do not bring anything that you don't really need.

Examples: Purses or backpacks (lock in the trunk of your vehicle if you are driving)
Misc. items (books, magazines, journals, etc)
Chewing Gum
Smoking – Our facility is a non-smoking. You will not be allowed to smoke on site.

We ask you to refrain from making personal phone calls during your experience at the hospital. If it is necessary that students make a phone call, please ask.

Be sure to eat well on the day of the shadowing experience. Report to the Human Resources Department unless otherwise instructed the morning of your shadowing.

Do not come in if you feel ill, have a fever 100 or more, or have a contagious disease. Call the assigned employee to let them know you will not be coming to the hospital.

Wash your hands—sing Happy Birthday to yourself twice while washing hands Be sure to wash hands at the beginning of the experience, frequently during the shadowing and before leaving the hospital. Do not enter a room marked isolation. They will have colored cards beside the door and will say Contract, Airborne, Droplet, or Protective. Do not transport specimens. Do not touch blood or body fluids or any questionable substance, If you accidentally do, wash the area and report it IMMEDIATELY. Do not remove trash or dirty linen from patient rooms. Do not take any potentially contaminated items outside of the hospital. Remember this is an observational experience only.

Once you have completed your packet, please send the complete packet to the Shadowing Program contact, Jannelle Olson. Your information can be faxed to our office at 605 882 7720, dropped off at the Human Resource Office, or mailed to our office at the following address:
Prairie Lakes Healthcare System
c/o Shadowing Program/Human Resources
401 9th Ave NW
Watertown, South Dakota 57201

If you have any questions feel free to contact us by phone at (605)-882-7710 or email at jannelle.olson@prairielakes.com. Once we have your completed paperwork, you can schedule your shadowing hours. We look forward to helping you explore your career options in healthcare,
and hope your experience will be rewarding.

Regards,

Jannelle Olson
Human Resources

Shadowing/Observation Application (*Please Print Clearly)*

Observer's Name:_____Age *(Must be 16+)*_____

Address_____Social Security_____

City_____State_____Zip_____Phone_____

Email Address_____Cell Phone_____

_____High school student Name of School: _____
_____College student Name of School: _____
_____Non-student observer

Purpose for experience:

_____ School Requirement
_____ Business Reasons
_____ Other
_____ Pre-Entrance Requirement for Professional Program
_____ Possible Career Choice

Instructor_____

If Applicant is under the age of 18,
Name of Parent or Guardian & Relationship: _____
For the observers who are minors, parent/guardian permission:
I give my permission for _____to shadow an employee of Prairie Lakes Healthcare System on _____.

_____
Signature of parent/guardian *Date Signed*

Home Phone: (___)_____-_____ Cell Phone: (___)_____-_____

Schedule Preference: Please include the days of the week, the dates, and hours you would be available to shadow
Participants may shadow in an area up to 8 hours.

Each shadowing schedule is based on a careful matching process between the student's initial request and working out the best opportunities available.

Career/ Job Shadowing Interest's):

Choice 1.)_____Choice 2.)_____Choice 3.)_____

Day of the Week:

Choice 1.)_____Choice 2.)_____Choice 3.)_____

Date: Hours: Date: Hours:

Choice 1.)_____Choice 2.)_____Choice 3.)_____

For Those Pre-Arranged:
If you have already talked to a physician or employee who agreed to allow you to shadow, please give us:
Physician or Employee's Name:
Unit/area or Specialty:

Shadow/Observers must be escorted at all times.
All Students will park in the west parking lot on Skyline Drive.

Shadowing/Observation Program – Dress and Appearance Policy

Prairie Lakes Healthcare System's Job Shadow/Observers have a responsibility to adhere to the hospital's dress policy. Therefore, your attire, grooming, and personal hygiene are critically important. We require that you observe the following specific standards regarding personal appearance and neatness while shadowing/observing in the hospital:

Shirts and Blouses - No lingerie or spaghetti straps, cut-off sleeves, racer back tops, or revealing or plunging necklines are allowed. Short or cropped shirts are not allowed. Cleavage must be covered. No see-through clothing or clothing with indented armholes. Shirts need to be tucked in.
Dress and Skirt Lengths - Lengths of dresses and skirts must be professional and show good taste. Tight dresses and tight skirts are not acceptable.
Sleeves - Clinical personnel must wear shirts and dresses with sleeves. Non-clinical personnel may wear sleeveless shirts or dresses as long as they are in good taste and undergarments are covered.
Pants - No stirrup pants, blue jeans, bike shorts, leggings, sweat pants, jogging pants, and skorts are allowed.
Hair - No distracting extremes in hair styling, dyeing, bleaching, or coloring are allowed.
Hosiery - Personnel must wear complementary socks or hosiery.
Shoes - Shoes must be worn at all times and must be clean and in good repair. Athletic shoes must coordinate with uniforms and should be white. Shoes should match or complement your uniform or outfit. Open toed shoes are not acceptable areas. Shoe heels cannot be more than three inches high. Flip flops and stiletto heels are not permitted.
Fingernails – Those who have direct contact with patients, who transport patients, or who will be in the Food Nutrition Department are not permitted to wear artificial nails. Artificial nails include acrylic/gel overlays, acrylic/gel nails, wraps, tips, and nail strengthener or hardener that is not removable by acetone. Artificial nails are discouraged in non-patient care areas, No employees should have fingernails that exceed ¼ inch from the tip of their finger, have extreme nail art, or wear extreme colors.
Perfume, Aftershave, and Lotions - No strong, heavy scents or fragrances are allowed. All scents are discouraged.
Body Piercing - Visible body piercing other than earrings is not permitted; this includes tongue piercing and forking, eyebrow piercing, and nose rings.
Tattoos - Candidates should wear clothing that covers tattoos.

Candidates may be required to wear scrubs or special attire for certain areas.

*Candidate Signature:*_____ *Date*_____

(Signature verifies that you have read the above statements & understand guidelines for Prairie Lakes Healthcare System)

HIPAA Fundamentals Training

Introduction

- At Prairie Lakes Healthcare System, privacy of patient information has always been considered a basic right.
- What can happen when protected health information is inadvertently exposed? Personal harm to individuals, embarrassment, community mistrust, lawsuits, etc…

What is HIPAA

- HIPAA stands for **Health Insurance Portability and Accountability Act**. HIPAA is a relatively new federal law that protects Protected Health Information, or **PHI**.

- The law allows for penalties such as fines and/or prison for people caught violating patient privacy.

- HIPAA Privacy Regulations became **effective in April 2003** and the Security Regulation in April 2006.

- Part of our compliance with the HIPAA law is to provide the required awareness training for employees and workforce members.

Protected Health Information

- Protected Health Information (PHI) is **about patient information – whether it is spoken, written, or on the computer.** It includes health information about our patients. It can be information as simple as their name.

- Certainly we can share PHI when it is part of our job to do so, but beyond that you may have broken the law if you share patient information.
-

Need to Know

- A good way to determine if you should share patient data is to ask yourself… **"Do I or others need this information to do the job?"** Use this little test before you look at patient information or share it with others.

- Sometimes you may inadvertently hear or see information that you don't need to know. If so, just keep it to yourself.

Dispose of PHI Properly

- Trash and garbage bins are another place that might contain PHI. Be sure to dispose of patient lists and other documents that contain PHI in non-public areas.

- **If you see PHI in the trash in public areas, notify the supervisor immediately**.

- If you transport PHI, make sure it is secure when not in your sight, such as a locked vehicle.

The Privacy Officer

- **At PLHS we have a person responsible for insuring that privacy is maintained – The Privacy Officer.** However, no one person can know if we have a possible threat in every area of such a large organization.
- Each of us must do our part to protect patient information. **You should always report possible privacy problems to the manager in your area or to the Privacy Officer**.

Co-Workers, Friends, and Family Situation: *You hear about a friend that has had surgery, so you call a nurse on that floor to find out the details.*

- Friends and co-workers deserve the right to privacy just like any other patient. You cannot seek or share patient information for personal reasons. You may only obtain/share information that you need to know to do your job.
- You may personally ask the individual you know about their condition, and it is their choice what to share with you.
- You may also ask their permission to share their information with a common friend, but you should never do this without their permission.

"Don't be Curious"

Situation: *You like to look at the patient directory or surgery schedule daily to see if you know anyone.*
- This is not within the scope of your job at this hospital.
- You are in violation of HIPAA laws and Prairie Lakes Healthcare System policies

Respect the Privacy of Patients

Situation: *You are working in an area where caregivers are discussing health information with a patient, a family member, or another caregiver.*

- You can ask if you need to leave the area.
- You may quickly finish your task and leave.
- You must keep any health information you overhear to yourself.

Protect information in your Possession Situation: *In the process of doing your job, you use a list that contains patient names and possibly other patient information.*

- You should keep the information in your possession at all times.
- You should make sure that it is protected from others who would not need the information.
- You can turn it over so the information can't be viewed.
- You should make sure when you are finished with the information that you have disposed of it properly.
- Your supervisor may give you instructions for disposal of PHI.

HIPAA Fundamentals Test

This completes the fundamental overview of the HIPAA regulations. You now know and are responsible for what is required of you as a Job Shadowing/Observation Program Participant
- HIPAA laws also require that we keep a record to show that you have been trained in patient privacy. You should now take the HIPAA FUNDAMENTALS TEST.

Shadowing/Observation Program – HIPAA Fundamentals Test

Name_____Date _____

1. HIPAA stands for:
   a. Health Information Protection Agency Association
   b. Human Instinct Protection Association Awareness
   c. Health Insurance Portability and Accountability Act

2. PHI stands for:
   a. Patient Health Initiatives
   b. Personal Health Institute
   c. Protected Health Information

3. The Privacy HIPAA law became effective:
   a. As soon as everyone in our hospital is trained
   b. April 2002
   c. April 2003
   d. December 2002

4. Patient Information is protected when it is:
   a. Spoken
   b. Written
   c. On the computer
   d. All of the above

5. If you are in a public area and you see PHI in the trash, you should:
   a. Report this to a supervisor
   b. Dispose of it properly
   c. Show it to a friend
   d. Both a.& b.

6. The Privacy Officer is responsible for:
   a. Checking the trash
   b. Pulling medical records of patients
   c. Making sure PLHS protects patient information.

7. You should ask yourself before you view or share patient information:
   a. Is this a personal friend or a relative not under my care?
   b. Will anyone see me reading this?
   c. Do I need this to do my job at PLHS Hospital?

8. Patient information that I use for my job:
   a. Isn't important to anyone else
   b. Should be protected until I have disposed of it properly
   c. Is the responsibility of my manager

9. If I want to know about a friend that I see in the hospital, I should:
   a. Look at their medical record
   b. Ask the nurse
   c. Ask the individual

10. If you see another person violating the HIPAA Privacy Laws or the HH Policies:
   a. You should ask them to stop
   b. Ignore it and mind your own business
   c. Report it to your manager or the privacy office

Shadowing/Observation Program –
Affirmation Statement on Security & Privacy of Information

HIPAA Fundamentals: HIPAA stands for Health Insurance Portability and Accountability Act. HIPAA is a federal law that was enacted in 2003, which protects Protected Health Information or PHI for patients. The law allows for penalties such as fines and/or prison for people caught violating patient privacy.
Protected Health Information, or PHI, is any patient information – whether it is spoken, written, or on the computer. PHI includes health information about patients in the hospital, and it can be as simple as their name. PHI cannot be shared outside of the hospital, even if you see the information in a public area like the trash. If witness PHI being shared, it needs to be reported

Affirmation Statement: I, the undersigned, have read and understand the Prairie Lakes Healthcare System policy on confidentiality of protected health information as described in the HIPAA Fundamentals Policy, which is in accordance with applicable state or federal law.
I also acknowledge that I am aware of and understand the policies of Prairie Lakes Healthcare System regarding the security of protected health information including the policies relating to the use, collection, disclosure, storage and destruction of protected health information. This protection includes proprietary information.
In consideration of my job shadowing/observation program or association with Prairie Lakes Healthcare System, and as an integral part of the terms and conditions of my association, I hereby agree, pledge and undertake that I will not at any time, access or use protected health information, or reveal or disclose to any persons within or outside Prairie Lakes Healthcare System , any protected health information except as may be required in the course of my duties and responsibilities and in accordance with applicable legislation and policies governing proper release of information. I understand that user identification codes and passwords are not to be disclosed (or shared), nor should any attempt be made to learn or use another code.
If I am an instructor, I understand that I assume responsibility for the actions of the students under my supervision to comply with the Security and Privacy of Information Policy.

Corporate Compliance: It is the responsibility of all and those associated with Prairie Lakes Healthcare System to uphold all applicable laws and regulations. Develop an awareness of the legal requirements and restrictions applicable to their respective positions and duties. The hospital has a corporate compliance program to further such awareness and to monitor and promote compliance with such laws and regulations. I am not aware of any violations of applicable laws or regulations and agree to report any violations to the Corporate Compliance Officer. Any questions about the legality or propriety of actions undertaken on or behalf of the Hospital should be referred immediately to the appropriate supervisory personnel, or to the Corporate Compliance Officer.
Excluded Party Status: I affirm that I am not an excluded party from participating in Federal health programs, nor am I under investigation which may lead to such sanctions.
Computer Applications: I further understand that I may be provided access to certain hardware and software applications, some of which may be proprietary to their respective vendors. I agree to keep the hardware and software applications confidential, to not disclose to third parties, and to use such hardware and software applications only for the benefit of Prairie Lakes Healthcare System.

I understand that violation of this affirmation statement could result in disciplinary action up to and including termination of Job Shadowing/Observation contract/ association/appointment, the imposition of fines pursuant to HIPAA, and a report to my professional regulatory body.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

RELEASE OF PATIENT INFORMATION/CONFIDENTIALITY

PURPOSE:

1. To meet internal and external requests for patient health information (PHI), including medical records while maintaining patient confidentiality.

POLICY:

1. Health care professionals, whether medical staff or hospital employees, are bound by both ethics and regulations to respect and protect the patients they care for. Cooperation is essential to balance the patient's right to privacy and well-being with the public's right to know. The right to privacy must be afforded to all patient's regardless of their social, economic or moral qualities.
2. Confidential information to which employees have access is to be used only in the course of their job, whether it concerns patients, their families, or hospital employees. Information about the diagnosis, treatment of care of a patient or an employee is confidential. Release of such information without proper authorization may be cause for immediate dismissal.
3. All users of computerized patient information must sign a Computer User Agreement Form (G-0070a)
4. PHI can be shared with healthcare providers to assure continuum of care.
5. Staff will verify identify of requestors.

PROCEDURE:

1. All medical records are the property of the hospital. The information contained therein belongs to the patient and can be released only after gaining proper authorization, except in rare emergent situations, and subject to the following provisions:
   1.1 After any patient's discharge, the hospital is no longer in a position to disclose information about the patient to the media. All media inquiries should be directed to the patient.
2. Confidential information requires a signed patient authorization in order to be released (see attachment A), except as required by law, statute, regulation or properly issued court orders. Verbal authorization shall be secured from the patient or guardian (after proper identification has been secured, i.e., Social Security number, birth date, etc.), before releasing any confidential information for other than the sole purpose of patient treatment. See also P-108
   2.1 Verbal authorization may be necessary if a written authorization cannot be obtained. If unable to secure the patient's signature and the guardian is not immediately available, hospital staff may obtain verbal permission by calling the guardian. In these cases, two staff members should take part in the telephone conversation; one to secure the authorization and one to witness the conversation. Evidence of the verbal authorization shall be noted in the permanent medical record, signed and witnessed by both staff members. A written authorization shall be sent to the guardian for signature and return to the hospital.
   2.2 When patient cannot sign:
      2.2.1 If the patient is an unemancipated minor, signature must be gained from the parent or guardian.
      2.2.2 If the patient is incompetent, signature must be gained from the guardian or power of attorney.
      2.2.3 If the patient is deceased, the order of signature preference is: Power of attorney, executor, adult spouse, children, parent, siblings.

2.3 Should there at any time be doubt as to the legitimacy of any request, access to any information may be denied until the request is further clarified. Questions shall be referred to the Director of Health Information and Business Office .

3. Medical records shall be removed from the hospital property only in accordance with court order, search warrant, subpoena or as may be required by statute.

3.1 No person shall remove a medical record from the Health Information Department after closing hours. All requests for records after closing hours shall be made through the nursing service, only the house supervisor or designee shall remove records after hours.

4. If a personal representative of a deceased patient has not been appointed, the following surviving family members, in the priority listed, have a right to copies of the patients medical record to the same extent as the patient would have the right to copies of the medical record while still alive.

4.1 The spouse, if not legally separated at the time of patient's death;

4.2 An adult child;

4.3 A parent;

4.4 An adult sibling;

4.5 A grandparent or an adult grandchild

4.6 An adult aunt or uncle, or an adult niece or nephew

4.7 The hospital may request proof of family members relationship to the deceased patient.

5. Physicians: Any physician who is a member of the medical staff of Prairie Lakes Hospital may have access to any medical record of any patient whom he is now treating or has treated in the hospital, in his office or has seen in consultation. This includes access to computerized information.

5.1 If the physician is not caring for the patient, written authorization must be gained from the patient.

5.2 Physicians may use patient information as part of Medical Staff Quality Improvement.

5.3 Physician may use patient information for research purposes, but shall exclude patient identification

PRAIRIE LAKES HEALTHCARE SYSTEM
CONFIDENTIALITY POLICY

When a patient enters the facility, Prairie Lakes Healthcare System assumes an obligation to keep in confidence all that pertains to that patient. Every individual in any capacity at Prairie Lakes Healthcare System shares this responsibility.

Federal and state statutes require our patient records and other patient information be treated as confidential. Persons accessing and/or using this information for purposes other than in performance of assigned responsibilities in the administration of Prairie Lakes Healthcare System programs may be acting in violation of the law.

Persons in training at Prairie Lakes Healthcare System for educational purposes are not to selectively recommend any physician or treatment to a patient/resident/ family members.

The use of automated systems within Prairie Lakes Healthcare System has added another dimension in the safeguarding of confidential material. Any person who is authorized to access the computerized patient record will be issued a confidential password. The use of another person's password is considered unauthorized accessing of the patient record.

Any knowledge of a breach of confidentiality is to be reported to your immediate supervisor who will be responsible for advising the Director of the division involved. This information will then be presented to the Director of Human Resources for review.

Breach in confidentiality by any person in training at Prairie Lakes Healthcare System regarding information about patients, past or present employees will be cause for immediate termination of the training session and disciplinary action.

I have read and understand the above statements. My signature below indicates that I have been educated and training on the importance of confidentiality.

_____

Signature Date

EVALUATION FORM

Thank you for choosing Prairie Lakes Healthcare System as your location to shadow your desired career. Though your time with us was brief, we hope that your time was worth the investment and you were exposed to a variety of different aspects of the career your chose to shadow.

We ask that you take a moment to complete the evaluation below to better prepare future shadowing students for their experience with us. Please return this evaluation form to the Human Resource Department. Thank you again for your input.

What career did you choose to follow at Prairie Lakes Healthcare System?

What was the date of your shadowing experience with us at Prairie Lakes Healthcare System?

Were you appropriately orientated prior to being taken to your department?

Did you feel as if the department you shadowed was prepared for your arrival?

Did you have a good experience shadowing your chosen career at Prairie Lakes Healthcare System?

Would you recommend Prairie Lakes Healthcare System as a place to shadow to others?

Please feel free to share other comments you may have about your shadowing experience:

Prairie Lake Healthcare System
Influenza Vaccine Consent/Declination Form

Print Full Legal Name * of Person to be vaccinated | Date of Birth

Please include middle initial (e.g. William R. Smith)

Please check one:
( ) PLHS Employee - Department:_____
( ) Family Member of - Department _____
( ) Student - School _____

Please review and mark the questions.

Yes No
( ) ( ) Do you have a severe allergy to eggs or egg products?
( ) ( ) Are you allergic to Thimerosal (preservative) other than contact lens sensitivity?
Note: the Fluzone vaccine dose not contain thimerosal.
( ) ( ) Have you ever had Guillian-Barre Syndrome within 6 weeks of taking the flu shot?
( ) ( ) Have you had an anaphylactic (allergic) reaction to the influenza vaccine?
( ) ( ) Are you allergic to latex? Note the Fluzone vaccine does not contain latex.
( ) ( ) Is this the first time you have received the flu shot?
( ) ( ) Are you pregnant? The vaccination is recommended for any woman who will be breastfeeding during the influenza season, or will be pregnant during the influenza season. The vaccination can be administered in the 2nd or 3rd trimester.

If you have had recent chemotherapy, radiation therapy or steroids, the vaccination is still safe and encouraged.

( ) YES, I would like to have the influenza vaccine given to me/my child. I have been provided with the opportunity to read the Vaccine Information Statement. (VIS)

Signature_____Date_____

DECLINE STATEMENT
( ) I am not able to receive the flu shot due to a permanent contraindication List the contraindication:
_____
( ) I am not able to receive the flu shot today because I have a fever / do not feel well. I may be evaluated at a later date and may be able to receive a flu shot at that time.
( ) I have had a flu shot already this year. Date vaccinated:_____Provider:_____

DECLINED: Signature _____Date_____

Influenza (Fluzone)_____Dose_____Lot #_____
Expires_____Manufacturer_____
Site ( ) Left ( )Right Deltoid

Signature:_____(RN) Date_____