

Pre-Rotation Unit Specific Orientation: Clinical Faculty (Nursing & Nursing Related)

Faculty Name: _____ School Name: _____

Unit Name (1 unit per form ONLY): _____ School Course #: _____ Date: _____

Faculty:

- **It is your responsibility to coordinate an orientation date with the Unit Manager for each clinical unit you bring nursing students.** Only an approved facilitator (Manager / or Manager’s Pre-Approved Designee) will orient you to the unit and sign off below.
- Make sure you have received the unit’s float cheat sheet and other unit specific documents to assist in preparing for an optimal rotation on this unit. It is your responsibility to ask questions and understand the limitations on your scope of practice while working in this area.

Facilitator Name (Unit Manager / Pre-approved Designee): _____

- Please complete the following orientation checklist below with the clinical faculty, who is responsible for bringing clinical students to your unit. The purpose of this document is to ensure the clinical faculty’s unit specific orientation (regulatory requirements, life-safety, patient safety and quality expectations and initiatives) is reviewed, acknowledged, and documented for regulatory and auditing purposes. Thank you in advance for helping to ensure that this clinical faculty is prepared to work in your area and provide safe, quality patient care.

Questions/ Remit Form To: NursingAcademics@PrismaHealth.org

| CLINICAL UNIT ORIENTATION | Orientee’s Initials | Facilitator’s Initials |
|--|------------------------|---------------------------|
| <i>*Elements listed are covered in-depth through various methodologies as applicable to content (didactic / discussion, simulation, testing, demonstration, touring)</i> | | |
| Unit Layout | | |
| Overview of Patient Population | | |
| Overview of Roles and Unit Routines | | |
| Fire Safety – location of alarms, extinguishers, exits | | |
| Crash cart – locations | | |
| Patient Call System / Paging Systems | | |
| Clean Supplies/ Omnicell Supply | | |
| Infection control and Dirty Utility Room | | |
| Unit Specific Floor Charge Items and Proc. Trays – <i>if applicable</i> | | |
| Bed/Stretcher Operation | | |
| Hand off Communication Requirements for this unit - BSSR | | |
| Patient Rounds/Expectations | | |
| Review of Unit Specific Procedures / Policy / Clinical Specific Tasks | | |
| Unit Forms (location, process)- <i>if applicable</i> | | |
| Unit Quality and Patient Safety/Patient Experience Expectations and Initiatives | | |
| HIPAA / AIDET / Post Conference Location Opportunities | | |

Faculty Signature: _____ **Date:** _____

Facilitator(s) Signature: _____ **Date:** _____