Thank You for your interest in becoming a Patient Experience Partner at Bluewater Health!

The goal of the Volunteer program at Bluewater Health is to provide quality and continuous support to patients, visitors and staff. In order to do this, volunteers are asked to pick a day and time that they can commit to each week for 2-4 hours. Due to the complex application process, we ask volunteers to commit to volunteering for one year.

Step One: Complete and submit the Volunteer Application Package in full that includes:

- Volunteer application form
- Signed Confidentiality agreement
- 2 complete references. Suitable references include: employers; co-workers; teachers, church leaders; coaches. Please do not use family members as references.
- Current Police Clearance

Volunteer Application Packages may be dropped off at the Welcome Desk just inside the front entrance of Bluewater Health – please make sure a volunteer is present to accept the package. Volunteers are at the desk Monday to Friday from 8:00 a.m. to 4:00 p.m. Packages can also be mailed to: Volunteer Resources, 89 Norman St. Sarnia, ON, N7T 6S3 Attention: Lisa Hendra-Pavey

Step Two: Volunteer Resources will contact the most suitable candidates for each position for interview. Once the interview process is started, you will be required to complete a Pre-Placement Medical Form*** and a Criminal Record Check***. You will also be required to complete a Health Clearance and Two-Step Tb test in our Occupational Health Department.

****Pre-Placement Medical Form**: it is your responsibility to ensure that **all** sections of the Pre-Placement Medical form are completed and signed. **You will need to bring a copy of your immunization record to your Health Clearance appointments.**

***Criminal Record Check:**
Applicants 18 years of age and older must submit a current (*dated within 6 months of application)* Criminal Record Check, including a Vulnerable Sector Search after the interview. Offers of volunteer shifts are conditional upon a satisfactory criminal record check. The hospital is not able to provide reimbursement for the cost of the Criminal Record Check.

Step Three: All successful interview candidates attend a general orientation session of six hours in length.

Step Four: All volunteers will obtain an ID badge (no charge). Volunteers will complete appropriate training for the area they will be volunteering in.

If you have further questions, please contact Volunteer Resources at 519-464-4400 ext. 5406 or send an email to lhendra@bluewaterhealth.ca

Due to the high volume of applications we receive, and the limited number of spots, we are not able to place everyone that applies.

Lisa Hendra-Pavey, Manager
Volunteer Resources & Student Affairs
464-4400, Ext.5406
lhendra@bluewaterhealth.ca

BLUEWATER HEALTH

Application Form for Patient Experience Partners

Last Name	First Name

Home Phone Number	Daytime Phone Number	Cell Phone Number

(Home) Street Address	Apartment Number	
City	Postal Code	Email Address

Date of Birth: Day __ Month __ Year ____ **Language(s) You Speak**: _____

In case of Emergency Notify:

Name	Relationship	Phone Number

Will you allow your contact information to be shared with other Patient Experience Partner members?

Yes ☐ **No** ☐

I am: ☐ **A patient** ☐ **A family member of a patient**

My care provided at Bluewater Health was primarily: (check all that apply)

☐ Hospitalization (inpatient)
☐ Clinic Visit (outpatient)
☐ Both inpatient and outpatient
☐ Emergency Department Care
☐ Other programs, departments, services

The dates of my active care experience at Bluewater Health include: (check all that apply)

☐ 2010 to current year ☐ 2007 – 2009 ☐ 2004-2006 ☐ 2003 or before

Within the past two years, what care services have you or your family member used? (check all that apply)

- ☐ Cancer Care/Oncology
- ☐ Complex Care
- ☐ Diagnostic Imaging
- ☐ Ear, Nose and Throat
- ☐ Emergency Department
- ☐ Endocrinology/Diabetes
- ☐ Eye/Cataract Care
- ☐ Gastroenterology/GI
- ☐ Intensive/Cardiac Care
- ☐ Laboratory Services
- ☐ Mental Health
- ☐ Neurology
- ☐ Nutrition
- ☐ Orthopaedic
- ☐ Palliative
- ☐ Pregnancy/Childbirth/Infant
- ☐ Rehabilitation
- ☐ Surgery
- ☐ Urology
- ☐
- ☐
- ☐
- ☐

Other _____

Why would you like to serve as an Advisor at Bluewater Health?

Please list times when you are available to attend meetings: (Check all that apply)

☐ Day ☐ Evening ☐ Weekend

I/We would be interested in helping with (identify all of your interest areas):

- ☐ Long term advisory council membership to have impact and influence on policies and practices that affect the care and services patients receive.
- ☐ Member of a quality council attached to a specific program eg. Rehabilitation or Surgery
- ☐ Reviewing patient and family satisfaction tools.
- ☐ Developing/reviewing educational materials.
- ☐ Presenting patient stories to groups.
- ☐ Planning for the hospitalization (inpatient) care experience.
- ☐ Planning for the design of systems of care and facilities for the surgical experience.
- ☐ Planning for the clinic (outpatient or ambulatory) care experience.
- ☐ Planning for the design of systems of care and facilities for the emergency care experience.
- ☐ Planning for patient and family resources.
- ☐ Ensuring patient safety and the prevention of medical errors; planning for patient safety week.
- ☐ Educating medical students and residents, new employees, and other staff about the experience of care and effective communication and support.
- ☐ Participating in facility design planning.
- ☐ Improving the coordination of care and the transition to home and community care.
- ☐ Issues of special interest (please describe).
- ☐ Educate future Patient Experience Advisors.

If you have served as an advisor, been an active volunteer committee member, or completed public speaking for other programs or organizations, please briefly describe this experience:

What are some things that health care professionals did or said that was most helpful to you/your family?

What are some specific things that you or your family would like health care professionals to do *differently* in order to be more helpful?

REFERENCES: Please list two people:. The address, phone number and email (if available of the individual providing the reference must be included. No family members please.

1

Name:	Relationship:
Address:	Postal Code:
Phone:	Email:

2

Name:	Relationship:
Address:	Postal Code:
Phone #:	Email:

Have you been convicted of an offence in respect of which a pardon has not been granted, under the Criminal Records Act and has not been revoked:
Yes___ No ___ (Ontario Human Rights Code)

In applying to perform duties for Bluewater Health at the Sarnia or CEEH Site, as a volunteer, I do fully understand and agree to the following:

- I understand and agree that the hospital will request information from the above references. I authorize my references to release all information as requested.
- That I will not receive any remuneration, salary, wage or payment or any employee benefit whatsoever, or be covered by Worker's Compensation Benefits.
- That except as authorized, I will not use the hospital's facilities and equipment or disclose or make any use of any confidential information (staff conversations included).
- That I acknowledge that volunteer work may involve personal risk and could result in personal injury. I hereby release the Hospitals from all claims for said damage or injury resulting from my participation as a volunteer, unless such damage or injury is caused by the negligence of the Hospitals.
- That I understand that the Hospitals carry liability insurance, which would, subject to the conditions of the policy, cover me in the event of a claim arising out of the good faith performance of authorized volunteer duties at the Hospitals.
- That I agree to accept the responsibility of wearing, caring for and returning the volunteer uniform, at the conclusion of my volunteer experience.

By signing this form, I acknowledge having read, understood and agreed to the above conditions, release and waiver.

_____ _____

Volunteer Witness

Date: _____

BLUEWATER HEALTH

Confidentiality Agreement

Please print
Last Name: _____ **First Name:** _____

Department: _____ **Extension:** _____

Position: _____ **Supervisor:** _____

I acknowledge that I have read and understood the Bluewater Health policy and procedure on privacy, confidentiality and security.

I understand that:

- all confidential and/or personal health information that I have access to or learn through my employment or affiliation with Bluewater Health is confidential,
- as a condition of my employment or affiliation with Bluewater Health, I must comply with these policy and procedure, and
- my failure to comply may result in the termination of my employment or affiliation with Bluewater Health and may also result in legal action being taken against me by Bluewater Health and others.

I agree that I will not access, use or disclose any confidential and/or personal health information that I learn of or possess because of my affiliation with Bluewater Health, unless it is necessary for me to do so in order to perform my job responsibilities. I also understand that under no circumstances may confidential and/or personal health information be communicated either within or outside of Bluewater Health, except to other persons who are authorized by Bluewater Health to receive such information.

I agree that I will not alter, destroy, copy or interfere with this information, except with authorization and in accordance with the policy and procedure.

I agree to keep any computer access codes (for example, passwords) confidential and secure. I will protect physical access devices (for example, keys and badges) and the confidentiality of any information being accessed.

I will not lend my access codes or devices to anyone, nor will I attempt to use those of others. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. If I have reason to believe that my access codes or devices have been compromised or stolen, I will immediately contact my direct supervisor.

I understand that the Hospital will monitor confidentiality by:

- Performing random reviews of patient charts
- Reviewing my use of the health care information system when necessary

Please sign, date and return to Volunteer Resources, Norman Site. Thank you.

_____ _____

Signature **Date Reviewed**

OCCUPATIONAL HEALTH AND SAFETY DEPARTMENT

COMMUNICABLE DISEASE SURVEILLANCE PROTOCOLS

( ) VOLUNTEER ( ) CO-OP STUDENT ( ) OTHER PLACEMENT

NAME: _____ ***PHONE:*** _____-_____
ADDRESS: _____
_____
_____

DATE OF BIRTH: ____/____/____ **HEALTH CARD #:** _ _ _ _ _ _ _ _ _ _ _ _
YY MM DD

FAMILY PHYSICIAN: _____

DEPARTMENT: _____

DATES OF PLACEMENT: (IF APPLICABLE) ____/____/____ **TO** ____/____/____
YY MM DD YY MM DD

PERSON TO CONTACT IN CASE OF EMERGENCY:

_____
(NAME)

_____
(RELATIONSHIP)

_____-_____ _____-_____
(HOME PHONE) (WORK PHONE)

	YES	NO
Do you have allergies?		
If yes, please list: _____ _____		
Do you have any physical disability that requires accommodation by the workplace? If yes please explain_____		
In the event of an emergency evacuation, would you require assistance in leaving the building?		
If yes, an accessibility plan needs to be developed with the placement manager.		

COMMUNICABLE DISEASE SURVEILLANCE PROTOCOLS

The following information is required to comply with the Communicable Disease Surveillance Protocols for Ontario Hospitals, under the Public Hospitals Act.
Please complete the applicable area in each section. The completed form is to be submitted to the Occupational Health and Safety Department.

IMMUNIZATION RECORD:

- **Rubella (considered immune to Rubella if):**
  - ☐ Laboratory evidence of immunity: TITRE date : _____(attach result), **or**
  - ☐ Documentation of immunization with live rubella vaccine on or after first birthday
  - ☐ VACCINATION DATE: _____
- **Measles: One of the following is accepted as proof of measles immunity, please ✔ the appropriate:**
  - ☐ Documentation of receipt of 2 doses of live measles virus vaccine on or after the first birthday: _____ **or,**
  - ☐ Laboratory evidence of immunity: (attach result) DATE: _____
- **Mumps: One of the following is accepted as proof of mumps immunity, please ✔ the appropriate:**
  - ☐ Documentation of receipt of 2 dose of mumps vaccine (or trivalent measles-mumps-rubella (MMR) vaccine) on or after the first birthday **or,**
  - ☐ Laboratory evidence of immunity (attach result) DATE: _____
- **Varicella/zoster:** History of disease: ☐ No (see below), ☐ Yes , if yes provide history of disease and date, if possible:

  _____

  ☐ **If unknown or no history of Varicella, titre is required**:
  Laboratory evidence of immunity required : TITRE: _____DATE: _____(report attached)
  Varicella vaccine is recommended for all non-immune staff.
- **Tetanus/Diptheria**
  - ☐ VACCINATION DATE:_____

  Tetanus/ Diptheris/Pertussis (Tdap) Vaccination Date _____

TUBERCULOSIS: History of disease: ☐ No ☐ Yes DATE: _____
Prophylactic Treatment: ☐ No ☐ Yes DATE: _____ **BCG**: ☐ No ☐ Yes DATE: _____

A) Mantoux skin test status, unknown or previously identified as tuberculin negative:
A 2-step mantoux skin test PPD/5TU is required.
1st Test DATE GIVEN**:** _____ Lot # _____ Expiry date: _____ Result: ☐ Positive ☐ Negative
2nd Test DATE GIVEN**:** _____Lot # _____ Expiry date: _____Result: ☐ Positive ☐Negative

B) Documentation of results of a prior 2-step PPD test, in which case a single mantoux skin test PPD/5TU is required. DATE GIVEN:_____ Result: ( ) Positive ( ) Negative
Documentation of a negative PPD within the last 12 Months Date given: _____
2 or more documented negative PPD at any time but the most recent was > 12 months Date Given _____.

C) History of BCG vaccine: a history of BCG vaccine is <u>not</u> a contraindication of tuberculin testing, person needs further evaluation. Review policy. Review contraindication list for mantoux testing, listed in policy. Do not give to individual if any of the contraindications met.

Mantoux test positive: ( ) Yes ( ) No. If no, evaluate with two-step Mantoux.

If person has not had a mantoux test in the last several years, they should be evaluated with a two-step skin test.

If contraindicated, do not give mantoux.

If Chest X-ray is required. The Occupational Health and Safety Department will arrange this through the direction/order of the Occupational Health physician or the individual's physician.

Chest X-ray Appointment: DATE _____ TIME: _____

If you have any questions pertaining to the required information, please contact the Occupational Health and Safety Department at Ext. 4420

_____ _____

Signature of person completing form YY/MM/DD Nurse Signature YY/MM/DD

REQUIRED SURVEILLANCE TESTING
INFORMATION SHEET

TUBERCULOSIS SURVEILLANCE:

a) Two step mantoux skin tests are required on individuals whose **tuberculin status** is **unknown**, and those **previously** identified as tuberculin **negative**, require a baseline two-step Mantoux skin test with PPD/5TU, unless there is documentation of a negative PPD test during the preceding 12 months in which case a single-step test may be given. Or 2 or more documented negative PPD at any time but the most recent was > 12 months.

b) Individuals who have had a **previous Bacille Calmette-Guerin (BCG)** vaccine may still be at risk of infection and should be assessed as in (a) above. Individuals with a history of BCG vaccine who are tuberculin skin test negative, or who have not had a Mantoux test in the last several years should also be evaluated with a two-step skin test. (A history of BCG vaccine **is not** a contraindication to tuberculin testing unless there is a history of severe reaction with blistering following the test.)

c) For individuals who are **known** to be **tuberculin positive**, or for those who are tuberculin skin test positive when tested in (a) or (b) above, further assessment should be done by the Occupational Health Service (OHS) under the direction of a physician, or by the individual's personal physician. Chest x-rays should be taken on individuals who have:
   i) never been evaluated for a positive Mantoux skin test or for tuberculosis;
   ii) had a previous diagnosis of tuberculosis but have never received adequate treatment for tuberculosis; or
   iii) pulmonary symptoms that may be due to tuberculosis.

If the X-ray suggests pulmonary TB, the individual should be evaluated to rule out the possibility of active disease and documentation of the results of the evaluation should be in place before he/she is cleared for work.

MEASLES SURVEILLANCE:

The following information is required:

- Documentation of receipt of 2 doses of live measles virus vaccine on or after the first birthday, or
- bLaboratory evidence of immunity

MUMPS SURVEILLANCE:

The following information is required:

- Documentation of receipt of 2 does of mumps vaccine (or trivalent measles/mumps/rubella (MMR) vaccine on or after the first birthday, or
- Laboratory evidence of immunity

RUBELLA SURVEILLANCE:

The following is required:

- Documented evidence of immunization with live rubella vaccine on or after their first birthday, or
- Laboratory evidence of rubella immunity

VARICELLA/ZOSTER (CHICKENPOX/SHINGLES) SURVEILLANCE:

The following is required:

Documentation of a definite history of chickenpox, zoster, or

If no history and working in high risk areas such as paediatrics, obstetrics, nursery, neonatal intensive care unit or oncology, a blood test is required to determine whether they have had chickenpox.

TETANUS DIPHTHERIA and TETANUS DIPTHERIA PERTUSSIS:

Tetanus Diphtheria is indicated for adults who have been previously immunized against Tetanus and Diphtheria.

Tetanus Diphtheria is required every 10 years. The current Pertussis immunization status is to be determined. The current status of each health care worker is to be documented and updated if required.

BLUEWATER
HEALTH

Sarnia Police Department
Lambton O.P.P. Detachments

To Whom It May Concern,

This letter verifies that _____ has applied to be a registered volunteer or to complete a student placement at Bluewater Health.

Volunteers and students could be working with persons who are considered vulnerable. We require all volunteers and students to obtain a release of any information related to criminal activity. ***Please provide a routine and vulnerable police check for this individual.***

Sincerely,

Lisa Hendra-Pavey

_____

Lisa Hendra-Pavey,
Manager, Volunteer Resources & Student Affairs
(519) 464-4400 Ext. 5406

** NOTE: Police checks at the Sarnia Police Department can be processed: Monday to Friday from 8:00 am. - 4:30 pm.