Clinical Observation and Apprenticeship Experience

I. **Policy Statement**: Under the direct supervision of a director, manager, or a designee, Saint Alphonsus permits qualified Observers to participate in a clinical or business/management observation/shadowing experience. Such persons will be processed through the director, manager or designee of the Observer's desired unit/department, according to the procedures outlined below.

II. **Definitions:**
   A. For purposes of this policy, "Observation and Shadowing Experience" is defined as an authorized, approved, designated time period spent with 1) a physician, clinician, therapist or associated personnel; or 2) business or management personnel (including, but not limited to, Finance, PR/Marketing, Foundation, Quality Improvement, Materials Management, Health Information Management) in order to obtain an understanding of the challenges, demands and lifestyles of the profession.
   B. Observer is defined as a student seeking to observe/shadow clinical or non-clinical professionals in the hospital or clinic setting.
   C. This policy does not apply to Students in a Clinical Rotation based upon an Educational Affiliation Agreement between Saint Alphonsus and the Student's Educational Institution.

III. **Equipment**: None.

IV. **Procedure**:
   A. **General Procedures**
      1. All inquiries about an observation/shadowing experience are to be referred to the director, manager or designee of the unit/department/clinic of interest to the prospective Observer.
      2. The director/manager or designee will approve and schedule, through direct communication with the prospective Observer, participation in the observation/apprenticeship experience.
      3. Observation for provider shadowing is limited to two (2) twelve-hour or six (6) four-hour periods for a maximum of 24 hours.
         a. Observers are permitted to return to the facility for an additional observation experience.
         b. (Length of time spent in observation may be adjusted at the discretion of the manager.)
      4. Observation for an apprenticeship of several weeks or months, must have specific dates, course of study, hours and supervisor signature indicating approval on checklist.
B. Observation/Shadowing Requirements
   1. Observers in the Operating Room, Emergency Department, ICU, or any other trauma-related care area must be a minimum of 18 years of age.
   2. Observers in units/departments (other than those referenced in B.1) must be a minimum of 16 years of age.
   3. Observers must show manager/designee proof of a negative TB test (at their expense) within last 12 months.
   4. Flu shot verification must be obtained if shadowing/observing at a SAHS hospital or clinic between November 1 and March 31.
   5. Observers must provide manager/designee an approval statement or letter signed by a school official, if applicable, sanctioning the observation and time period and dates.
   6. Observers will wear an ID badge at all times.
      a. Observers will bring a clear photo ID (student ID/driver's license) and have it verified by the manager at the start of the observation experience.
      b. It is the manager/designee's responsibility to ensure the photo ID is worn by the Observer in the badge sleeve at all times during the observation in a clear sleeve on a lanyard.
   7. Observer will dress appropriately in business-casual attire
   8. Observer must complete checklist prior to start date
   9. Documents verifying items 1 through 7 as noted above will be retained at the Office of Medical Affairs for a period of six (6) years.
   10. Student must provide: completed checklist with provider's signature; TB Test Results; Flu Shot verification (between November 1 and March 31); signed confidentiality agreement; and school confirmation letter, if applicable, to the unit/department/clinic before observation/shadow can be done.

C. Confidentiality/Privacy and Security Procedures:
   1. The physician, nurse, or other attending care provider must obtain a verbal consent from each patient to have the Observer present and document the consent in Progress Notes of the patient's medical record.
      a. The documentation must be done by the physician or clinician who obtained the consent.
      b. It is acceptable to ask consent once, per patient/per shift, for EACH Observer in the unit/department.
   2. At no time will an Observer have direct physical contact with a patient.
   3. At no time will an Observer be left alone in a non-public area for any reason.
   4. At no time will an Observer access electronic or paper medical record.
   5. At no time will Observers access Saint Alphonsus' computer systems or any business sensitive information in hard copy.
   6. At no time will Observer participate in patient care in any way, including touching or handling of instruments.
D. Documentation Retention
   1. All documents required under this policy (See B.1 through B.9 above) will be sent to the Office of Medical Affairs and retained for a minimum of six (6) years from its effective date.
   2. No documents will be destroyed before consultation with the Privacy Officer and/or legal counsel.

E. Contact for Questions
   1. Office of Medical Affairs

V. Related Policies/Forms: None.

VI. References: None.

VII. Approval Committee(s): None.
CLINICAL OBSERVATION EXPERIENCE - ADMINISTRATIVE POLICY

Process Check List

Observer Name and Phone Number
__________________________________________________________

Name and Phone Number of person being Observed/Shadowed
__________________________________________________________

Signature of person being Observed/Shadowed
__________________________________________________________

Location (Site name and Address) of Observation/Shadowing
__________________________________________________________

Date(s) and hours of Observation/Shadowing
__________________________________________________________

I. Observer/Shadower Requirements

___ Must be 16 YOA; 18 for OR, ED, ICU or other trauma-related area

___ Proof of negative TB test within last 12 month period – must attach proof

___ Confidentiality and Network Access Agreement (CA): - must attach form (SAHS provides)

___ Current Flu Shot verification if observing between November 1 and March 31 – must attach proof

___ Approval statement or letter signed by school official, if applicable; and parent(s) for Observers under 18 YOA

II. Hospital Manager, Clinic Manager or Designee Responsibilities Prior to Observation/Shadowing Experience

___ Verify Photo ID of Observer and age; and that photo ID is worn during Observation/Shadowing

___ Verify appropriate mandatory education is provided to Observer (See attached education tool)

___ Collect checklist and supporting documentation
For Clinic Observations/Shadowing: A copy of the check list and supporting documentation must be turned in to SAMG clinic/department manager prior to observation/shadow. Original paperwork must be submitted to the Office of Medical Affairs for record retention.

For Hospital Observations/Shadowing: Check list and supporting documentation must be turned into Office of Medical Affairs prior to observation/shadowing for approval and record retention.

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December 2018
Clinical Observation Mandatory Education

Privacy & Security Practices (HIPAA)
Why We Do What We Do
HIPAA Privacy and Security compliance within the Saint Alphonsus organization is grounded in our Mission, Core Values, and Standards of Conduct:

1. Respect
2. Justice
3. Compassion
4. Excellence
5. Stewardship
6. and OIP Standards of Conduct “Respecting Right Relationships”

It takes a long time to gain a person’s trust but only a moment to lose it.

PHI: Protected Health Information & Patient Identifiers

Protected Health Information (PHI) is information related to a person’s health care treatment and the corresponding payment for those services. PHI includes 18 patient identifiers + sensitive health information.

"Patient Identifiers"
- Names - Account #
- Street Address - Certificate/License #
- Dates (birth, DOS) - Vehicle ID
- Telephone/Fax - Device ID
- E-mail - URLs
- SS # - IP Address
- MR # - Full face/biometric ID
- Health plan # - Any unique identifier

"Sensitive Health Information"
1. Diagnosis
2. Procedures
3. Medications
4. Physician name & specialty
5. Location of Service (e.g., FMC, CCC, ICU)
6. Service Type (e.g., radiology, in-patient)
7. Test Results
8. Amount charged and paid

Note:
Any one or combination of the above items is considered to be “Protected Health Information” or “PHI” under HIPAA regulations.

Disclosure of PHI includes places such as social networks sites like Face Book, My Space, Twittering, and blog site – any public network site. Posting patient-related information on these sites is a violation of the Non-Workforce Confidentiality Agreement.
Enterprise-Wide Security
1. At no time will an observer access electronic or paper patient information.
2. At no time will an observer access electronic or paper business sensitive information.
3. Observers will sign a *Confidentiality and Network Access Agreement* that will be kept on file for a period of six years.
4. Observers will wear an ID badge at all times while in the facility.

Infection Control
1. Standard Precautions
2. Avoid exposure to all body fluids unless Personal Protective Equipment is being used
3. Hand washing is the single most important procedure for preventing infections
4. If It Is Wet And It Is Not Yours – DON'T Touch it!!

Fire Safety
1. For fire, SIGNAL F will be paged overhead. Follow R.A.C.E.:
   - R – Rescue
   - A – Alarm (pull fire alarm and dial 555)
   - C – Contain (close doors and windows)
   - E – Extinguish or Evacuate
2. For Fire Extinguisher Use follow P.A.S.S.:
   - P – Pull pin
   - A – Aim nozzle at fire base
   - S – Squeeze handles together
   - S – Sweep nozzle from side to side

Cell Phones & Photography
1. Cell phones and cell-phone-like devices may potentially cause interference with the safe operation of medical equipment. Cell phones may only be used in designated areas in the hospital
2. Photographs of patients and staff may not be taken via camera-phones or portable video-equipment.

Smoking / Tobacco Use
1. No one is allowed to smoke or use any tobacco product anywhere on the hospital’s property (including parking lots, sidewalks, roads, landscaped areas and cars).

Security Services
1. Contact Security by dialing 3232 or pager 855-7442 for assistance with
   a) Unruly patients, visitors, staff
   b) Building access
   c) Vehicle assistance / towed vehicle
   d) Door keys/swipe cards
   e) Lost & Found
2. Dial 555 if there is an immediate safety or security threat
TRINITY HEALTH
CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT

The following rules for Confidentiality and Network Access apply to all non-public patient and business information (Confidential Information) of Saint Alphonsus Health System (SAHS), Trinity Health, and related organizations. The rules also apply to the non-public and business information of joint ventures, or of other entities and persons collaborating with Saint Alphonsus Health System and Trinity Health, to which the user has access. As a condition of being permitted to have access to Confidential Information relevant to my job function or role I agree to the following rules:

1. Permitted and required access, use and disclosure:
   - I will access, use or disclose Confidential Patient Information (PHI) only for legitimate purposes of diagnosis, treatment, obtaining payment for patient care, or performing other health care operations functions permitted by HIPAA and I will only access, use or disclose the minimum necessary amount of information needed to carry out my job responsibilities.
   - I will access, use or disclose Confidential Business Information only for legitimate business purposes of Saint Alphonsus Health System or Trinity Health.
   - I will protect all Confidential Information to which I have access, or which I otherwise acquire, from loss, misuse, alteration or unauthorized disclosure, modification or access including:
     - Making sure that paper records are not left unattended in areas where unauthorized people may view them;
     - Using password protection, screensavers, automatic time-outs or other appropriate security measures to ensure that no unauthorized person may access Confidential information from my workstation or other device;
     - Appropriately disposing of Confidential Information in a manner that will prevent a breach of confidentiality and never discarding paper documents or other materials containing Confidential Information in the trash unless they have been shredded;
     - Safeguarding and protecting portable electronic devices containing Confidential Information including laptops, smart phones, PDAs, CDs, and USB thumb drives.
   - I will disclose Confidential Information only to individuals, who have a need to know to fulfill their job responsibilities and business obligations.
   - I will comply with Saint Alphonsus Health System /Trinity Health's access and security procedures, and any other policies and procedures that reasonably apply to my use of the computer systems and/or my access to information on or related to the computer systems including off-site (remote) access using portable electronic devices.

2. Prohibited access, use and disclosure:
   - I will not access, use or disclose Confidential Information in electronic, paper or oral forms for personal reasons, or for any purpose not permitted by Saint Alphonsus Health System /Trinity Health policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at Saint Alphonsus Health System to gain access to my own PHI in medical and other records.
   - I will not use another person’s, login ID, password, other security device or other information that enables access to Saint Alphonsus Health System/Trinity Health's computer systems or applications nor will I share my own with any other person.
   - If my employment or association with Saint Alphonsus Health System/Trinity Health ends, I will not subsequently access, use or disclose any Saint Alphonsus Health System/Trinity Health Confidential Information and will promptly return any security devices and other Trinity Health property.
   - I will not engage in any personal use of Saint Alphonsus Health Systems’ computer systems that inhibits or interferes with the productivity of employees or others associated with Saint Alphonsus Health System/Trinity Health's operations or business, or that is intended for personal gain;
I will not engage in the transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission, values, policies or procedures of Saint Alphonsus Health System/Trinity Health;

I will not utilize the Saint Alphonsus Health System/Trinity Health network to access Internet sites that contain content that is inconsistent with the mission, values and policies of Saint Alphonsus Health System/Trinity Health.

3. Accountability and sanctions:

I will immediately notify the Saint Alphonsus Health System/Trinity Health Security Official or Privacy Official if I believe that there has been improper/unauthorized access to the Saint Alphonsus Health System/Trinity Health network or improper use or disclosure of confidential information in electronic, paper or oral forms.

I understand that Saint Alphonsus Health System/Trinity Health will monitor my access to, and my activity within, Saint Alphonsus Health System/Trinity Health’s computer system, and I have no rightful expectation of privacy regarding such access or activity.

I understand that if I violate any of the requirements of this agreement, I may be subject to disciplinary action, my access may be suspended or terminated and/or I may be liable for breach of contract and subject to substantial civil damages and/or criminal penalties.

If I lose my security device I will report the loss to the Trinity Health Resolution Center immediately and I may be charged for its replacement.

4. Software use:

I understand that my use of the software on Saint Alphonsus Health System/Trinity Health’s network is governed by the terms of separate license agreements between Trinity Health and the vendors of that software.

I agree to use such software only to provide services to benefit Trinity Health.

I will not attempt to download, copy, or install the software on any other computer.

I will not make any change to any of Trinity Health’s systems without Trinity Health’s prior express written approval.

5. Network:

I understand that access to Saint Alphonsus Health System/Trinity Health’s network is “as is”, with no warranties and all warranties are disclaimed by Trinity Health.

Trinity Health may suspend or discontinue access to protect the network or to accommodate necessary down time. In an emergency or unplanned situation Trinity Health may suspend or terminate access with out advance warning.

Trinity Health may terminate this agreement, user access and use of Confidential Information at any time for any reason or no reason.

6. Employer acceptance of responsibility for an individual with access to Confidential Information:

(Applies to physicians/physician practices; other individual or facility providers; a vendor that is not a business associate; payers; any other unaffiliated organization).

I accept responsibility for all actions and/or omissions by my employees and/or agents

I agree to notify the Trinity Health Resolution Center within 5 business days if any of my employees or agents who have access to Trinity Health systems or applications no longer need or are eligible for access due to leaving my practice/company, changing their job duties or for any other reason.

I agree to report any actual or suspected privacy or security violations made by my employees and/or agents to the Saint Alphonsus Health System/Trinity Health Privacy Official or Security Official.

I understand that Saint Alphonsus Health System/Trinity Health may terminate my employee and/or agent’s access.
I am a: (Please check all that apply to you)

- Associate (employee) with Saint Alphonsus Health System
- Physician Credentialed on (Saint Alphonsus Health System) Medical Staff
- Volunteer at the Saint Alphonsus Health System Facility
- Temporary/Contractor at the Saint Alphonsus Health System Facility: (name of agency) __________________________
- Student at Saint Alphonsus Health System: (name of educational organization) _________________________________
- Employed by or Associated with a Saint Alphonsus Health System Credentialed Medical Staff Member
  - Medical Staff Member’s Employee or Temp Staff (name of practice) ___________________________________________________________________________
  - Medical Staff Member’s Vendor’s Employee (name of vendor) ________________________________________________________________________________
- Vendor Providing Goods or Services to Saint Alphonsus Health System
  - Employee/Temp Staff of SAHS clinical services vendor: (name of vendor) _______________________________________________________________________
  - Employee/Temp Staff of SAHS business services vendor: (name of vendor) ______________________________________________________________________
  - Employee/Temp Staff of SAHS IT services vendor: (name of vendor) __________________________________________________________________________
- (Saint Alphonsus’ Joint Venture or a Facility Managed by Saint Alphonsus Health System
  - Employee of a SAHS Joint Venture (name of joint venture) _________________________________________________________________________________
  - Employee of a Hospital/Other Facility Managed by SAHS (name of facility) ___________________________________________________________________
  - Credentialed Physician on Medical Staff of a Hospital/Other Facility Managed by SAHS: (name of facility):
  - Employee or Temp Staff of a Credentialed Physician on the Medical Staff of a Hospital/Other Facility Managed by
    SAHS: (name of physician’s practice) _________________________________________________________________________________________________
- Other
  - Unaffiliated (non-credentialed) Physician/Other Provider: (name of practice) __________________________________________
  - Employee of an Unaffiliated Physician or Facility: (name of practice or facility) _____________________________
  - Employee of a Payer: (name of payer) _________________________________________________________________________________
  - Researcher (Research study name): __________________________________________________________________________________________
  - Other (name of employer) ________________________________________________________________________________________________

USER SIGNATURE

If there are any items in this agreement that I do not understand I will ask my Saint Alphonsus supervisor or other appropriate Saint
Alphonsus contact person for clarification. My signature below acknowledges that I have read, understand and accept this agreement
and realize it is a condition of my employment or association with Trinity Health. I also acknowledge that I have received a copy of the
Confidentiality and Network Access Agreement.

Print Name                                             Signature of individual to be given access                                         Date

EMPLOYER SIGNATURE (Required)

When user is an employee or agent of: a physician/physician practice; other individual or facility provider; a vendor that is not a
business associate; any other organization unaffiliated with Saint Alphonsus Health System or Trinity Health. My signature below
acknowledges that I have read, understand and accept my responsibilities as the employer or the sponsor of the user who has signed
this agreement above.

Print Name

Signature of employer of the individual to be given access                                    Date

Please return the original document to your local OTE/HR Department.