[X]	UCH/ENTERPRISE
[ ]	UCMC
[ ]	WCH
[ ]	DRAKE – LTCH
[ ]	DRAKE – BWP
[ ]	DRAKE – SNF
[ ]	DRAKE – OUTPATIENT
[ ]	AMBULATORY/UCPC
[ ]	LEGAL/COMPLIANCE
[ ]	MEDICAL STAFF
[ ]	MEDICATION MGMT
[ ]	OTHER

POLICY

POLICY #	**UCH-ADM-010-02**
POLICY NAME	**Observation of Patient Care**
ORIGINATION DATE	**05/01/2005**
SPONSORED BY	**Alex Terhar Maus, MPAS** **UC Health- Clinical Placement Project Manager**
SPONSORED BY	**Philip Diller, MD, PhD** **UC Health – VP for Education**
ADMINISTRATIVE APPROVAL	**Clarence Pauley** **SR VP- Chief HR Officer**
LAST REVIEW / REVISION DATE	**11/20/2019** **NEXT REVIEW DATE** **11/20/2022**

I. POLICY

[X] Administrative [ ] Interdepartmental [ ] Departmental [ ] Unit Specific

UC Health has established requirements related to patient safety, confidentiality, regulatory requirements, and patient rights for any individual observing patient care. Individuals who request to observe patient care must abide by these requirements. Management has the right to revoke permission for observation at any time.

II. PURPOSE

This policy establishes documentation requirements for observation, methods of approval, and identification of individuals who have been granted permission for an Observation Visit.

This Observation of Patient Care Policy is designed for short-term observation by individuals who are not UC Health associates and who are not approved through educational or clinical services contracts.

This policy covers Job Shadowing for individuals who are applying for positions within one or multiple units or divisions within UC Health. The requirements need to be met by any individuals who will be Job Shadowing for 3 days or less.

III. DEFINITIONS

None

IV. PROCEDURE

A. Guidelines

1. The following guidelines must be followed at all times:
    a. The provider is responsible for determining the appropriateness of the observing experience for the Observer.
    b. The provider is responsible for obtaining verbal permission from the patient to have an Observer present during the patient's medical discussions and procedures/surgeries.
    c. Patient rights and patient safety always have primary consideration. Observation may be rescinded at any time if determined to be detrimental to patient safety or patient rights.
    d. There must be a valid reason for request. Observation is not designed to circumvent established Medical Staff or Human Resources policies and processes.
    e. Observations should be done in patient care areas, as we are an academic health center.
    f. All applicants must provide information as requested by the organization prior to Observation Visit
    g. The manager in coordination with the Medical Director of the unit where the observation will occur must approve the request prior to the Observation Visit.
    h. An Observation Visit is designed to be a short-term event. Requests are divided into two categories: 3 days or less and 4 days or greater, not to exceed 30 days.
    i. The Observer must wear a UC Health photo ID Observer Badge clearly identifying individual as an observer. Observation Badges will not have any hospital access coded into the badge.
        1) For inpatient: observer will receive a badge through the appropriate badging office (UCMC, WCH, or Drake); not to exceed 30 observation days
        2) For ambulatory
            a) Hospital Based Clinics: observers will receive a badge through the appropriate hospital badging office (UCMC, WCH, or Drake)
            b) Professional Practices: if the observer is observing on a hospital campus (UCMC, WCH, Drake), badge will be issued at the campus badging office; if the observer is observing at a satellite campus, UC Health Parking and Badging on the UCMC campus will provide the badge. Exceptions for badging at

satellite campuses can be made by the Vice President of Education or designee.

j. A log of approved Observation Visitors will be kept in a central location in the UC Health Department of Education or appropriate location.

k. Observation by family members of associates in the same work area of the associate is discouraged, unless arranged through one of the approved alternate processes or part of a group visit approved by Human Resources Director at the site.

l. Exceptions to these guiding principles must be approved by the Vice President of Education or designee.

m. Observers must be at least 16 years of age. (Appendix E must be complete if under the age of 18.)

n. Observer should be accompanied by a UC Health associate at all times during the visit.

B. Alternate Processes for Observation Requests

1. Forms and information about the Observation requests will be available on the intranet. In some situations, alternate processes exist. However, all observation visits regardless of approval process, must follow the guidelines listed above. Any exceptions must be approved by a member of UC Health Senior Leadership.
2. Alternate Approval Processes include but are not limited to:
   a. **Community Groups/High School Student Groups** visits are coordinated through Community Relations. Contact **Community Relations at 513-585-8124** for more information.
   b. **Student in any professional training programs**: Students currently enrolled in an educational program requesting a rotational opportunity at UC Health must be in a program that has a fully executed Clinical Affiliation Agreement with UC Health. Human Resources maintains a listing of all approved educational programs. **Contact UC Health Department of Education HR 513-585-5320. T**he sponsoring or supervising physician must be a member of the UC Health Medical Staff at the appropriate location.
   c. All other requests should be submitted directly to the hospital manager in the area where the observation will occur, following the procedure listed below. **Contact UC Health Department of Education 513-585-5320** if you are unsure who would be the appropriate approving manager.
3. The following categories are also not observers and should follow the corresponding policy:
   a. Clinical Research Assistant
   b. Provider with Temporary Privileges
   c. Public Media/Photography
   d. Vendors and other Health Care Industry Representative

V. RESPONSIBILITY

A. Notification

1. All individuals who wish to observe patient care must notify the appropriate department manager in advance of the planned visit, and submit the required information and documentation at least one week before visit to the UC Health Department of Education for approval.
    a. The documentation is broken down into two groups: less than or equal to 3 days of observation in UC Health or greater than or equal to 4 days, but less than 30 days of observation in UC Health. If greater than 30 observation days is requested, please contact the UC Health Department of Education for Vice President approval.

B. Documentation Requirements

1. All requests for observation must contain the following information on the appropriate forms at least one week prior to the observation.
    a. Appendix A – Observer Request Form
        1) Name, date of birth
        2) Contact information – phone and email
        3) Reason for Observation
        4) Number of Days Observing in UC Health
        5) Start/End Dates of Observation
        6) Area/Unit/Clinic to be observed
        7) Provider/Clinician observing and their contact information
        8) Approval of manager in the area to be observed
        9) Photocopy of Government Identification Document/Passport
        10) Copy of flu vaccine documentation October 1st – March 31st
        11) TB Attestation, if observing 3 days or less and no risk factors; TB documentation within the last 12 months, if 4 days or greater or risk factors
    b. Appendix C – Signed Observer Consent and Release includes statements regarding:
        1) Signed Confidentiality and Date Security Agreement form for contractors and non-employees (Appendix D)
        2) Right of hospital to revoke permission without appeal
        3) Acknowledgement that they will leave if requested by hospital manager
        4) Acknowledgement to abide by visitor restriction policy for illness
        5) Acknowledgement of being free of communicable diseases and appropriate vaccinations
        6) Liability release
    c. Appendix C - Signed consent and release by the sponsoring staff outlining the responsibilities of the staff. The consent will indicate the staff who is responsible for obtaining patient consent for observation.
    d. Specific types of requests may require additional documentation

1) Visitor must 16 years of age or older. Parental consent must be obtained for anyone under the age of 18. (Appendix E)
2) Requests from individuals outside of the U.S. must include documentation of immunizations as requested.

C. Approval Process

1. All requests must be approved by the manager in the department to be observed, by the staff member responsible for the activity of the observer while in a UC Health facility and by the staff responsible for obtaining patient consent. Managers will evaluate requests for visits for those under the age of 18 on a case-by-case basis, consistent with specific departmental policies.
   a. The request form must be submitted by a member of management of the area to be observed. Each area will define the appropriate person to receive the initial request.
   b. The designated person in each department will transmit the completed Observation Forms to the UC Health Department of Education (education@uchealth.com). The UC Health Department of Education will not accept incomplete applications.
   c. The UC Health Department of Education will confirm the application and all other forms are complete.
   d. The UC Health Department of Education will indicate approval by signing the Observation Request is complete by signing each of the required attachments A, B, C, D, E (if applicable) and the TB attestation or verification/seasonal flu/photo ID.
   e. The UC Health Department of Education will inform the designated person/unit that the application and documentation is complete by email. The unit-designated person is responsible for communicating to the visitor the process for presenting at the area the day of the visit, including issuance of visitor badge, and any other department protocols. Any departmental policy that has requirements in addition to those in this policy must be communicated and followed (i.e. Operating Room and Labor and Delivery).
   f. Once approved, including signature by the manager, and the visitor has presented appropriate identification, the UC Health Department of Education will provide approval. The visitor must present a copy of a government photo identification to establish proof of identity.
      1) The UC Health Department of Education will communicate with the Parking and Access offices for approval.
   g. The designated person from the unit/clinic/area will accompany the applicant to the Parking and Access Office to obtain a photo Observation Badge. Badges will not be issued without the observer being accompanied by a UC Health associate.

h. The UC Health Department of Education will retain a copy of the completed paperwork and IDs. These will be retained for three (3) years in a central location.

i. The staff member is responsible for informing the patient(s) that his/her care will be observed, by whom, and for what reason(s). If the patient or family declines consent for participation by the Observer, the Observer cannot observe that patient's health care, including discussion or observation of patient's medical information.

j. Photography or Video of the patient by the observer is strictly prohibited.

k. The manager who signed Observation request forms is responsible to return the Observation Badge to the Parking and Access Office within 24 hours of conclusion of the visit, if applicable.

D. Identification of Approved Observer

1. Approved Observers must display approved badge identifying them as a "Visiting Observer". Staff are empowered to question anyone who is not wearing identification and report through the appropriate chain of command for assistance.

   a. The observer may not observe any patient care or view patient data without the Hospital Observer badge. Patient data may not be copied or transcribed in any manner.

   b. The department manager or designated representative will collect the visitor badge at the end of the approved visit and return it to the Parking and Access Office within 24 hours of conclusion of the visit. The sticker should be discarded.

VI. KEY WORDS

Observation
Patient
Care
Visitor
Job Shadowing

VII. APPENDIX

None

VIII. RELATED FORMS

A. Observation Request Form

B. Consent and Release Form (Sponsoring Staff)

C. Consent and Release Form (Observer)

D. Confidentially and Data Security Agreement for Contractors or Non-employees

E. Consent and Release (Parent or Legal Guardian)

IX. REFERENCES / CITATIONS

None

Appendix A

UC Health Observation Request Form Return all documents to:
Department of Education: education@uchealth.com
Phone: 513-585-5320

Name _____ Date of birth _____

Email _____ Phone _____

Number of Days Observing: _____ Reason for Visit: _____

Requested Start Date(s): _____ * End Date: _____

Observations are limited to 30 clinical days. Badge card will indicate expiration date above or 30 days after issue, whichever is shorter. Extensions after 30 days require new badge card authorization from Vice President of Education.

Sponsoring Staff Member: _____

Contact Person Name: _____ Phone / E-Mail: _____

All activities of the observer are to be performed in conjunction or in consultation with the sponsor or in conjunction or in consultation with the sponsor's designee.

Unit(s) where Observation will occur:

- Hospital Unit or Procedure Area : _____
- Hospital Clinic: _____
- Location: _____

I approve observation of this applicant for the time period stated above.

Signature of Responsible Manager _____ Printed Name _____ Date _____

The following are required and must be attached:
Attach a copy of the following:

- Observation Request Form (Appendix A)
- TB Attestation/TB test results within previous 12 months
- Consent and Release (Sponsoring Staff) (Appendix B)
- Consent and Release (Observer) (Appendix C)
- Signed Confidentiality Statement (Appendix D)
- Consent and Release (Parent or Legal Guardian - if applicable) (Appendix E)
- Copy of Government Issued Photo ID/Passport
- Evidence of seasonal flu vaccine if observation request between October (10/01) and March (3/31)

Approved: _____ _____
Signature of UC Health Department of Education Date

Department Name for Badge: _____

UC Health TB Attestation

Tuberculosis/Travel:		Yes	No
A	I have been vaccinated with BCG.		
B	Have you spent time with a person known to have active TB or suspected to have TB disease		
C	I have had a "positive" tuberculin skin test (e.g., PPD) in the past.		
D	I have taken anti-tuberculosis medications (e.g., INH) in the past		
E	If Yes to C or D above, when was your last chest x-ray?		
F	Have you traveled to or had visitors/family members' travel to/from the Arabian Peninsula in the past three weeks?		
G	Have you traveled to a country where TB disease is common for more than a 2 week period (e.g., Latin America, Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, or Russia)?		
H	Work/Volunteer with those in need where TB disease is more common: Homeless shelter, migrant farm camp, prison or jail and some nursing homes?		
I	Have you had visitors from countries where TB disease is common (most countries in Latin America and the Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, and Russia) living in your home for more than 2 weeks?		

By signing below, I acknowledge that I have truthfully answered the questions above. By signing below, I acknowledge that, for the health and safety of UC Health patients, visitors, and personnel, I should not participate in UCH activities if I have symptoms of a communicable disease (e.g., fever, cough, or rash illnesses) until those symptoms have resolved.

_____ _____

Signature Date

_____

Printed Name

UC Health

Appendix B

Consent and Release (Sponsoring Staff)

Visiting Observer: _____

Date of Visit: _____

Facility and Location where Observation will take place: _____

1. I agree that I have the primary responsibility of supervision of the observer's activities during the duration of the visit. I agree to abide by all hospital and departmental policies and procedures related to observation of patient care.

2. I agree to obtain informed consent of the patient to include agreement to observation by the visitor.

3. I understand that requests from individuals under the age of 18 will be evaluated by the manager of the area to be observed on a case-by-case basis. Parent/Guardian consent must be obtained.

4. I understand that individuals who are observers are not permitted to scrub for operative procedures, or operate equipment or otherwise participate in patient care.

5. I hereby release UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) from any and all civil liability that may arise from my sponsorship of the visitor listed above. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to the activity of the visitor listed above.

_____ _____

Signature of Sponsoring Staff **Date**

_____

Printed Name

Appendix C

Consent and Release (Observer)

In requesting approval for observation of patient care at _____, I expressly accept these conditions during the processing and consideration of my request, and throughout the observation period.

1. I understand and agree that I have the burden of producing adequate information for proper evaluation of my qualifications or any other matter that might directly or indirectly have an effect on patient care or the orderly operation of the facility to which I am seeking access.

2. I certify I'm free from communicable diseases, and that within 24 hours of a request by UC Health personnel I can provide evidence that I am free of active tuberculosis (as shown by PPD skin testing or chest X-ray), immune from hepatitis B (or declined in writing to be immunized against hepatitis B), immunized against influenza (annually), and is either immune from or has been immunized against rubella, mumps, measles, and varicella (chicken pox).

3. I understand and agree to the requirements in the UC Health **CONFIDENTIALITY AND DATA SECURITY AGREEMENT for Contractors and Non-employees. (Appendix D)**

4. I understand that additional observation to the unit or area may be required by the hospital unit manager. I agree to meet any additional requirements as needed.

5. I understand that the management of the hospital has the right to revoke permission for observation at any time, and agree that I will immediately leave the Patient Care Area if requested to do so.

6. I hereby release UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) from any and all civil liability that may arise from my activity at the facility to which I am seeking access during my observation period. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to my activity at the facility to which I am seeking access.

7. I hereby represent that I have voluntarily signed this Consent and Release; and, that I have no questions regarding the content herein.

_____ _____

Signature **Date**

_____ _____

Printed Name **Date of Birth**

CONFIDENTIALITY AND DATA SECUITY AGREEMENT
Contractors or Non-employees

PLEASE READ THE ENTIRE AGREEMENT.

As a contractor or non-employee of UC Health, you have a legal obligation to protect the rights of patients as defined under the Health Insurance Portability and Accountability Act (HIPAA). You are required to keep confidential Protected Health Information and other vital data you may access during the course of your work for or associated with UC Health. The following defines this information and provides a series of statements you must review to fully understand your obligations, as well as appropriate use of the Internet at UC Health.

Description of Protected Health Information (PHI)
PHI includes patient identifiable health information, medical records and financial or billing information relating to a patient's past, present or future mental or physical condition; or past, present or future provision of healthcare; or past, present or future payment for provision of healthcare. It may be in oral, paper or electronic form and contains any of the following identifiers that may be used to identify the patient:

- Name
- Place of residency (including street address, county, city, zip code)
- Telephone/fax numbers
- E-mail addresses
- Social Security Number
- Medical Record Number
- Health plan beneficiary number
- Account numbers
- Birth date, admission date, discharge date, date of death, all ages over 89
- Certificate/license numbers
- Vehicle identifiers and serial numbers including license numbers
- Device identifiers/serial numbers
- Web Universal Resource Locators (URLs, i.e. web page identifiers), Internet Protocol (IP address number)
- Biometric identifiers (voice, finger prints)
- Full face photo image
- Any other unique identifying number, characteristic, or code

<u>Description of Other Confidential Information</u>
Confidential information also includes, but is not limited to, combined clinical data, employee records, processes, marketing plans or techniques, product or service plans, strategies, forecasts, customer/patient lists, supplier lists, discoveries, ideas, pricing policies and financial information. This confidential information can be obtained through hearing it, seeing it, viewing the paper or electronic medical record or accessing it in a hospital computer system.

Requirements of All UC Health Contractors or Non-Employees Regarding PHI and Confidential Information

The services provided by UC Health and corresponding PHI are highly confidential and must not be released or discussed with unauthorized persons. There are both Federal and State Laws which safeguard the privacy and confidentiality of PHI and other confidential information from unauthorized access, use or disclosure.

Contractor or Non-Employee Agreements Regarding Use of PHI, Confidential Information and the Internet

- I agree to abide by UC Health HIPAA policies on privacy and confidentiality of PHI.
- I agree to access, use or disclose only PHI for which I am authorized through my work for or associated with UC Health and as complies with UC Health HIPAA policies. I agree not to invade patient privacy by examining PHI or data for inappropriate review.
- I agree not to discuss PHI in unauthorized areas such as hallways, elevators and cafeterias, where it could be overheard.
- I agree not to make unauthorized disclosures, copies or transmissions of PHI in any form including electronic transfer of PHI to personal devices.
- I understand that any access to PHI for research purposes requires proper documentation and approval according to HIPAA policies.
- If given a system password(s) to use, I agree to keep it (them) confidential and not share it (them) with any individual or allow any individual to access information through my password(s). I understand that giving a password to an unauthorized individual may result in disciplinary action up to and including contract or account access termination.
- I understand my password(s) may identify information that I have accessed, which may be monitored and audited
- I understand my password(s) may be changed periodically to help maintain the security of UC Health.
- I understand that I must safeguard data at all times – during its origin, entry, processing, distribution, storage and disposal. This includes data in electronic, paper, film, video or other forms.
- I understand that I must safeguard data from unauthorized access (accidental or intentional), modification, destruction or disclosure.
- I understand that data used in business and clinical operations is an asset of UC Health.
- I understand that e-mail is the property of UC Health and its member institutions and may be monitored. I further understand that I should have no reasonable expectation of privacy when using UC Health e-mail or Internet.
- I understand that, should I have access to the Internet, it is provided by UC Health to assist in completion of work assignments (i.e. patient care, research, education). I understand that this access should be considered an extension of my work environment.
- I understand that the use of unlicensed or unapproved software constitutes a serious risk to UC Health operations.
- I understand that upon my contract termination or end of work with UC Health, my ability to access UC Health information will end. I agree that I will not attempt to access

the systems or disclose any confidential information and/or PHI to any person or entity at that time.

- I understand at the termination of my contract or end of work with UC Health, I will return any confidential information including PHI that is in my possession, to UC Health.
- I understand I must continue to honor all of the obligations mentioned above after termination of my contract or end of work with UC Health.
- I understand that UC Health reserves the right to immediately terminate my access to electronic medical records if there is inappropriate access to PHI.
- I understand that unauthorized access, use or disclosure may have serious legal repercussion for me and/or my employer.
- I understand unauthorized access, use or disclosure of PHI may subject me and/or UC Health to Federal and State fines and penalties
- I understand that access to PHI for illegal purposes will subject me to prosecution to the full extent of the law.

I have read this document and understand that my signature constitutes my acceptance of the terms of this agreement and that a violation of it can result in disciplinary action, up to and including termination of my contract or relationship with UC Health and/or termination of my access to UC Health electronic systems including the electronic medical record. I also recognize that by signing this agreement, there may be serious legal, ethical and personal consequences for violating its terms.

Name (Print)	Organization (Print)
Signature	Date of Signature
Date of Submission or Receipt	

Appendix E

Consent and Release (Parent or Legal Guardian)

I, _____, certify and agree to the following:
[*printed parent or legal guardian name*]

1. My child/ward named below has my permission to participate in a job shadowing experience at the following UC Health facility or facilities: _____.

2. I understand that the terms and provisions of UC Health's *Consent and Release (Observer)* and *Confidentiality and Data Security Agreement* shall be incorporated herein by reference. I consent to this Consent and Release and to the incorporated terms and provisions on behalf of myself and my child/ward. I certify that I have explained all such terms and provisions to my child/ward and both I and my child/ward shall abide by them.

3. I certify that my child/ward is free from communicable diseases, and that within 24 hours of a request by UC Health personnel I can provide evidence that he/she is free of active tuberculosis (as shown by PPD skin testing or chest X-ray), immune from hepatitis B (or declined in writing to be immunized against hepatitis B), immunized against influenza (annually), and is either immune from or has been immunized against rubella, mumps, measles, and varicella (chicken pox).

4. I understand that job shadowing could include observing patients and/or medical, laboratory, and business procedures in a healthcare setting. I understand that UC Health facilities offer medical services for the care and treatment of a wide range of illnesses, diseases, and injuries, including but not limited to infectious diseases such as tuberculosis, hepatitis, and HIV. I understand that there is a risk that my child/ward could inadvertently be exposed to such diseases while participating in the job shadowing experience.

5. In the event of a medical emergency, I understand that while every attempt will be made to contact me before medical action is taken, I nonetheless consent to any emergency treatment or procedure deemed by UC Health staff to be necessary for my child/ward's health or wellbeing.

6. On behalf of myself and my child/ward, and to the maximum extent permitted by law, I assume all risks and liabilities associated with my child/ward's participation in the job shadowing experience, and I hereby release, discharge, and relieve UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) (collectively, the "Indemnitees") from any and all civil liability that may arise from my child/ward's participation in the job shadowing experience. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to the activity of my child/ward named below. Furthermore, I agree to indemnify, defend, and hold harmless the Indemnitees from and against any and all actions, claims, lawsuits, or proceedings and all resulting damages, liability, costs and expenses (including attorneys' fees) related to the acts or omissions of my child/ward or the breach by me or by my child/ward of this Consent and Release or any incorporated terms and provisions.

Printed name of child/ward: _____ **Date of Birth:** _____

_____ _____

Signature of Parent or Legal Guardian **Date**