Once your request to observe has been approved, you will need to contact Materials Management to make arrangements to obtain a temporary badge.

Letty Del Campo

(909) 920-4807

SAN ANTONIO REGIONAL HOSPITAL	Department: Medical Staff Services				
	Section:				
	Title: Medical Staff Observer Policy				
	Number: 8710.4400			Page 1 of 2	
	Hospitalwide	Interdepartmental	Department	Patient Care	Non- Patient Care

Policy History		Approval:	Dates
Effective Date:	01/30/2012	MEC	12/19/2011; 10/15/12; 01/2019
Revision Date(s):	11/21/2011;10/12; 01/2019	BQC	01/30/2012/10/22/12; 01/2019
Review Date(s):	11/21/2011;10/12		

Record the review and revision dates for 6 years. Exception: Record the dates for policies that refer to minors for 8 years.

PURPOSE:

To define the conditions under which an individual is permitted to observe in the patient care areas of the hospital. To govern the activities of individuals who will be permitted access to SARH facilities for the purpose of observing patient care activities for the purpose of furthering their educational mission. To provide an environment that protects patient confidentiality, rights and safety. To ensure compliance with HIPAA privacy requirements.

POLICY:

A member of the SARH Medical Staff (M.S. member) may request approval for an observer to accompany them within the facility, with approval to be granted on an individual basis. Each observer will be limited to a maximum period of 30 cumulative or consecutive days per calendar year. Observers may not participate in any form of direct or hands-on patient care or contact and the observation must be done in such a way that it does not compromise or interfere with patient care. Observers may not have access to patient health information. Observers will not be allowed in patient care areas unless accompanied by the member of the Medical Staff.

CRITERIA FOR OBSERVERS

Age Requirements: An observer must be at least 16 years of age.

PROCEDURE:

1. The M.S member requesting an Observer must submit a request to Medical Staff Services Department. The M.S. member must provide the Medical Staff Services Department with the name of the observer and the date(s) of observation. The M.S. member must submit their request a minimum of two weeks in advance to allow time to process the request and obtain approvals.

2. The Medical Staff Services Department will prepare the following forms which must be signed and dated by the M.S. member, observer, and patient. It is the responsibility of the M.S. member to obtain all the necessary signatures and return the completed forms to the Medical Staff Services Department two weeks prior to the scheduled rotation.

   Forms:

   a) Observer Form (Signed by observer and Medical Staff Member).

   b) Authorization to Use and Disclose Health Information (signed by the patient). This form will be placed on the patient's medical record.

   c) Documentation of required immunization(s) as follows:

      i. PPD
      ii. Flu vaccination or signed Influenza Vaccine Written Declination/Attestation Form

3. Approval will be requested from the chairman of the applicable department, or the President of the Medical Staff or the Hospital President. Once approval is received the requestor and the appropriate department of the hospital (i.e. Operating Room) will be notified by Medical Staff Services. Approved observers must obtain a temporary badge from Materials Management for identification purposes.

4. Patient Authorization:
   a. The MS Member must, prior to the observer entering any treatment or patient room, obtain the patient's permission for the Observer to be present;
   b. The patient must be informed of his/her right to withdraw approval of an observer.

5. Shadowing shall be restricted from areas where patients may be unable to provide consent before receiving treatment.

6. Responsibilities:

Observer Responsibilities:

a) Observers must obtain a temporary badge from Materials Management for identification purposes

b) Observers are not permitted to discuss, use or disclose, confidential patient information with anyone other than the person/designee they are observing

c) Observers may not make entries into the medical record

Supervising Physician Responsibilities:

a) Notify patients that observations are taking place and ask for the patient's consent to having the observer present during their examination

b) Must accompany the observer at all times in clinical areas

RELATED POLICIES/ATTACHMENTS/FORMS:

END

SAN ANTONIO REGIONAL HOSPITAL

Observer Checklist

NAME: _____

Observation Dates: Start Date: _____ End Date: _____

SARH Medical Staff Sponsor: _____

ALL of the following items MUST be completed and turned in with your request to observe at San Antonio Regional Hospital.

_____ SARH Confidentiality and Nondisclosure Agreement

_____ SARH Observer Form

_____ Influenza Vaccination Record/Documentation

_____ TB Record/Documentation

Observer's Name **Clearly PRINT**	Phone Number Cell and/or Home	Email Address

If you have any questions please contact:

- Medical Staff Services @ 909-920-4851

SAN ANTONIO REGIONAL HOSPITAL

SARH Confidentiality and Nondisclosure Agreement

(For non-employed workforce members, contractors, or vendors)

I acknowledge that, as a member of the workforce or a contractor to San Antonio Regional Hospital (SARH), and by virtue of my relationship and work assignments for SARH, that I may acquire access to confidential information. Confidential information includes, but is not limited to, all patient data or protected health information (PHI), social security numbers, credit card data or cardholder information, and other sensitive or proprietary information such as SARH financial or personnel information regardless of format – paper, electronic, magnetic or optical media, or oral. I understand that confidential information is protected through SARH policies and may also be protected under Federal and State law.

Therefore, as a condition of my working relationship with SARH, I agree to the following responsibilities and expectations:

Access and Disclosure

- I will not disclose or disseminate (except as needed to perform my work) any confidential information and I will restrict my access to the minimum necessary
- I understand that the uses and disclosure of patient information is governed by SARH's HIPAA Privacy policies which can be made available upon my request
- My responsibility for maintaining confidentiality continues even after my business relationship with SARH ends

Storage and Retention

- I will securely store media containing confidential information when it is not in use
- I will ensure that media containing confidential information will remain on SARH property unless a valid business need exists to take the media off-site
- I will contact the SARH Information Security Officer (909-985-2811, ext. 26995) to obtain approval for the use of any mobile computing device or portable storage devices prior to storing SARH confidential information
- I understand that access to SARH confidential information does not convey a transfer of ownership and that I will return all documents or media containing confidential information when I no longer have a legitimate business need

Transmission

- When I fax confidential information on SARH's behalf, I will use an approved SARH cover sheet with a confidentiality notice
- I will use encryption approved by Information Services (IS) when sending any confidential information to or from SARH via electronic communications

Disposal

- I will properly dispose of confidential paper documents by shredding them or by placing them in a secure shred bin *(A cross-cut shredder is highly recommended)*

SAN ANTONIO COMMUNITY HOSPITAL

SARH Confidentiality and Nondisclosure Agreement

(For non-employed workforce members, contractors, or vendors)

Agreement

I have read and agree to the provisions in this agreement and understand my responsibilities for protecting confidential information.

I understand that failure to adhere to the terms in this agreement may result in an inappropriate or unauthorized disclosure of confidential information which may lead to sanctions. I also acknowledge that I may be subject to penalties or liabilities under state or federal laws.

I will immediately report any known or suspected breaches of confidentiality to SARH management or my SARH sponsor.

I will abide by the applicable SARH policies and procedures as required, and especially when physically working on-site at a SARH facility.

Printed Name	Signature	Date

Identify your SARH sponsor (Point of contact and/or department)

Briefly describe your role with SARH: _____

SAN ANTONIO
REGIONAL HOSPITAL

OBSERVER FORM

Dates of Observation Period: _____

As per the Medical Staff Observer Policy and Procedure (8710.30012.00), each Observer will be limited to a maximum period of 30 cumulative or consecutive days per calendar year.

Observer

I agree that I will not provide any medical care or have any physical contact with the patient.

I understand that my supervising physician must obtain written consent from the patient to allow me access to the patient's protected health information.

I agree as a condition of participation to keep confidential all patient names and personal medical information obtained from or about the patients I observe. I agree not to divulge any of this information to third parties other than to those individuals that are directly responsible for the care of the patient. I agree not to remove any hospital property including material containing protected health information.

I agree to wear a temporary badge issued to me by the Materials Management Department. I will not wear anything that might imply I am a healthcare provider or employee at SARH.

I understand I am not an employee of San Antonio Regional Hospital, (SARH). SARH will not provide me with any salary or benefits during my observation period. SARH is not responsible for any medical, travel, housing needs, injuries to me while on the premises, or any other type of employee-type benefits.

I agree to assume full responsibility for my health insurance, payment for injuries or illnesses suffered by me while at SARH.

I agree that as condition of participation in this observation activity to hold harmless and indemnify SARH, its trustees, officers, employees, and agents from any and all injuries, illnesses, liability, damages, claims and costs of any kind resulting from my participation.

I agree that breach of this confidentiality is a violation of state and federal law and San Antonio Regional Hospital's policies, procedures and rules.

I have received a copy of the Observer Policy and Procedure and agree to abide by its rules.

I have read and agree to the requirements listed above.

Observer Printed Name: _____

Observer Signature: _____

Date: _____

[illegible] San Bernardino Road, Upland, CA 91786 [illegible] SARH.org

San Antonio Regional Hospital Medical Staff Member

I agree that observation means no physical contact with the patient or performance of medical care of any kind.

I agree that I am responsible for the Observer at all times.

I agree that I am responsible for all HIPAA policies and procedures.

I agree to obtain prior written consent from the patient to allow the Observer access to the patient's protected health information.

I have read and agree to the requirements listed above.

Medical Staff Member Printed Name: _____

Medical Staff Member Signature: _____

Date: _____

(This section is for office use only)

APPROVED BY:

_____ _____

Department Chairman or designee *Date*

OR

_____ _____

President, Medical Staff or designee *Date*

OR

_____ _____

President and CEO or designee *Date*

SAN ANTONIO REGIONAL HOSPITAL

Authorization to Use and Disclose Health Information

NOTE: ***(Processing of this request takes 5-10 working days)***

Req. #_____

OBSERVER INFORMATION PATIENT INFORMATION

Individual's Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

Social Security #: _____

My Health Information: The health information that is subject to this Authorization includes:

Dates of Services: _____

☐ Outpatient Services ☐ Emergency Room ☐ Inpatient

User or Discloser: Name or function of person or class of persons hereby authorized to use or disclose my health information: **San Antonio Regional Hospital Medical Records Staff.**

Recipient: (Name or function of person or class of persons to whom ***San Antonio Regional Hospital*** may disclose my health information)

Name: _____

Address: _____

_____
(City) (State) (Zip Code)

Term: This Authorization will remain in effect:

☐ From the date of this Authorization until: _____
(Date)

SA000007

By my signature, I hereby authorize ***San Antonio Regional Hospital*** to use/disclose to the Recipient my health information for the following specific purpose(s):

☐ Insurance	☐ Disability	☐ **Pickup records**
☐ Personal Use	☐ Attorney	☐ **Mail Records**
☐ Continuing Care (to a physician/healthcare facility)	☒ Other: OBSERVER	

I understand that my health information may contain the following types of sensitive information:

- Documentation or analysis of any communications between me and my psychiatrist, psychologist, social worker, psychiatric nurse, mental health specialist, sexual assault counselor, domestic violence counselor or other allied mental health or human services professional.
- Venereal disease(s).
- Treatment for substance abuse.
- AIDS, ARC or HIV (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

RESTRICTIONS: California law prohibits ***San Antonio Regional Hospital*** from making further disclosure of my health information unless ***San Antonio Regional Hospital*** obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

I understand that once ***San Antonio Regional Hospital*** discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, ***Antonio Regional Hospital*** cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may, at any time, make a written request to ***San Antonio Regional Hospital*** to inspect and/or obtain a copy of my health information, and that ***San Antonio Regional Hospital*** will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that ***San Antonio Regional Hospital*** may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I have a right to receive a copy of this Authorization.

☐ **Copy of signed Authorization to individual**

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of ***San Antonio Regional Hospital's*** treatment of me.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to ***San Antonio Regional Hospital's*** Health Information Management (Medical Records Department) at the address listed below. The revocation will be effective immediately upon ***San Antonio Regional Hospital*** receipt of my written notice, except that the revocation will not have any effect on any action taken by ***San Antonio Regional Hospital*** in reliance on this Authorization before it received my written notice of revocation. The address of ***San Antonio Regional Hospital*** is 999 San Bernardino Road, Upland, CA 91786 and I may contact the Medical Records Department by telephone at (909) 920-4750.

PATIENT SIGN & DATE

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize upon ***San Antonio Regional Hospital*** to use or disclose my health information in the manner described above:

Signature of Individual	Date	Signature of Witness

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of authorized Legal Guardian, Health Care Agent or Other authorized Personal Representative	Relationship
Witness	Date