HCA Va
Henrico, Parham & Retreat Doctors' Hospitals
Campuses of Henrico Doctors' Hospital / An HCA affiliate

Origination:	*10/2015*
Effective:	*08/2020*
Last Review:	*08/2020*
Last Revised:	*08/2020*
Expiration:	*08/2023*
Owner:	*MJ Plance: Dir Med Staff Services/Quality*
Policy Manual:	*Admin - Medical Staff*
Applicability:	*Henrico Doctors' Hospital*

Students, Clinical Observers and Job Shadowing

SCOPE:

Members of the Medical Staff requesting a Student to job shadow and observe at Henrico Doctors' Hospital.

PURPOSE:

To define the Medical Staff process for allowing Students, Clinical Observers and Job shadowing to work with Members of the Medical Staff.

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POLICY:

It is the policy of the hospital to provide a method for individuals to be on site in the Hospital to shadow specific physicians, or via remote monitoring observation to observe Da Vinci procedures. Henrico Doctors' Hospital is not considered a "teaching hospital" and does not offer formalized training programs for students desiring to enter medical school and other advanced medical training programs. However, there are occasions when medical or advanced practice professional staff agree to allow clinical observers to observe them in the hospital setting, allowing them to gain a broad understanding of some of the many duties encountered within the medical profession or during a surgical procedure to gain greater understanding of robotic techniques.

DEFINITIONS:

1. The individual may only observe and may not touch the patient.
2. The individual must be at least sixteen (16) years of age
3. The department chair/vice chair reserves the right to accept or deny observational experience.
4. Each observer must be have a provider with clinical privileges during the observational experience and must be approved in advance by the Medical Staff Office.
5. The provider must be supervised by the provider throughout their time in the facility (exception Da Vinci remote observation).
6. It is the responsibility of the provider to obtain patient consent for the observer to be present in order to observe care.
7. The provider is responsible to assure the observer follows all departmental and hospital policies regarding infection control, safety, aseptic technique, patient confidentiality or HIPAA as applicable.
8. Observer status is granted for up to 120 days

ON SITE OBSERVATION PROCEDURE:

1. The Medical Staff Office shall provide written communication with instructions for completing the required paperwork to the applicant being considered for approval to observe the identified provider. The communication shall include:
    a. Privilege Application
    b. Health Screening Attestation
    c. Observing Provider Authorization Agreement
    d. Privacy and Confidentiality Acknowledgment
    e. Observation Agreement and Release from Liability
    f. Badge instructions
2. When the completed paperwork has been returned, it will be reviewed and approved by the Department Chair/Vice Chair.
3. Upon approval, prior to the observation period, the applicant must obtain a badge from the medical staff office. Medical staff office hours are M-F 8AM to 4:30PM. Medical staff office can be reached at 804-289-4951

DA VINCI REMOTE MONITORING OBSERVATION PROCEDURE:

1. The Medical Staff Office shall provide written communication with instructions for completing the required paperwork to the applicant being considered for approval to observe the identified provider. The communication shall include:
    a. Privilege Application
    b. Privacy and Confidentiality Acknowledgment
    c. Observation Agreement and Release from Liability

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REFERENCES:

Medical Staff Bylaws, Rules and Regulations

ATTACHEMENTS:

Da Vinci Remote Observation Consent

Privilege Application

Health Screening Attestation

Observing Provider Authorization Agreement

Privacy and Confidentiality Acknowledgment

Observation Agreement and Release from Liability

Attachments

Da Vinci Remote Observation Consent
HEALTH SCREENING ATTESTATION
OBSERVATION AGREEMENT AND RELEASE FROM LIABILITY
OBSERVING PROVIDER AUTHORIZATION
PRIVACY AND CONFIDENTIALITY AGREEMENT
PRIVILEGE APPLICATION

Approval Signatures

Step Description	Approver	Date
Board of Trustees	MJ Plance: Dir Med Staff Services/Quality	08/2020
Med Exec Committee	MJ Plance: Dir Med Staff Services/Quality	08/2020
Bylaws Committee	MJ Plance: Dir Med Staff Services/Quality	08/2020

Applicability

Henrico Doctors' Hospital

COPY

Da Vinci Remote Observation Consent

I, _____ hereby consent to remote observation through Intuitive
Patient Name

Surgical Inc. during my procedure/treatment performed by _____
Surgeon Name

scheduled on or about _____ at Henrico Doctors' Hospital.
Date of Procedure

I understand that Remote Observation may be used for:

1. Remote Proctoring: to engage with experienced health care providers for proctoring at the request of the operating physician for consultation on a specific medical procedure,

2. Remote Support: to engage with Intuitive remote technical support, such as a support engineer or customer service representative, to provide support and guidance regarding the appropriate use, calibration, or adjustment of Intuitive products at a physician's request and in support of treatment for a particular patient in the operating room, and/or

3. Remote Observations: to demonstrate the use of Intuitive products or other operating room activities to remote observers in a controlled environment with appropriate patient consent.

I also understand that Intuitive will not use, disclose, have access to, or store any video and/or audio during remote observation.

Patient Signature:_____Date:_____Time:_____

Witness Signature:_____Date:_____Time:_____

Printed Name of Witness:_____

Henrico Doctors' Hospital

Patient Label

Da Vinci Remote Observation Consent

TREAT 08/2020



Henrico Doctors' Hospital
Forest, Parham & Retreat Campuses
HCA Virginia Health System
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OBSERVING PROVIDER AUTHORIZATION / AGREEMENT

Observing Dates: _____

I hereby certify that _____ is under my supervision as a Medical Staff Observer and he/she will be under my direction at all times.

I accept complete responsibility for the above-named individual while observing me on hospital premises, attesting that the Observer will at no time be permitted to direct the patient's care or to order any tests or services.

To my knowledge, his/her health status is adequate to permit observation in the Hospital.

I understand that the above-named individual is only approved to observe during the time period indicated above.

Signature of Provider being observed: _____

Printed Name of Provider being observed: _____

- Henrico Doctors Hospital at their discretion may remove the Observer from the premises if his/her behavior is unprofessional, disruptive or detrimental to the Hospital and/or its patients.
- Written consent from the Patient is required for the Observer to enter any treatment area.
- The Observer must complete the attached ***Health Screening Attestation***.
- The Observer must sign and abide by the terms set out in the attached ***Privacy and Confidentiality Agreement.***
- The Observer must dress in accordance with dress and personal appearance standards in accordance with Hospital standards regarding same.
- The Observer must, at all times when observing on Hospital premises, wear his/her Hospital identification badge.

APPROVED BY: _____ **DATE:** _____
Department Chairman/Vice-Chairman



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OBSERVER PRIVILEGE APPLICATION

Instructions: Applicant must fill out the application in its entirety and include all required documentation in accordance with the instructions given in the application cover letter. Failure to do so will result in the return of the application to the applicant and may delay processing.

Printed Name: _____

Signature: _____

Contact Telephone Number: _____

Date of Application: _____

Date(s) Observing Privileges Are Needed: _____

Name of Provider You Will Be Observing: _____

Purpose of the Observing Assignment:

_____

_____

_____

_____



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OBSERVATION AGREEMENT AND RELEASE FROM LIABILITY

As a condition of my observational experience, I agree to not divulge to unauthorized persons (including family and friends) any confidential information obtained from my observations, conversations, correspondences, personal records and clinical materials.

Ethics and Confidentiality

When a patient enters the hospital we assume an obligation to keep in confidence all that pertains to him/her and his/her personal affairs. Every person shares this responsibility. Patients' names, reasons for admission, diagnoses, and all treatments are confidential information and must be guarded and not shared with peers or with others in the community. Release of Medical Information should only occur after proper authorization is obtained. Any person who discusses such information with patients, volunteers, contracted or regular employees, or persons outside of the hospital is engaging in a breach of ethics of Henrico Doctors' Hospital.

In the event I should breach any confidentiality standards or laws, I understand I will be personally liable for damages or penalties under the law.

Release from Liability

Insofar as permitted, the observer agrees to indemnify, defend and hold harmless Henrico Doctors' Hospital from any and all liabilities, expenses, attorney's fees, suits or claims for damages or injury caused by or resulting from the negligence or intentional acts or omissions of him/her.

I have read, understand, and agree to abide by these statements throughout the duration of my observational experience at Henrico Doctors' Hospital. I understand that I must be with my supervising provider at all times during my observation experience. I have read and agree to comply with Henrico Doctors' Hospital Observation Guidelines.

Observer Signature Date

Print Observer Name

Observer Address Telephone Number

School Representative Signature (if applicable) Date

School Name & Address

***If under 18 years of age this must also be signed by the observer's legal guardian below:**

Printed Name Signature



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PRIVACY AND CONFIDENTIALITY AGREEMENT

I have been asked by Henrico Doctors Hospital (HDH) to reaffirm my commitment made at the time of my observation to protect the confidentiality, privacy and security of health information. My signature below, I acknowledge that I made the commitment set forth below during my presence at HDH.

HDH has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my observation at HDH I may come into possession of confidential patient information, even when I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest confidence. As a condition of my observation, I hereby agree that, I will not at any time during or after my experience with HDH disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other than as necessary in the course of my observation.

When patient information must be discussed with other health care providers in the course of my observation, I will use discretion to assure that others who are not involved in the patient's care cannot overhear such conversations.

The following rules must be complied with:

1. I will not publish, disclose or discuss any Confidential Information with others, including coworkers, peers, friends or family, who do not have a need to know it; or by using communication methods I am not specifically authorized to use, including personal email, Internet sites, Internet blogs or social media sites.
2. I will not copy, transfer, photograph, or store Confidential Information on any mobile devices, portable devices or removable media, such as laptops, smart phones, tablets, CDs, thumb drives, or external hard drives.
3. I will not take any form of media or documentation containing confidential information from HDH premises.

I understand that violation of this agreement may result in corrective action, up to and including immediate termination of observing rights and possible revocation of any future observation privileges.

I have read, understand, and agree to abide by these statements through the duration of my experience at HDH. I understand that I must be under the guidance of my designated provider that I was assigned to at all times during my experience.

_____

INDIVIDUAL SIGNATURE DATE

_____

PRINT INDIVIDUAL NAME SCHOOL AFFILIATION **(if applicable)**

***If under 18 years of age this must also be signed by the observer's legal guardian below:**

_____ _____

Printed Name Signature



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HEALTH SCREENING ATTESTATION

In accordance with Medical Staff requirements, completion of the health screening record is required.

I. TB Screening:

Do you have documentation of a previous tuberculosis skin test within the last 12 months?
OR
An Interferon Gama Release Assay (IGRA) blood test?
☐ Yes ☐ No

If you answered Yes, Please attached documentation

If you answered No, Please complete the below screen:

1	Do you have a fever, chills and swollen glands?	☐ Yes	☐ No
2	Do you have night sweats?	☐ Yes	☐ No
3	Do you have weight loss without dieting and a loss of appetite?	☐ Yes	☐ No
4	Do you get easily fatigued?	☐ Yes	☐ No
5	Do you have a cough that has lasted for more than two weeks?	☐ Yes	☐ No
6	Are you coughing up blood?	☐ Yes	☐ No

II. Vaccine Preventable Diseases:

I have immunity to chickenpox/varicella, measles, mumps, rubella, seasonal flu through history of disease and/or vaccination.
☐ Yes ☐ No

If you answered no, Please indicate the viral diseases you do not have known immunity to:
☐ Chickenpox/Varicella
☐ Measles
☐ Mumps
☐ Rubella

I attest that the above information is correct.

Printed Name _____ Signature _____ Date _____

***If under 18 years of age this must also be signed by the observer's legal guardian below:**

Printed Name _____ Signature _____