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Ascension

Origination	07/2011	Owner	Sherry Harness
Approved	02/2021	Area	Nursing Education
Expires	02/2024	Applicability	Ascension Genesys Hospital

Evaluation and Approval of Student Request to Observe Patient Care

Scope:

Ascension Genesys Hospital

Policy Statement:

Request for an observational encounter by a student who is currently enrolled in high school or in a college/university program (does not include Medical School Students) will be submitted using a formal, systematic process.

Purpose of Policy:

The purpose of this systematic process is to:

1. Promote Patient Safety in accordance with federal and state regulations as well as Joint Commission accreditation standards.
2. Control exposure and contamination either by or to the individual observer in relation to the patients and health care team.
3. Preserve patient confidentiality in accordance with HIPAA regulatory requirements.
4. Establish a control to prevent an individual, with unknown background, health condition, behavior, and justification, from having unfettered access throughout the facility.
5. Establish a point of accountability as the individual nursing or medical staff member who has agreed in writing to accept responsibility for direct oversight of the student during an observational encounter.
6. Provide an opportunity for observation of and exposure to patient care with the purpose of promoting education and careers in nursing and/or medicine.

Policy Detail:

Process:

1. At least seven (7) days prior to the beginning of the intended observation encounter, the individual desiring to be an Observer must submit a completed **"GRMC Request Form for Student Observation"** to the Ascension Genesys Clinical Professional Development or the Human Resource (HR) Student Program Coordinator. See Addendum A.
2. In addition, the individual will be required, as part of the information needed for evaluation leading up to an approval decision, to provide to the Nursing Education Department or HR the following information which is not meant to serve by way of any limitation: (i) current proof of ***negative*** TB test (within the last 12 months) and Pertussis immunization, (ii) signed security/HIPAA agreement, (iii) the signed **"GRMC Nursing/Medical Staff Observer Agreement"** See Addendum B, (Iv) Current ID (driver's license and/or immigration status).
3. The Student Program Coordinator will facilitate verification of the information submitted. If there are no issues with the information submitted, then the (1) Requester will be notified of approval of the requested observation (2) Supervisor of the area where the observation will occur will be notified by the Student Program Coordinator or Nursing Education.
4. Nursing or Medical Education reserves the right to deny a request for a student observational experience. Any concerns with a request will be discussed with Nursing Leadership and/or the Medical Staff Member prior to a final decision being made.

Conditions:

1. No one will be permitted to participate in providing patient care during any observational encounter.
2. Only an Ascension Genesys nurse or medical staff member in good standing can serve as a supervising individual under this policy.
3. In the event a member of the medical staff provides an observational encounter without ensuring appropriate prior evaluation and approval has been provided, the member will be subject to referral to MET for disciplinary considerations and the observational encounter will immediately cease.
4. In the event a member of the nursing staff provides an observational encounter without securing appropriate prior evaluation and approval, the staff nurse member will be subject to disciplinary considerations and the observational encounter will immediately cease.
5. The nurse and/or physician must directly supervise the observer at all times and not permit the observer to go to other patient care areas without an escorted.
6. The evaluation and approval process cannot occur on the same day that the observation is to begin, nor can it take place after the observation request has transpired. Each additional observation experience requires a new request (although new documentation will not need to be submitted).

Attachments

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SECURITY ACKNOWLEDGEMENT AND AGREEMENT FOR STUDENTS/OBSERVERS

As a student/observer at Genesys Health System, I acknowledge that I am responsible for maintaining the security of confidential information including on-line data and hard copied reports. All information relating to employees, the Health System and its finances is legally and ethically confidential information. I understand that all information about the patient, their admission, diagnosis, and treatment is absolutely confidential. I therefore understand and agree to the following when applicable to my clinical experience:

- I will protect the confidentiality of my computer password and the information used and obtained with said password.
- I agree that I alone will use the password (which represents my electronic signature) that I have been assigned and/or chosen, and I recognize my obligation to access only the information I need to have in order to perform my duties. I will be diligent in maintaining the security of same and report all known or suspected violations or breaches to my instructor or appropriate management.
- I understand that I am responsible for any activity that occurs under my user ID and password, and I will not lend my password to others nor use any other persons' password under any circumstances. • I understand that any chart that is accessed in the clinical documentation system records the ID and legal signature in the chart Access Log and is available for monitoring. Passwords are inactivated between clinical rotations.
- If I have reason to believe someone may have obtained and/or used my password, I will notify my instructor or appropriate management and request a change in my password if necessary.
- I will not load, download, modify or copy any computer software or information.
- I understand that the careless handling of confidential patient health information (see box below), obtaining, attempting to obtain, possessing or disclosing confidential information without authorization is a serious policy violation, and I further understand that I will be subject to disciplinary action and/or asked to leave the premises.
- I acknowledge that my obligations to adhere to this policy shall continue following the ending of my clinical experience.

Name (please print):_____

Signature: _____Program/Internship:_____

Date:_____ School/College: _____

Protected Health Information or "PHI" or "Patient Information" is defined as information that is: (1) individually identifiable; (2) transmitted or maintained in any form or medium (hard copy, verbal or electronic – including "ePHI"); and (3) relates to (a) a patient's past, present, or future physical or mental health condition, (b) the provision of health care to a patient, or (c) the payment for health care by or on behalf of a patient. PHI includes but is not limited to:

- ◈Names
- ◈Zip Codes
- ◈All Dates
- ◈Telephone & Fax Numbers
- ◈-Mail Addresses
- ◈Social Security Numbers
- ◈Any other unique identifying number characteristic or code
- ◈Medical Record Number
- ◈Health Plan Number
- ◈License Number
- ◈Vehicle Identification Numbers
- ◈Account Numbers
- ◈Biometric Identifiers
- ◈Full Face photos

Please return this form with completed forms

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REQUEST FORM FOR STUDENT OBSERVATION AT ASCENSION GENESYS HOSPITAL

Please complete this request form in order to ensure timely prior permission to observe with a designated credentialed member of the medical staff or Nursing Staff. No observational encounter can be permitted unless prior permission is granted and it is communicated to the requester. **No permission will be granted on the same day as the observation is to begin or after it has occurred.**

Completion of this request form does NOT in any manner constitute prior approval to observe at Ascension Genesys Hospital.

Observer:_____ Date:_____

Mailing Address: _____

_____ E-Mail

Address: _____

Observer Contact Phone No.: _____

Medical staff or nursing staff member who will both participate in and be responsible for direct oversight of you during the requested observational encounter: _____

Date(s) of Requested Observation:_____

Observer's Date of Birth: _____

The following documents are required to be attached and/or completed with this request form to allow processing without delay:

- Immunization Records **(Proof of *negative* TB test – *within the last 12 months* and Pertussis Immunization)**
- Complete HIPPA Requirements (i.e. signed Security Acknowledgement and Agreement #1028426)
- Signed acceptance by physician or nurse providing direct oversight of student
- Current Identification (i.e., driver's license, passport, and/or immigration status documentation)
- Proof of Complete COVID vaccine

ACKNOWLEDGEMENT

I hereby affirm that the information provided on this request form and the required accompanied information as noted above is true, complete, and current to the best of my knowledge. Submission of incomplete or false information will result in a denial of this request.

Please initial each line and sign below

I understand and agree that (please initial each item below):

_____ – Approval of this request shall be for observation only under the direct oversight of the physician or nurse and his/her designated medical staff participants.

_____ – Such an observational encounter will require the oversight physician or nurse to obtain the prior permission from all patients who are observed during this encounter.

_____ – Any approved observation encounter **does not** allow student "hands-on" involvement at any time, nor does it allow for participating in or providing patient care/treatment at GRMC.

_____ – No initial period of approved observational encounter will be extended. If an extension is needed a new request will be initiated.

_____ – I agree to release, indemnify and hold harmless the Hospital, including its present and former trustees, officers, employees and agents from and against any and all losses, expenses, claims, actions, liabilities and judgments which I may have as a result of my participation in this Observation.

NOTE: If you are under 18 years of age at the time of the observational encounter, approval will also be contingent upon the authorization by the student's parent's or legal representative expressed by the parent or guardian signature at the bottom of this form.

_____ _____

Student Signature Date

As the parent or legal representative of the student applicant, I authorize without reservation or limitation, this student's participation in the above requested observational encounter on the date requested.

_____ _____

Parent Signature Date

_____ _____

Nursing Education Department Approval Date

OR

_____ _____

Human Resources Department Approval Date

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Ascension Genesys Staff Observer Agreement

This Agreement must be signed by the Ascension Genesys Hospital credentialed physician or Registered Nurse to indicate his/her permission and acceptance of responsibility for oversight of the observational encounter by

_____ on _____.

This acceptance must be signed with sufficient time prior to the date of the observational encounter in order for the Nursing Education Department or Human Resources Department to complete its review of all relevant information submitted by the Observer.

Please initial each line and sign below

____I agree and confirm that this Observer will at all times remain under my direct oversight during this observational encounter at GRMC.

____I accept responsibility for ensuring that this Observer will be knowledgeable of and in compliance with all GRMC HIPPA and Safety Rules at all times.

____Further I confirm that this Observer will NOT have any "hands-on" involvement at any time regarding participating in or providing patient care/treatment at GRMC.

____It is understood that final prior approval for this observational encounter must be provided by the Nursing Education Department or Human Resources Department.

____I will do nothing to cause such an observational encounter to commence prior to final approval.

____Further, I accept responsibility for securing patient(s) permission prior to Observer's participation during this encounter.

Printed Name:_____

Signature:_____

Date:_____

Relationship to Student Applicant (please print)_____