Frederick Memorial Hospital
Job Shadow/Healthcare Observer Tip Sheet

Healthcare Observations are intended as a time limited arrangement to allow persons to observe clinical or non-clinical staff for education purposes.

The following must be complete before the observation event can be scheduled:

_____ Review/sign/return the fact sheet entitled HIPAA Training Observers/Vendors

_____ Review/sign/return the Confidentiality and Non-Disclosure Agreement

_____ Obtain signature and return the Mentor Agreement (mandatory if you are observing a physician **or** you have already made arrangements with an employee to shadow).

_____ Signed Parental Consent form if you are less than 18 years old.

_____ Produce evidence of the following immunizations:

- TB test within the last year prior to placement at FMH or a negative chest x-ray within the last year of TB skin test is positive
- Documentation of 2 doses of MMR vaccine or documentation of positive antibody titers
- Documentation of Tdap (tetanus, diphtheria and pertussis) vaccine, unless Td (tetanus and diphtheria toxoids) vaccine has been received within the past 2 years or less
- Documentation of positive history of chickenpox, or positive antibody titer; if negative history and/or titer, 2 doses of varivax vaccine is required.
- Documentation of seasonal flu vaccine
- Hepatitis B Vaccine or signed FMH declination. ***Hepatitis vaccine is the only exception for non-clinical placements.***

Key Points

- Arrive on time to the designated location.
- Observers do not participate in patient care in any manner.
- Dress should be appropriate to the setting and/or as specified when scheduled.
- Observers should not carry cell phones or other electronic personal devices during the experience.
- Observers are not allowed to enter isolation rooms.
- Observation experiences are not allowed or will be suspended in the event of type of incident such as a disaster, or if the observer has evidence of any illness such as cough, fever, etc.
- Once all requirements are met the observation experience will be scheduled.
- Observers are expected to be respectful of patients, staff, and others they encounter and follow appropriate Standards of Behavior.
- Patients have the right to refuse having an observer in their room; respect this right and remain flexible if a patient is uncomfortable having you observe.

HIPAA Training Observers/Vendors

HIPAA is a Federal law 3 Key Areas:

- Privacy of Protected Health Information (PHI)
- Security of electronically stored health care data
- Electronic transaction standards (financial billing standards)

PHI = Protected Health Information

- PHI includes demographic information such as:

Name, address, phone, date of birth, Social Security Number and any other information that could identify the individual.

- **PHI** can be used for treatment, payment and operations only without authorization from the patient.

Mum's The Word

- Keep conversations out of elevators, cafeteria, and individuals not involved in the treatment of the patient.
- Do not view, share, discuss PHI without a need to know, or unless it is for the following: treatment, payment and operations.

Key Patient Rights:

- Notice of Privacy Practice- document outlining ways patient information can be used, shared and disclosed by law.
- Request Restriction- Patient may request a restriction such as "confidential status" no information given out to visitors.
- Access to PHI- Patient may request a copy of their medical record, refer patient to Health Information Management (HIM).
- Amendment to PHI- A patient requests a change in their medical record due to incorrect/inaccurate data. Refer to Privacy Officer.
- Accounting of the uses/disclosures of PHI-A patient request a listing of disclosures of PHI made by the Organization. Exceptions: treatment, payment and operations and applicable laws.
- Right to file a complaint privacy complaints are investigated by the Privacy Officer.

All Patient Rights have corresponding policies; you may request a copy of any policy, or contact the Privacy Officer, Cathleen Casagrande, x3877 for any questions/concerns.

FMH Expectations:

- We take privacy seriously and our patients expect our Healthcare System to demonstrate this commitment.
- As a Vendor /Observer we expect compliance with our Confidentiality Agreement. Any inappropriate sharing, copying, and disclosing of PHI will result in the termination of your experience at FMH.

I have reviewed the above information and agree to comply with its contents.

Signed ______________________________ Date ____________________

Frederick Memorial Hospital
Confidentiality and Non-Disclosure Agreement
Non-Computer Access Version

Organizational information that may include, but is not limited to, financial, patient identifiable and, employee identifiable, from any source or in any form may be considered confidential. Information's confidentiality and integrity are to be preserved and its availability maintained. The value and sensitivity of information is protected by law and by the strict policies of FMH.
The intent of these laws and policies is to assure that confidential information will remain confidential through its use, only as a necessity to accomplish FMH's organizational mission.

1. I will not access or request any information I have no responsibilities for. In addition, I will not access any other confidential information, including personnel, billing, financial, health or other private information I do not need to perform the duties assigned me by FMH.
2. I will not to disclose or communicate any Confidential Information to any person whatsoever, except in connection with the performance of my assigned duties.
3. I will not copy or reproduce, in whole or in part, or permit any other person to copy or reproduce, in whole or in part, any Confidential Information other than in the regular course of the FMH business;
4. I will comply with all policies and procedures about the confidentiality of information.
5. I will not disclose protected health information or other information that is considered proprietary, sensitive, or confidential unless there is a need to know basis or unless I am otherwise required by law to do so.
6. I agree that disclosure of confidential information is prohibited indefinitely, even after termination of employment or business relationship, unless specifically waived in writing by the authorized party.

I further understand and agree that my failure to fulfill any of the obligations set forth in this Confidentiality Agreement or my violation of any terms of this Agreement may result in my being subjected to: 1) Volunteer opportunities would be terminated for the individual, in accordance with the FMH's policies and procedures, 2) termination of the individual and/or contract, 3) appropriate legal action and/or 4) other action as deemed appropriate by Hospital Administration.

Name ______________________________ Date: ______________
(Please Print)

Signature
______________________________ Department ______________

If I have any questions about FMH's HIPAA Compliance Program or other Privacy/ Security Concerns I understand that I should call at x3877.

FMH Mentor Agreement

Participant Name: ____
(Please Print)

Name of Mentoring Staff Person/Physician: ___________________________________
(Please Print)

I have been in communication with the above person who would like to do an observation experience with me on this date: ____

I agree to act as their mentor while they are in FMH. As such, I assume responsibility for directing this individual in their interactions with patients and staff.

I will be responsible for:

- Obtaining observation consent from patients for this person
- Facilitating this individual's learning objectives
- Encouraging his/her adherence to FMH behavior standards
- Helping him/her maintain patient confidentiality

I realize that FMH has a process for allowing observers, which includes necessary vaccinations, appropriate dress, and prior notification of units where observational activities will take place (among other requirements). I understand that permission for this observation experience will not be granted until these requirements have been satisfied by the individual to be mentored.

Signature of Mentor: ____

Signature of Participant: ____

Date: _____________________________________

FMH Parental Consent Form

If observer is under 18 years of age, parent/guardian must complete:

Permission is granted for my son/daughter:

· To participate in a job shadowing experience with Frederick Memorial Hospital

· To be provided emergency medical care if injured while participating in the Job Shadow Program.

Observer's Name: ____

Parent/Guardian Name (please print): ________________________________

Parent/Guardian Signature: ____