HENRY FORD HEALTH

GRADUATE MEDICAL EDUCATION DOMESTIC OBSERVERSHIP POLICY

I. **PURPOSE**: To insure observers, as defined as US Students (High School, University, College, or Medical School), trying to obtain hospital experience, are appropriately identified, approved and supervised to observe patient care for educational purposes.

II. **SCOPE**: This policy will apply to Henry Ford Warren Hospital Graduate Medical Education Department, individuals seeking observerships any Henry Ford Warren clinical site, GME training programs, and all faculty sponsors of the observer.

III. **POLICY**: Observerships may be granted on a case-by-case basis and require a two week notice. The availability of an observership is at the discretion of each GME training program director based on that department's availability of resources. The existence of this policy creates no obligation on the part of a training program or any clinical department at HF (Henry Ford) Warren Hospital to provide such an experience. No observer may participate in direct patient contact. They are permitted to observe the interaction of the team with their patients and each other. Observers may participate in discussions and didactic sessions. Please Note: This policy does not apply to resident applicants who return to the hospital for a "second look" day.

IV. **IMPLEMENTATION**: It is the responsibility of all attendings and faculty associates and/or department chairs who sponsor individual observers to implement this policy. A. Types of Observers:

1. Shadow a resident team at HF Warren Hospital: Must be accepted by the program director, however, this is a departmental decision. Once accepted, the observer must register with the GME office and complete required paperwork.
2. Shadow an employed physician in their office: Must be accepted by a HF WarrenHospital Physician Sponsor. This is a departmental decision. Once accepted, the observer must register with the GME office and complete required paperwork.
3. Shadow a private physician in their private office: this is a private matter. The observer may not, under any circumstances, follow the physician to the hospital for patient care activities nor claim to have done an observership at Henry Ford Warren Hospital despite the private physician being on staff.

V. **PROCEDURE**:

A. All individuals who desire to be an observer at Henry Ford Warren Hospital must be sponsored by a Henry Ford Warren Hospital Program Director, or Faculty member who will be responsible for insuring that the observer is approved through the GME office at Henry Ford Warren Hospital.

B. The sponsoring program director and program coordinator shall be responsible for insuring the observer is appropriately identified as an observer only.

C. All observers must wear an HF Warren ID badge, issued by the Security Department, any time they are in Henry Ford Warren Hospital facilities.

D. At the conclusion of the observership, the program coordinator must retrieve the observer's ID badge.

E. Observers must adhere to the Henry Ford Warren Hospital Dress Code Policy, appearing professional at all times. (No open-toed shoes, tank tops, blue jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry, in-tongue/in face piercings. Scrubs and lab coats are to be worn only when required by a specific department and must be removed when leaving).

F. Observers will not be compensated in any way.

G. Applicants may not apply for more than one (1) one-week observership.

H. Observers in Radiology and Nuclear Medicine must be issued and wear radiation badges.

I. Observers will not gain entry to the operating room.

J. Observers are expected to bear all costs and expenses including parking, meals, and health screens.

VI. **APPLICATION PROCESS**: Before you begin the application process, all observers must have a pre-arranged attending or faculty sponsor.

A. Observer applicant completes application form and gets required approvals.

B. Completed application is submitted to the GME office.

C. Notice is sent to the Henry Ford Warren Hospital Security Department and the department that will be sponsoring the observership.

E. Observer must have an Henry Ford Warren Hospital Hospital ID badge issued by the Security Department. The ID badge must designate Observer.

F. If approval is not sent from the Medical Education sent to the Security Department, no ID badge will be issued, and the observer will be referred to the GME Office.

Henry Ford Warren Hospital Graduate Medical Education

DOMESTIC EDUCATIONAL OBSERVATION PROGRAM CHECKLIST

Henry Ford Warren Hospital ("Hospital") is pleased to provide interested individuals an educational experience through observation of patient care, while ensuring patients receive quality care, treatment, and services. To further this endeavor, applicants are required to complete an application, acquire a hospital sponsor, adhere to all health screening requirements, and show proof of healthcare coverage. Applicants may apply for no more than one 1-week observership.

PROGRAM QUALIFICATIONS:

Participants must be at least 17 years of age and at least the educational equivalent of a senior in high school. Any observer at our hospital is required to show proof of a negative tuberculin test. If prior history of a positive test, you must present documentation of testing, symptom checklist (Section A on the Tuberculosis Screening Form), chest x-ray results and treatment plan. Each situation will be assessed on an individual basis.

- Observation opportunities in the NICU are limited and must be approved by the manager in that area.
- Observers in Radiology and Nuclear Medicine must be issued and wear radiation badges.

APPLICATION PROCESS:

All applicants must have the following completed before being allowing to observe. There are no exceptions. We only accept complete application packets. Use this as your checklist:

Application form (Attachment A) signed by: the applicant, a parent or guardian, if the observer is under age 18, the sponsor, the department chair or program director, the director of medical education (and the manager, if required). It is the observer's responsibility to secure a sponsor, confirm all dates and requirements and obtain all necessary signatures on the form.

Consent for Participation in Observation Program and Confidentiality Agreement (Attachment B); signed by the applicant and a parent or guardian, if observer is under age 18.

Proof of a negative tuberculin test. If prior history of a positive tuberculin test: present documentation of testing, chest x-ray results and treatment plan. Each situation will be assessed on an individual basis.

Proof of current influenza vaccination.

Proof of current and active healthcare coverage; photocopy of documentation of current coverage.

Photocopy of a photo ID; this can include a valid driver's license, state ID, school ID, or passport presented prior to the first day of observership to Henry Ford Warren Hospital Graduate Medical Education (HFWH) Security Department to secure a pictured ID badge.

Submit completed application packet to:

Michelle Markewicz or Kara Ramos
mmarkie1@hfhs.org
kramos2@hfhs.org

RESPONSIBILITIES OF OBSERVERS:

All observers are expected to bear all costs and expenses incurred by the observer, including parking and meals, and health screenings.

All observers are expected to adhere to the dress code: no open toed shoes, tank tops, blue jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry or in-tongue or in-face piercings. Scrubs and/or lab coats are to be worn only when required by a specific department and must be removed when leaving. All observers are expected to comply with all Hospital policies and procedures.

APPROVAL OF OBSERVER VISIT AND ADDITIONAL HOSPITAL RIGHTS:

By participating in this program, observers gain no rights or authority with respect to Hospital or its patients. In addition to all other rights, which are explicitly reserved by Hospital, Hospital reserves the right, in its sole and absolute discretion to:

1. Approve or disapprove of any observer or requested observation, for any legally permissible reason whatsoever.
2. Discontinue the observational program for any reason whatsoever.
3. Remove an observer from the observational program and/or Hospital facilities, for any legally permissible reason whatsoever.

ATTACHMENT A

Henry Ford Warren Hospital Graduate Medical Education

OBSERVATION APPLICATION TO BE COMPLETED BY THE OBSERVER:

PERSONAL INFORMATION			
Name:		Date of Birth:	
Home Address:	City, State:		Zip Code:
Preferred Phone #:	Alternate Phone #:	Email:	
Emergency Contact Name:	Phone #:	Alternate Phone #:	

HOSPITAL DEPARTMENT INFORMATION			
Department:	Start Date:	End Date:	# of hrs/wk requested:

Please describe why you are interested in doing an observation in this area:

I certify that the statements made in this Observation Application are true and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release the hospital from any liability whatsoever for supplying such information.

_____ _____

Applicant Signature Date

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TO BE COMPLETED BY THE SPONSOR:

Department:	Phone:
Attending Physician Sponsor:	Phone:
Contact Person Observer Reports to at Hospital:	Phone:
Location:	

I will follow the Hospital's Observation Policy and will ensure the above individual is supervised while they are on the Hospital campus. Also, in accordance with this policy, I will ensure the individual completes all procedures and paperwork prior to beginning the observation.

Attending Physician Sponsor _____ Date _____

Approved by:

Manager (if required) _____ Date _____

Residency Program Director or Department Chair _____ Date _____

Student Coordinator, Medical Education _____ Date _____

HENRY FORD HEALTH

ATTACHMENT B

Henry Ford Warren Hospital Graduate Medical Education

CONSENT FOR PARTICIPATION IN OBSERVATION PROGRAM AND CONFIDENTIALITY AGREEMENT

I understand that I/my child will be participating in the Educational Observation Program (the "Program") at Henry Ford Warren ("Hospital"). I understand that, in participating in the Program, I/my child will be exposed to the normal risks of any hospital visitor, as well as possible additional risks that arise because I/my child will be in patient care areas and observing patient care.

I understand that I/my child will at no time be allowed to give patient care, touch patients or instruments, or make entries into the patient chart or any other hospital document. I understand my/my child's role is simply to observe patient care and/or procedure(s), and at no time may I/my child participate in any patient care or procedure(s) observed. I understand that I/my child may experience physical and emotional reactions to the observation experience, which could cause me/my child to experience physical/or emotional injury. I hereby agree to release, indemnify and hold harmless Hospital, its medical staff members, employees, and agents from all liability related to my/my child's observation experience.

I understand and agree that I waive, for myself, my child, and any heirs and/or assigns, any and all claims, including any negligence claims which I or my child might have against the Hospital, or its agents or representatives, in any way arising from or relating to the Program, except for claims arising out of gross negligence or reckless or willful misconduct of Hospital or its agents, or representatives. I hereby agree that I will not sue Hospital from any claims I/my child, may have against it except for gross negligence or reckless or willful misconduct on the part of Hospital, its trustees, officers, agents, and employees. I also hereby agree that I will, for myself, my child, and any heirs and/or assigns, indemnify and hold hospital harmless against any and all claims or liabilities, including any negligence claims, for damages that I or my child cause to Patients and/or the Hospital, or its agents or representatives, in any way arising from or relating to the Program.

In the event of exposure to blood or other bodily fluids from a patient who is a carrier of a contagious or infectious disease or a patient who is, in the judgment of Hospital, at risk of carrying a contagious or infectious disease, Hospital shall, with my consent, administer immediate precautionary treatment to me/my child that is consistent with current medical practice without any further consent from me. I shall pay for the initial screening tests or prophylactic medical treatments should the need arise. Hospital shall have no responsibility for any further diagnosis, medication or treatment and I acknowledge and assume the risk of me/my child observing or being in the immediate presence of patents at risk of carrying a contagious or infectious disease. I/my child hereby forever release and discharge all claims and causes of action whatsoever, present and future, against Hospital, its directors, officers, employees and agents, related to or arising out of any illness, disease or health condition I/my child may contract, develop or come into contact with while on the premises of Hospital.

I certify that I/my child has no known physical or mental illness or condition, including any contagious disease, which could be detrimental to the welfare or interfere with the care of any of Hospital's patients or staff. I certify that I/my child am/is currently covered by health care insurance or Medicare/Medicaid and that it shall remain in effect through the end of my/my child's participation in the Program.

I understand that Hospital does not view this observational experience as subject to the Family Educational Rights and Privacy Act ("FERPA") and I/my child will be given no confidentiality consideration under FERPA.

I/my child will wear appropriate attire for this Program. Participants may not wear open toe shoes, sleeveless shirts, blue jeans, tank tops, exposed midriffs, heavy perfume or cologne, dangling jewelry or jewelry in-tongue or in-face piercings. I/my child will not be permitted to remain at Hospital unless dressed appropriately. I/my child will obtain and wear appropriate hospital badging pursuant to facility requirements, returning such badge and any other hospital property at the termination of the observation period.

I/my child agree to conform to all Hospital policies and procedures including those relating to safety, patient care and non-discrimination. These policies and procedures include all standards covered by the Hospital Code of Conduct, the Joint Commission, infection control standards, safety standards, confidentiality standards, and Occupational Safety and Health Administration (OSHA) requirements.

In addition to the above matters, I/my child also understand the following:

Confidential means that something is to be kept private or secret and it is not to be repeated to anyone or given to anyone.

Confidential Information means any and all information that I may learn about the Hospital or a patient at Hospital. This information is automatically private or secret and is not to be repeated to anyone or given to anyone. Confidential information about a patient includes: name, address, diagnosis, medical information, medical notes, resumes, pictures, and medical records including x-rays and medicines, as well as any descriptive that could cause any person to become aware of the identity of a patient. Confidential information also includes the name of any person at Hospital who is not Hospital employee or volunteer.

Disclosure means sharing or telling someone something I know about someone that is private or confidential.

Nondisclosure means not sharing or telling someone something. It means not to write, speak, or gossip about any patient I see or talk to at Hospital.

As an observer, I am governed by the same code of ethics that applies to physicians, nurses, and all other hospital employees. Patients expect the hospital to keep their charts, medical information, and even the fact that they are in the hospital confidential. This understanding between the patient and Hospital is an implied contractual agreement and

is legally enforceable through HIPAA (the Health Insurance Portability and Accountability Act of 1996) and the Health Information Technology for Economic and Clinical Health (HITECH) act.

I understand that while I/my child am/is observing at Hospital, I/my child may obtain Confidential Information about Hospital's patients. I understand for myself/I shall instruct my child that Program participants are to maintain in strict confidence all information and data relating to Hospital's patients and shall not disclose such information to any third party, including any family member or friend, under any circumstances. Additionally, confidential information is not to be removed from Hospital. I understand for myself/I will instruct my child that patient confidentiality is of such great importance that it is never to be disclosed to anyone outside of Hospital no matter how long after participating in the Program.

I/my child understand that I/my child will not be permitted to engage in patient care. I/my child agree that in the presence of a patient or in any patient care areas, I/my child will not be asked or allowed to answer questions about a patient's care or treatment, or otherwise provide medical or professional opinions. I/my child agree to follow the directives of the physician sponsor wile in patient care areas. I/my child understand that I/my child are on Hospital property at my/my child's own risk and insurance coverage, and that I/my child will not be indemnified/insured by Hospital. I/my child understand that for any reason in Hospital's sole discretion, I/my child's permission to act as an observer may be withdrawn and I/my child may be asked to leave immediately. I/my child understand that I/my child have no implied rights of employees, contractors or facility medical staff.

By signing this form, I agree that I have read, understand, and agree to the terms in every page of this consent form and confidentiality agreement, or, in the alternative, that I have read this form to my child and he/she understands and agrees to its terms. I give my full consent to my/my child's participation in the Educational Observation Program at Henry Ford Warren Hospital.

Observer:

_____ _____

Printed Name of Applicant Signature of Applicant

_____ _____

Name of School (if applicable) Date

Parent/legal guardian (if applicant is under the age of 18):

_____ _____

Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

_____ _____ _____

Street Address, City, State, Zip Code Date