TORRANCE MEMORIAL MEDICAL CENTER

DEPARTMENT:	MEDICAL STAFF	
POLICY/PROCEDURE:	NON-MEDICAL STAFF PHYSICIANS AND OTHERS (DESCRIBED BELOW) OBSERVING IN PATIENT CARE AREAS	
DATE APPROVED:	BYLAWS COMMITTEE	09/09/2011, 10/1/2014
	MEDICAL EXECUTIVE COMMITTEE	10/11/2011, 12/9/2014

PURPOSE: There may be the need for a physician who is not a member of the medical staff or a person to observe a physician on the medical staff at Torrance Memorial. Reasons would include physician education, for specific patient care reasons, (physicians, PT's, or others who might be interacting with a patient after the surgery), proctoring or students enrolled in medical school or another clinical discipline that would expand their knowledge by direct observation. Other requests will be evaluated on a case by case basis.

POLICY:

1. Members of the medical staff who wish to have physicians who are not members of the medical staff and others (described below) observe them in the medical center must contact the Medical Staff Services Department so that they may obtain the permission of the Chief of the Department in which the observation will occur and the Chief of Staff.

2. The observer must sign and adhere to the "Non Medical Staff Members or Others Observing in Patient Care Areas" form (see attached). No one under 18 will be approved to observe.

3. The observer must sign and adhere to the "HIPAA Privacy and Confidentiality Agreement – Visiting Observer, Form 14a." (see attached)

4. The Medical Staff Services Department will provide a temporary badge for the observer. (sticker type) The badge will not have a picture but will have "Observer" on it. The badge will have time range specified.

5. The physician must remain with the observer at all times.

6. The Medical Staff Services Department is responsible for getting the agreement signed, and must retain the signed agreement in the department for three years from the completion date of the agreement. A memo will be issued to the appropriate areas.

7. All observers who do not maintain the terms of the Agreement will be required to leave the premises if requested.

8. A request must be made at least 48 hours in advance of the time the observer starting time to assure that all of the approvals may be obtained and the paperwork completed.

9.

TORRANCE MEMORIAL MEDICAL CENTER

Non-Medical Staff Physicians and Others Observing in Patient Care Areas Agreement Form

NAME OF OBSERVER: _____
ADDRESS OF OBSERVER: _____
PHONE # OF OBSERVER: _____
NAME OF SCHOOL *(if applicable)*: _____
BEGINNING/ENDING DATES OF OBSERVATION: _____
UNITS TO BE OBSERVED: _____
NAME OF PHYSICIAN BEING OBSERVED: _____
NAME OF DEPARTMENT DIRECTOR: _____

For having the privilege of being an observer at Torrance Memorial, I understand and agree as follows:

1. I understand that I am here as an observer only. I will not touch or provide care in any way to any patient at Torrance Memorial.

2. I understand that assisting in patient care goes beyond my status as an observer. If I am asked to do anything beyond observation, I will decline such request and remind the staff member or physician that I am permitted only to observe. I will report any such requests to the Medical Staff Services Department.

3. I understand that I may not touch any equipment or related items that are being utilized on a patient. I also understand that I may not tamper with any medical equipment or supplies or related items at Torrance Memorial.

4. I understand that patient medical records contain sensitive and confidential information and I agree not to read or review any portion of the medical record unless I have an absolute need to know for the benefit of my observation status and with the permission of the patient and of the physician I am observing. I understand that I do not have any authority to document or make any entries whatsoever in the medical record. I agree that I will not make any entries in the medical record and I will not make any copies of any portion of the medical record.

5. I understand that if I improperly disclose any patient information that I learned while an observer at Torrance Memorial that I will be in breach of California and Federal laws and I agree to be responsible for any resultant fines or sanctions that arise from such disclosure. I agree not to discuss, release or disclose any patient information with anyone other than the physician I am observing. I understand that this includes any statement to anyone of the fact that I saw someone at Torrance Memorial regardless of whether or not I disclose any further patient information.

6. I understand that I may not participate as an observer if I have any communicable illness or disease.

7. I understand that I can be asked not to observe by a patient, the care giver, the patient's family, or the physician and I will honor that request.

8. I have read the information provided to me regarding codes and know what to do in the event of disaster or code. If I am unsure, I will report directly to the closest staff member.

   In addition, I agree to follow the directions of the physician I am observing in the event of a code, fire, disaster or drill.

9. I understand that I am not covered under the Workers' Compensation Program at Torrance Memorial. I agree that should I sustain injury or illness during my participation as an observer, I will not seek reimbursement or indemnification from Torrance Memorial for medical care or any loss whatsoever. Any medical care necessary is my responsibility.

10. I understand that my ability to observe may be terminated at any time and for any purpose. I understand that I will be immediately terminated from observation participation if I violate any portion of this agreement.

11. I agree to sign and follow all the terms of the HIPAA Privacy and Confidentiality Agreement – Visiting Observer Form 14a (See Attachment)

I agree to the following additional requirements listed below by my physician I am observing.

1.
2.
3.

Observer Name: _____

Signature: _____

Date: _____

TORRANCE MEMORIAL MEDICAL CENTER

PRIVACY AND CONFIDENTIALITY AGREEMENT
Visiting Observer

Torrance Memorial Medical Center has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their Protected Health Information (PHI), such as the patient name, birth date, diagnosis, treatment process, test results as well as the fact that the individual was a patient here. Additionally, Torrance Memorial must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information.

In the course of my visit or assignment at Torrance Memorial Medical Center, I may come into possession of confidential information. I agree that protecting confidentiality of PHI means protecting it from unauthorized use or disclosure in oral, fax, written or electronic form. When my visitation, affiliation or assignment with Torrance Memorial is completed, I will not take any PHI with me and I agree to continue to maintain the confidentiality of any information I might have learned or to which I was exposed to as a result of my visit or assignment.

INFORMATION USAGE REQUIREMENTS:

By signing this document, I understand and agree to the following:

1. I agree that any medical information I see or learn about regarding a patient at Torrance Memorial be kept confidential and not further discussed with anyone.
2. I agree not to disclose or discuss any patient information (PHI) with others, including friends or family, unless that individual is actively caring for that patient.
3. I agree not to discuss patient information (PHI), where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used.
4. I agree not to disclose, discuss, email, text or post any information or photographs regarding patients on social networking sites such as face-book or on personal devices such as cellular telephones, computer or I-pad. etc.
5. I agree that I have no right or ownership interest in any confidential information.
6. I agree that at all times; I will safeguard and maintain the confidentiality of all confidential (PHI) information.
7. I agree that I will be responsible for misuse or wrongful disclosure of confidential information and for failure to safeguard PHI.
8. I understand that I may contact Torrance Memorial Medical Center Privacy Officer at 310-517-4721 or email: *privacy.officer@tmmc.com* regarding any questions I have regarding patient confidentiality issues or my obligations under this Confidentiality Agreement.
9. I understand that if I do not keep PHI confidential, or I allow or participate in inappropriate disclosure or access to PHI, I may be subject to federal and state penalties and laws.
10. I understand that all-human resource; payroll, fiscal, research or administrative information I learn of while at Torrance Memorial must also remain confidential and not further disclosed to anyone.

Visiting Observer Print Name	Visiting Observer Signature and Date:
Company or Vendor Name	
Date and Time of Visit	**Department Name ***
Department Host / Contact Signature and Date:	

* If additional departments are to be visited, please document on the reverse side of this form.

HIPPA FORM 14A