	Department: MEDICAL STAFF Policy/Procedure: NON-MEDICAL STAFF PHYSICIANS AND OTHERS (DESCRIBED BELOW) OBSERVING IN PATIENT CARE AREAS

PURPOSE:
A physician or a privilege holder who is not a member of the medical staff or another person may wish to observe a medical staff physician or privilege holder at Torrance Memorial. Reasons: This observation would be for the purposes of education, for specific patient care reasons, (physicians, Physical Therapists, or others who might be interacting with a patient after a surgery or procedure), 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 or privilege holders who wish to have observers in the medical center must contact the Medical Staff Services Department to obtain permission from the appropriate Chief of the Department (s).
2. The observer shall sign and must adhere to the "Non-Medical Staff Members or Others Observing in Patient Care Areas" form (see attached) to include documentation of a current influenza vaccine (vaccine required during the flu season).
3. No one under 18 will be approved to observe.
4. The observer must sign and adhere to the "HIPAA Privacy and Confidentiality Agreement – Visiting Observer, Form 14a." (see attached)

A request must be made at least 48 hours in advance of the date and time of the observation to assure that all of the approvals may be obtained, and the paperwork completed. This request must be made by the medical staff member or privilege holder.

1. The Medical Staff Services Department will verify identity against a government issued ID badge (copy to be made) and 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.
2. The member of the Medical Staff or privilege holder must remain with the observer at all times.
3. The Medical Staff Services Department is responsible for obtaining the "Non-Medical Staff Members or Others Observing in Patient Care Areas" Agreement form and the HIPAA Privacy and Confidentiality Agreement – Visiting Observer, Form 14a, completed and signed. The signed agreement shall be maintained in the Medical Staff Services Department for three (3) years from the completion date of the agreement. The appropriate areas will be alerted about the presence of the observer noting the observer's name and Medical Staff Member or privilege holder who they will be observing.
4. All observers who do not maintain the terms of the Agreement will be required to leave the premises if requested.
5. Approvals shall be granted on a month to month basis not to exceed the last day of the month.

If additional time is needed, the Medical Staff member or privilege holder and the observer shall submit a separate request which shall be submitted for approval in the same manner as outlined in this policy.

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

NAME OF OBSERVER: ______________________

ADDRESS OF OBSERVER: ______________________
(ADDRESS, CITY, STATE, ZIP)

EMAIL 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 if approved, I will be permitted to act as an observer only for the time period approved which will not exceed the last day of the month.

2. If additional dates and times are needed, I shall submit a separate request for this new time period.
3. I understand that I am not permitted to touch or provide care in any way to any patient at Torrance Memorial Medical Center. 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.

4. 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.

5. 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.

6. 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.

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

8. 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.

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

10. 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.

11. 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.

12. 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 the physician or privilege holder that I am observing.

1.
2.
3.

Observer Name: ___________________________________

Signature: ___________________________________

Date: ___________________________________

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 Facebook 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 must not be disclosed to anyone.

Visiting Observer Print Name	Visiting Observer Signature and Date:
Company or Vendor Name	
NOT APPLICABLE FOR MEDICAL STAFF SERVICES	
Date and Time of Visit	**Department Name ***
NOT APPLICABLE FOR MEDICAL STAFF SERVICES	NOT APPLICABLE FOR MEDICAL STAFF SERVICES
Department Host / Contact Signature and Date:	
NOT APPLICABLE FOR MEDICAL STAFF SERVICES	

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

HIPPA FORM 14A

Initial Approval and Major Revisions:
Bylaws Committee: 09/09/2011, 10/1/2014, 9/30/2015, 10/3/2017; 8/29/2019; 08/18/2023
Medical Executive Committee: 10/11/2011, 12/9/2014, 12/9/2015, 12/12/2017; 10/15/2019; 10/10/2023
Board of Trustees: 10/31/2019; 10/31/2023