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
	MEDICAL EXECUTIVE COMMITTEE	10/11/2011

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 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 asked to leave the premises.

8. A request should 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.

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 OBSERVER: _____
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 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. The observer can be asked not to observe by a patient, the care giver, the patient's family, or the physician.

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.

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)

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

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

1.
2.
3.

Observer Name: _____

Signature: _____

Date: _____

TORRANCE MEMORIAL MEDICAL CENTER

CONFIDENTIALITY AGREEMENT
INFORMATION AND COMPUTER USAGE

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). Additionally, Torrance Memorial must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information.

In the course of my employment/assignment at Torrance Memorial Medical Center, I will come into possession of confidential information. My personal access codes ["USER ID(s)" and "PASSWORD(s)] used to access computer systems are also an integral aspect of this confidential information. Therefore, all persons who are authorized to access data and resources, both through hospital-wide information systems and through individual department local area networks and databases, must read and comply with the policies related to protection of PHI.

INFORMATION USAGE REQUIREMENTS:

By signing this document, I understand the following:

1. I agree not to disclose or discuss any patient (PHI) information and research information with others, including friends or family, who do not have a need-to-know.
2. I agree not to discuss patient (PHI) information and research information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on the shuttle buses, 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. This can raise doubts with patients and visitors about our respect for their privacy.
3. I agree not to access any patient (PHI) information, other than what is required to do my job, even if I don't tell anyone else this information.
4. I agree not to make any patient (PHI) inquiries for other personnel who do not have proper authority.
5. I understand that my obligations under this agreement will continue after termination of my employment.
6. I agree that I have no right or ownership interest in any confidential information.
7. I agree that at all times during my employment/ assignment or service; I will safeguard and retain the confidentiality of all confidential information.

8. I agree that I will be responsible for misuse or wrongful disclosure of confidential information and for failure to safeguard PHI.
9. I agree not to disclose or discuss any human resources, payroll, and fiscal or management information about employees, patients or others with anyone, (including friends or family,) who does not have a need to know. I understand that I may disclose my own personal information as I see fit.
10. I agree not to disclose, discuss, email, text or post any information or photographs regarding patients that I have obtained on the job, on social networking sites such as face book, twitter, my-space, you-tube etc.
11. I agree not to disclose, discuss, email, text or post any information or photographs regarding patients that I have obtained on the job, on my personal electronic devices such as cellular telephone, laptop, computer or I-pad, etc.
12. I understand if I make a reference to a diagnosis or other medical terminology or divulge other characteristics and details about a patient, even if the patient's name is not used or share about my patient-care experience, it can still identify the patient. This can raise doubts with patients and visitors about our respect for their privacy and our compliance with state and federal privacy regulations.
13. I understand I will be in violation of our hospital privacy polices and state and federal regulations for posting, texting or emailing any patient information or patient-care experience on social networking sites such as face book, twitter, my space, you-tube etc.
14. For employees only: I understand that I will be subject to corrective action, up to and including termination, under the existing policy "Corrective Action" Policy # 404 and "Corrective Action for Security Incident of PHI" Policy # 1410.20 for violations.
15. I understand that I may be personally liable under state and federal regulation for penalties, fines, jail time and judgments and/or any compensatory damages awarded as a result of a lawsuit.
16. I understand that if I hold any licensing by the state, I can be reported to that governing licensing board for patient confidentiality breach violations.

COMPUTER USAGE REQUIREMENTS:

Torrance Memorial Medical Center provides computers, computer files, software, E-Mail, Voice Mail and Internet access to employees for business use. Employees are assigned a Username and password which is a unique identification of the employee and that employee's computer systems accounts. Torrance Memorial Medical Center reserves the right to monitor, access, retrieve, and delete any message/document on E-Mail, Voice Mail, or any other computer system including

Internet activity without notice for any reason. Torrance Memorial Medical Center will not alter or delete any patient documentation records.

REMOTE ACCESS:

Definition:

The ability to access TMMC computing resources external to the hospital's physical network infrastructure via the Internet or other transmission method/media such as dial-up, point-to-point leased lines, DSL and cable broadband services, satellite broadband services, frame relay, microwave and all wireless protocols, secured or unsecured. Such access to computing resources includes, but is not limited to, e-mail, time & attendance, scheduling, clinical, financial, and administrative systems.

By agreeing to the Confidentiality Agreement, I am also agreeing to the terms and conditions of the Remote Access Agreement (HIPAA Form #34) as described under Section 2, Obligations of Remote Users, and its subsequent sections. In addition, I will be required to review and electronically sign this agreement annually when I take my annual Safety and Competency tests. The Remote Access Agreement is available to print and view online under the HIPAA Resources document.

By signing this document, I understand I will:

1. Respect the privacy and rules governing the use of any information accessible through the computer system or network and only utilize information necessary for performance of my job.
2. Respect the ownership of the hospital's software, For example, I should not make unauthorized copies of such software for my own use, even when the software is not physically protected against copying.
3. Respect the capability of the systems, and limit my own use so as not to interfere unreasonably with the activity of other users.
4. Respect the procedures established to manage the use of the system.
5. Prevent unauthorized use of any information in files maintained, stored or processed by Torrance Memorial Medical Center.
6. Not seek personal benefit or permit others to benefit personally by PHI or use of equipment available through my work assignment.
7. Not operate any non-licensed software on any computer provided by Torrance Memorial Medical Center.
8. Not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.

9. Not remove any record (or copy) or report from the office where it is kept except in the performance of my duties.
10. Notify my supervisor, the Information Security Officer, or Human Resources upon learning of violations of this agreement, for example if I detect that someone has accessed my files.
11. Understand that the information accessed through all Torrance Memorial information systems contains sensitive and confidential patient care, business, financial and hospital employee information that should only be disclosed to those authorized to receive it.
12. Not release my password to anyone else, or allow anyone else to access or alter information under my identity.
13. Not leave any open sessions unattended and not leave a workstation without logging off.
14. Not utilize anyone else's password in order to access any Torrance Memorial Medical Center system.
15. Respect the confidentiality of any reports printed from any information system containing patient or employee information and handle, store and dispose of these reports appropriately in the confidential destruction bins.
16. Understand that all access to the system will be monitored.
17. Understand that Torrance Memorial will monitor E-Mail, Voice Mail, Internet activity, and any computer files.
18. Not use E-Mail or Voice Mail to solicit other employees for any reason.
19. Not use Torrance Memorial's systems for non-work related purposes.
20. Understand that my obligations under this Agreement will continue after termination of my employment /assignment or service. I understand that my privileges hereunder are subject to periodic review, revision, and if appropriate, renewal or revocation.

- I understand that violation of this agreement may result in corrective action, up to and including termination or revocation of assignment or privileges and legal liability.
- I understand that in order for any "USER ID" to be issued to me, this form must be completed.
- Those who cannot accept these standards of behavior may be denied access to the relevant computer systems and networks.
- I agree to abide by the following:
  - "**Uses and Disclosures of PHI – General Rules"** Policy # 1410.01;
  - **"Confidentiality of PHI"** Policy #1410.03;
  - **"Authorization for Use or Disclosure of PHI"** Policy # 1410.10;

- **"PHI Access Controls and Minimum Necessary"** Policy # 1410.13;
- **"Release of Patient Condition and Location"** Policy # 1410.15;
- **"Complaint Handling Under HIPAA"** Policy # 1410.17;
- **"Corrective Action Process for Security Incident of PHI"** Policy # 1410.20
- **"Copying and Faxing of PHI"** Policy # 1410.06;
- **"Computer, E-mail and Voice Mail Usage"** Policy # 310;
- **Admin_800.04_01 "Adverse Event"**
- **"Fax Cover Sheet – Hospital – Hospital"** HIPAA Form #15;
- **"Fax Cover Sheet – Home Health/Hospice"** HIPAA Form #16;
- **"Authorization for Use or Disclosure of PHI"** HIPAA Form #17
- **"Security Incident of PHI Reporting Form"** HIPAA Form # 31
- **"Remote Access Agreement"** HIPAA Form # 34
- **California Law Senate Bill 541 and Assembly Bill 211**
- **HITECH regulations**

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Signature of Employee/Physician/Student/Volunteer/Registry/Traveler Staff/Contractor Date

_____

Print Name

_____

Name of Company, if not Torrance Memorial Medical Center:

To Be Filed with:

- Human Resources
- Medical Staff Office for medical staff members
- Department for students, registry, travelers and contractors
- Volunteer Office for volunteers.