

# **OBSERVER POLICY with MEDICAL AFFAIRS/CREDENTIALS**

Hamilton Health Sciences/St. Joseph's Healthcare Hamilton

## **A. PURPOSE:**

To provide guidelines to support observership placements for individuals who are requesting to gain knowledge and expertise about health care and/or services within a healthcare organization. This may involve the opportunity to observe specific procedures and/or patient care processes.

## **B. OBSERVERS:**

### Inclusions:

#### **Fees Applicable**

- IMG'S – who have been accepted to McMaster Postgraduate program
- IMG'S – who have completed the Medical Council of Canada QE1 examination
- Other Healthcare Practitioners, which include MD's from outside of Canada; and Non MD's from Canada or elsewhere

#### **Fees NOT Applicable**

- Canadian based actively practicing physicians

### Exclusions:

- ALL Medical Students Cdn / US / Overseas - should be supported through electives program
- ALL Residents Cdn / US/Overseas - should be supported through electives program
- Recruits in Process & wanting to observe while paperwork/appt is finalized
- Undergraduate and other students: Option: Hospital Job Shadow Policy – eligibility requirements are set out by the department handling these requests at the respective hospital

## **C. DEFINITIONS:**

An Observer is not considered an employee of the Hospital and therefore is not:

- Entitled to salary, benefits, reimbursement of expenses or other forms of compensation
- Covered under the Workplace Safety and Insurance Board (WSIB)
- Covered under the organization's liability insurance
- Entitled to receive educational credit or certification from the organization for time spent observing
- Entitled to access to Occupational Health Services

### **Role of an Observer:**

An Observer is not permitted, in any circumstances, to provide any patient care. This prohibition includes but is not limited to:

- Taking a medical history,
- Conducting physical examinations,
- Diagnosing or treating patient's conditions,
- Ordering, preparing or administering drugs,
- Documenting on patients' health records, either in electronic or hard copy format,
- Having independent access to health records, either in electronic or hard copy format,
- Performing or assisting in surgical procedures, or diagnostic patient interventions,
- Obtaining consent,
- Interacting directly with patient/SDM,
- Providing health care advice.

## **DOCUMENTATION:**

### **Documentation Required To Request Observership:**

- Completed Observer Request Form (Appendix A)
- Statement of Agreement and Acknowledgment of Role & Responsibilities (Appendix B)
- Confidentiality Agreement (Appendix C)
- Completion of PRE-EMPLOYMENT HEALTH FORM (Appendix D) and all requirements, officially translated, if not in English
- Up to date Curriculum Vitae
- Copy of Degree – officially translated, if not in English
- Passport size photo
- All internal Hospital Approvals (Appendix E)
- Completed Observer Application Fee Form – for full period of Observership requested (Appendix F)

*Note: Observership appointments are for a period of up to 4 weeks (1 month), renewable to a maximum of 12 weeks (3 months)*

### **Observers are expected to arrange their own:**

- accommodations during their visit
- health insurance
- liability coverage
- automobile insurance

## **E. POLICY:**

### **Observers and Patient Interaction/ Sponsor:**

- If the Observer will be present during any contact with a patient/SDM [substitute decision maker], prior to the Observer being present with the Sponsor individually or as part of a teaching group, the Sponsor must request verbal consent from the patient/SDM prior to any patient interaction
  - If the Observer is participating with the Sponsor as part of a teaching group, the consent obtained for the group will include the Observer; however
  - If the Observer is the only individual with the Sponsor, the Sponsor is to obtain individual patient consent.

#### **To Remember:**

- The Sponsor will introduce the Observer to the patient/SDM and explain the reason for the Observership.
- The Sponsor will document patient/SDM consent in the patient's health record.
- Verbal consent is required from the patient/SDM to attend rounds or team meetings where patient care is discussed, and documented in the patient's health record.
- Observers are not to view the patient's health care record under any circumstances.

The individual approving the Observership must consider whether the Observership is consistent with and based on:

- The mission and values of the organization,
- Ensuring the safety of the patient or the patient's Substitute Decision Maker (SDM),
- Respecting and maintaining the privacy of the patient and his/her family,
- Protecting the confidentiality of patient information and confidential business information of the organization.

All Observers must be partnered with an Active member of the Professional Staff/Sponsor, who is responsible for the supervision and safety of the individual participating at all times.

### **Termination of Observership**

- HHS/SJHH may terminate an Observership at any time at its sole discretion. Concerns regarding the appropriateness of the Observer will be addressed by the Sponsor and, if necessary, by the Sponsoring Department Chief.

## **F. PROCEDURE - OBSERVER APPLICATION PROCESS:**

- A. Prior to initial request for observership:
- Sponsoring physician will first seek approval from the relevant Clinical Department Chief.
- B. Prior to final approval of any Observer:
- Fully completed application and all required documentation must be received by the Credentials office minimum two weeks in advance of observation start date.
  - Letters of approval will be sent to the Sponsor prior to start date.
- C. Final approval:
- is granted by the VP Medical and the Medical Advisory Committee, if the applicant meets the necessary requirements.

**See Appendix G for a detailed chart outlining roles and responsibilities of the Observer, Sponsoring Physician, Chief of Department and Credentials office related to:**

- **Application Process**
- **First Date and Orientation**
- **Request for Extension of Observership**
- **Last day – Completion of Observership**

### **References:**

- CPSO Policy Statement: Shadowing: Observing Physicians in a Clinical Setting
- Code of Conduct
- Visitors in the OR Policy HHS / SJHH
- Confidentiality

### **Developed by:**

- Joint Credentials Committee

### **In Consultation with:**

- SJH and HHS Medical Affairs
- SJH and HHS Medical Advisory Committee(s)



Hamilton Health Sciences

St. Joseph's  
Healthcare  Hamilton

**CREDENTIALS: OBSERVER REQUEST FORM**

**NAME OF OBSERVER:**      **LAST NAME** \_\_\_\_\_ **FIRST NAME(S)** \_\_\_\_\_  
 [PLEASE PRINT]

**CONTACT INFORMATION**

**ADDRESS:** \_\_\_\_\_

<b>PHONE</b>	<b>FAX</b>	<b>E-MAIL</b>
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**FROM:** \_\_\_\_\_  
 (University/Hospital) \_\_\_\_\_ (Province/Country)

**PURPOSE OF VISIT / SPECIFIC LEARNING OBJECTIVES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ANTICIPATED START AND END**

**DATE(S) OF OBSERVERSHIP**      **From** \_\_\_\_\_ **To** \_\_\_\_\_

**LIST ALL DEPARTMENT(S) /** \_\_\_\_\_

**PROGRAMS OF OBSERVERSHIP:** \_\_\_\_\_

**OBSERVER LOCATION(S)**

**PLEASE CHECK WHICH FACILITY(IES) THAT APPLY TO YOUR REQUEST FOR OBSERVERSHIP**

- Hamilton Health Sciences: Site(s) \_\_\_\_\_
- St. Joseph's Healthcare Hamilton: Site(s) \_\_\_\_\_

**SPONSOR [UNDER THE SUPERVISION OF]:** \_\_\_\_\_

**DOCUMENTATION REQUIRED TO CONSIDER AN OBSERVERSHIP**

- Completed Observer Request Form
  - Statement of Agreement and Acknowledgment of Role & Responsibilities
  - Confidentiality Agreement
  - Completion of PRE-EMPLOYMENT HEALTH FORM, and all requirements, officially translated, if not in English
  - Up to date Curriculum Vitae
  - Copy of Degree - officially translated, if not in English
  - Proof of successful completion of Medical Council of Canada QE1 examination
  - Passport size photo
  - All internal Hospital Approvals
  - Completed Observer Application Fee Form, where applicable, [for full period of Observership requested]
- Observership appointments are for a period of up to 4 weeks, renewable to a maximum of 12 weeks [3 months]

**Observer's Statement of Agreement and Acknowledgement of  
Role & Responsibilities:**

1. An Observer **will not**, under any circumstances, be involved in any form of direct patient care. Patient care involves, **but is not limited to:**
  - Taking a medical history,
  - Conducting physical examinations,
  - Diagnosing or treating patient's conditions,
  - Ordering, preparing or administering drugs,
  - Documenting on patients' health records, either in electronic or hard copy format,
  - Having independent access to health records, either in electronic or hard copy format,
  - Performing or assisting in surgical procedures, or diagnostic patient interventions,
  - Obtaining consent,
  - Interacting directly with patient/SDM,
  - Providing health care advice.
  
1. All Observers must comply with Hamilton Health Sciences &/or St. Joseph's Healthcare Hamilton Observer Policy, and agree to abide by its By-Laws and Policies.
  
2. All Observers are required to maintain patient confidentiality regarding all cases observed. **(You must read and sign the HHS/SJHH Observer Policy & Confidentiality Agreement included in this package.)**
  
3. Your Sponsor must obtain a patient's verbal consent for your presence prior to any patient contact. A patient's right of refusal is to be respected at all times.

**OBSERVER:**

I have read and fully understand the information provided in this documentation package.  
I am aware of and agree to comply with the aforementioned roles and accountabilities

**I understand I may not Observe without all of the requirements being completed and having been cleared through the Occupational/Employee Health office:**

**Fully completed application to be received by the Credentials office minimum two weeks in advance of requested Observership.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Printed Full Name \_\_\_\_\_

## **OBSERVER CONFIDENTIALITY AGREEMENT**

Check the appropriate organization (or both)

Hamilton Health Sciences  
St. Joseph's Healthcare Hamilton

All residents/patients/clients under the care of Hamilton Health Sciences (HHS) and/or St. Joseph's Healthcare Hamilton (SJHH) and all staff and affiliates have a fundamental right to have their health/medical/personal information treated in confidence. I understand I am ethically bound to keep all information confidential and to treat patients and staff members with dignity and respect.

My signature below confirms my commitment to uphold the expectations, policies and ethical practice of confidentiality in all of my involvement with Hamilton Health Sciences (HHS) and/or St. Joseph's Healthcare Hamilton (SJHH). This includes any information I may be privy to regarding patients, patient-related discussions, patient-related records and/or plans for patient care which comes to my attention while attending at the organization(s) as an Observer.

**I commit to continue to respect and maintain the confidentiality of patients, residents, clients, and their families, staff and affiliates, as well as the confidential business information of the organization(s) even after my attendance at the organization(s).**

I understand that I may consult my Observership Sponsor for details regarding this Agreement.

I understand that misuse, failure to safeguard, or the disclosure of confidential information without appropriate approvals may be cause for loss of affiliation with HHS and/or SJHH.

Printed Full Name \_\_\_\_\_

Signature \_\_\_\_\_

Date (YYYY/MM/DD) \_\_\_\_\_

Sponsor name \_\_\_\_\_

Sponsor Department \_\_\_\_\_

**NOTE – For observers visiting patient care areas: verbal consent must be obtained from the patient before the Observer approaches the patient**



Appendix D

**PREPLACEMENT/OBSERVATION/PRE-APPOINTMENT HEALTH FORM**

**FOR ALL PROFESSIONAL STAFF**

**Medical, Dental, Midwifery, Special Professional**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
*Please Print* *First* *Last* *Day / Month / Year*

Address: \_\_\_\_\_

Profession: \_\_\_\_\_

Contact information: [phone # or e-mail]: \_\_\_\_\_

Indicate facility applying to:  HAMILTON HEALTH SCIENCES  ST. JOSEPH'S HEALTHCARE HAMILTON

The Communicable Disease Surveillance Protocols for Ontario Hospitals, was developed by the Ontario Hospital Association and the Ontario Medical Association; approved by the Ministry of Health and Long Term Care and endorsed by the Canadian Medical Protective Association, pursuant to Regulation 965/90 Section 4 of the Public Hospitals Act, which requires known immune status on all health care workers. This includes physicians, dentists, midwives and special professional staff.

**1. MMR -- Measles, Mumps and Rubella Vaccination**

If you have received 2 Doses of MMR vaccine, given at least 4 weeks apart on or after your first birthday, provide proof, complete the dates below and move to step 5.

Date MMR #1 \_\_\_\_\_  
Date MMR #2 \_\_\_\_\_

If you have NOT had 2 documented MMR vaccinations, please complete sections 2, 3, and 4.

**2. Mumps: Evidence to Mumps immunity required:**

Laboratory evidence of mumps immunity -- Attach report  
**OR**

Documentation of receipt of 2 doses of mumps vaccine (or trivalent measles-mumps-rubella (MMR) vaccine) given at least 4 weeks apart on or after the first birthday  
Date/Name of vaccine #1 \_\_\_\_\_  
Date/Name of vaccine #2 \_\_\_\_\_

**3. Rubella (German Measles):**

Laboratory evidence of rubella immunity -- Attach report  
**OR**

Documented evidence of immunization with live rubella vaccine on or after your first birthday  
Date/Name of vaccine \_\_\_\_\_

4. **Measles**

Laboratory evidence of measles immunity – Attach report  
**OR**

Documented evidence of immunization with 2 doses of live measles virus vaccine on or after the first birthday  
Date/Name of vaccine #1 \_\_\_\_\_  
Date/Name of vaccine #2 \_\_\_\_\_

5. **Varicella/Zoster (Chickenpox/Shingles):**

Varicella vaccine is recommended for those aged 12 months or older. Two doses are recommended for all ages.

Date/Name of vaccine #1 \_\_\_\_\_  
Date/Name of vaccine #2 \_\_\_\_\_  
**OR**

The immune status of a health care worker may also be ascertained by history, and for those with a negative history of varicella, serological testing of immunity should be done.

Have you ever had Chickenpox or Shingles?

**Yes** (Further follow-up not required)

**No or Unknown -- Please have follow up blood work done for varicella immunity**

Laboratory evidence of immunity is required if you do not have a history of 2 varicella vaccinations or a history of having had varicella.

Laboratory report of immunity is attached

6. **Hepatitis B:** Although not required, protection against Hepatitis B is strongly recommended.

Hepatitis B Immunization Series:

Dose #1 Date: \_\_\_\_\_

Dose #2 Date: \_\_\_\_\_

Dose #3 Date: \_\_\_\_\_

If you have post vaccination documentation of Hepatitis B antibodies greater than 10 IU/ml, you are immune.

Laboratory proof of immunity attached

If you do not have proof of immunity by serology, and wish to have antibody testing done. You will be notified if your serology does not demonstrate immunity

Elected to have serological testing of immunity

Not vaccinated against Hepatitis B

7. **Tetanus Diphtheria Acellular Pertussis Vaccine(Tdap):**

Pertussis immunization must be documented.

*All healthcare workers and persons carrying on activities in the hospital who have not previously received an adolescent (age 14 and older) or adult dose of Tdap should receive a single dose of Tdap. The interval between the last tetanus diphtheria booster and the Tdap vaccine does not matter.*

Please provide the date and name of any pertussis-containing vaccine received after 14<sup>th</sup> birthday.

Date/Name of last Pertussis vaccine \_\_\_\_\_

*Routine vaccination with Tetanus and Diphtheria is recommended at 10 year intervals.*

**Tetanus and Diphtheria Vaccination:**

Date of last Td booster \_\_\_\_\_



If acceptable history or documented immunity to measles, rubella, mumps, pertussis, hepatitis B or varicella is not provided, appropriate immunization should take place.

*Vaccinations and Tb skin tests must not be given by you and must be administered and recorded by another qualified health professional.*

I am having blood drawn for:

- Measles
- Rubella
- Varicella
- Hepatitis B
- Mumps

AT:

**Employee Health Offices are open Monday to Friday 0800 to 1600**

If you have any questions please contact one of the following Employee Health Offices:

**Hamilton Health Sciences:** (905) 521-2100

General Site ext. 46307  
Juravinski Site ext. 42314  
McMaster Site ext. 75573  
St. Peters Site ext. 12213

**St. Joseph's Healthcare Hamilton:** (905) 522-1155

Charlton Campus ext. 33344  
West 5th Campus ext. 36361

**8. Tuberculosis Screening**

If tuberculin status is negative, documentation of a two-step TB skin test is required.

Complete one of the following options A, B or C.

*Pregnancy is not a contraindication to tuberculin skin testing.*

**Option A**

Provide documentation of a previous two-step TB skin test -- if the second step is within the last 12 months no additional testing is required

**Option B**

Provide documentation of a previous two-step TB skin test – if the second step is dated longer than 1 year ago—an additional single step TB skin test is required

Single Step TB Skin Test	Date Given	Date Read	Induration /mm	Interpretation	Health Care Providers Signature
Step 1					

**Option C**

Completion of a 2 step TB skin test

2 Step TB Skin Test	Date Given	Date Read	Induration /mm	Interpretation	Health Care Providers Signature
Step 1					
Step 2					

**Tuberculin Skin Test Positive:**

Complete the following if you have a documented history of a positive TB skin test and provide a copy of the chest x-ray.

Positive TB Skin Test	Date Given	Date Read	Induration /mm	Chest X-ray Date	Chest X-ray Result

Chest x-ray attached

**BCG Status:**

Never immunized

Immunized -- Date: \_\_\_\_\_

Previously treated for Latent or Active TB

Treatment provided and dates: \_\_\_\_\_

**NOTE:**

A determination regarding your exposure risk to tuberculosis and further testing will be dependant on the areas that you work in and the type of activities you perform.

TST testing within 6 months or annually may be requested.

Example:           Respirologists performing bronchoscopy -- (high risk activity) TST every 6 months

                          Emergency Room Physician -- (moderate risk activity) TST annually

                          Family Physician/Midwife -- (generally low risk activity) post exposure TST (Contact tracing)

**To the best of my knowledge the preceding information is true and correct.**

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Hamilton Health Sciences



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION  
Between  
Hamilton Health Sciences and St. Joseph's Healthcare Hamilton**

I, \_\_\_\_\_ authorize **Employee Health Offices of  
Hamilton Health Sciences and St. Joseph's Healthcare Hamilton to release  
and share the following:**

- Copy of the completed Pre-placement/Pre-appointment Health Form for Professional Staff and relevant chest x-ray and/or lab results

I understand this information will become part of my confidential health file.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness Signature: \_\_\_\_\_





**Roles and Responsibilities**

**Appendix G**

**A. OBSERVER APPLICATION PROCESS:**

**Responsibilities:**

<b>Observer:</b>	<b>Sponsor:</b>	<b>Department Chief:</b>	<b>Credentials Office:</b>
Observer will seek sponsor & request Observership. Initially will provide to Sponsor: <ul style="list-style-type: none"> <li>• C.V.</li> <li>• Purpose of visit and observership/objectives</li> <li>• Requested time frame</li> </ul>			
	Sponsoring physician will first seek approval from the relevant Clinical Department Chief and will Provide to Chief: <ul style="list-style-type: none"> <li>• C.V. of applicant</li> <li>• Purpose of visit and observership/objectives</li> <li>• Requested time frame</li> </ul>		
	If request denied by Chief, Sponsor will notify Observer	Chief will: Deny and notify Sponsor OR Support and notify Sponsor & Credentials Office	
			E-mail application package to Sponsor
	Provide Observer with application package		
Complete & sign the <ul style="list-style-type: none"> <li>• Observer Request Form</li> <li>• Privacy &amp; Confidentiality Agreement</li> <li>• Statement of Agreement</li> <li>• PRE-EMPLOYMENT HEALTH FORM &amp; ATTACH <u>COPIES</u> of all required immunization reports/documentation</li> <li>• Application Fee Form</li> </ul> AND Forward all required documentation and requirements to Sponsor			
	<ul style="list-style-type: none"> <li>• Review completed documentation submitted to ensure information is complete, forms signed and the request for observership is compliant with this policy.</li> <li>• Forward the pre-placement health form and all attachments to the appropriate Occupational/Employee Health Office</li> </ul>		

**OBSERVER APPLICATION PROCESS (Cont.)**

Observer:	Sponsor:	Department Chief:	Credentials Office :
			Health office to notify Credentials office &/or Sponsor of any outstanding requirements
Observer will submit all outstanding requirements to meet expected observership timeframe	Sponsor will continued to follow-up with Observer to submit any/all outstanding requirements to meet submission deadline.		
			Notify Sponsor of any outstanding requirements Notify Sponsor and Chief's office when Observer is compliant with pre-placement protocols
	Forward the completed and signed documentation to the Department Chief's office		
	If request is denied by Chief, Sponsor will notify Observer	Review the completed documentation and Sign Page 3 of the Request Form either to: <ul style="list-style-type: none"> <li>• Deny the Observer's request if it is not consistent with this policy and</li> <li>• Notify sponsor &amp; Credentials office</li> </ul> OR <ul style="list-style-type: none"> <li>• Support AND Forward entire package to Credentials Office</li> </ul>	
			Once all requirements have been met and application is deemed to be complete: Approval letter will be sent <ul style="list-style-type: none"> <li>• to the Sponsor with a copy to be provided to the Observer upon arrival,</li> <li>• to the Department Chief.</li> </ul>
			Observership will be added to the Credentials Agenda recommendations / information to MAC and Board.

**Fully completed application to be received by the Credentials office minimum two weeks in advance of requested start date of Observership.**

**B. ON THE OBSERVER'S ARRIVAL DATE :**

**Responsibilities of:**

Observer:	Sponsor:	Department Chief:	Credentials Office:
	Validate the Observer's photo identification		
	Provide copy of approval letter to Observer		
Wear ID badge at all times while in the organization	Facilitate Observer obtaining an HHS / SJHH visitor badge. ID badges must be obtained from the Security Office of the site the Observership will be affiliated, where applicable		
	Provide orientation to the Observer, including: <ul style="list-style-type: none"> <li>• Overview of observing events and times</li> <li>• Physical layout of department / program / service area</li> <li>• Safety training, as applicable</li> <li>• Any applicable departmental policies or procedures</li> </ul>		
	Ensure that the Observer is under the responsibility of a Professional Staff member at all times.		
Respect that unforeseen events may interfere with the Observership, and in this case, the Observer will recognize that his/her Observership may be terminated at the request of the Sponsor, or other leaders in the department or the organization			



### C. OBSERVER REQUESTS AN EXTENSION TO OBSERVERSHIP:

**Responsibilities of:**

<b>Observer:</b>	<b>Sponsor:</b>	<b>Department Chief:</b>	<b>Credentials Office:</b>
Submits a request in writing to the Sponsor asking for extension of current observership			
	If in agreement Sponsoring physician will request approval from Department Chief		
		Chief will: Deny and notify Sponsor OR Approve and notify Sponsor & Credentials Office	
	Will notify Observer		
If approved, will submit appropriate additional fee to Credentials Office			
			Upon payment of fee and receipt of all appropriate recommendations, extension will be granted Approval letter will be sent <ul style="list-style-type: none"> <li>• to the Sponsor with a copy to be provided to the Observer:</li> <li>• to the Department Chief.</li> </ul>
			Observership will be added to the next Credentials Agenda recommendations / information to MAC and Board.

### D. COMPLETION OF THE OBSERVERSHIP (last day)

**Responsibilities of:**

<b>Observer:</b>	<b>Sponsor:</b>	<b>Department Chief:</b>	<b>Credentials Office:</b>
Return ID Badge to Sponsor or directly to the Security office where it was issued	Ensure that the ID badge is returned upon completion of the Observership		
	Where desired, obtain feedback / evaluation from the Observer regarding his/her overall experience to ensure on-going positive relations and quality assurance		
	Notify Chief's office	Notify Credentials Office	Close file