OBSERVATION POLICY
STORMONT-VAIL REGIONAL HEALTH CENTER

Any person who wishes to observe direct patient care at Stormont-Vail Regional Health Center must comply with the following standards if he or she is not a member of the Medical Staff, involved in the care of the patient being observed, an employee of SVHC not assigned to the area, or a student whose educational activities are included in an affiliation agreement between his or her educational institution and Stormont-Vail.

A. Observation approval will only be given to the following:
   1. Hospital personnel with a legitimate need to observe a specific procedure or procedures.
   2. Students in the medical field (minimum of 18 years of age).
   3. Physicians licensed in Kansas or another state.

B. No observers are allowed in any hospital patient care area without approval of the Department Director (or Directors, if more than one area is requested), and the Chairs of the appropriate Medical Staff Department(s) or their designees after submission of a completed application on the approved form. An application form will not be considered complete unless all requested information is included.

   Surgical observation approval must include the surgeon, anesthesiologist, Director of Surgical Services or their designee.

   NOTE: Family members, regardless of status that might otherwise apply, may not observe surgery.

C. While an observer is in any hospital department, he or she must adhere strictly to all department policies and procedures. For surgical observations, the Surgical Specialty Coordinator/Clinical Educator or his or her designee will be responsible for orienting observers. Students should contact the appropriate educator in advance to schedule an orientation.

   While an observer is in any hospital department, he or she will need to have a hospital issued picture identification or name badge .

D. During any part of the observation experience, all observation rights may be suspended without prior notice by any physician or any caregiver.

E. An observer who is not employed by SVHC has no implied rights of employees. A physician observer has no implied rights of Medical Staff Members.

F. At the time of application for observation status, the observer is required to provide the following:

- Proof of TB Skin Testing Results (read within the past 12months)
- Proof of personal health insurance (copy of card, front and back)
- Letter of reference from the educational program director or instructor or supervising physician. (**Not required for Physician observers)**
- Copy of Kansas or other US state medical license (Physicians only)
- Proof of professional liability insurance (Physicians only)

G. Authorization Process: The application should be submitted **a minimum of 3 days** prior to the Observer's scheduled presence in the hospital. Medical Staff Services will assist in obtaining the signatures of the Hospital Department Director, and the Anesthesia Director or designee (if necessary) based on the schedules of the above named individuals.

H. The observer is responsible for maintaining compliance with this policy at all times during the approved observation period. This includes providing documentation of a current TB screen, personal health insurance or professional liability coverage when applicable.

I. All observers are required to sign the confidentiality clause on the application.

J. Observation may not include providing patient care.

K. Observation status shall be approved for a specific period of time or for a specific procedure.

- For observation status with regard to surgery, the approval period shall be specific either to a particular procedure(s) or for one day.
- Observation status that includes accompanying a physician on hospital rounds or a hospital-based physician shall be limited to three days or to a time period as designated by the sponsoring physician.
- Unaffiliated medical students, Physicians Assistants (PA) students or Advanced Registered Nurse Practice (ARNP) students may be annually approved to participate on a scheduled intermittent basis, with approval by the sponsoring physician.

Please send completed application to:

Stormont-Vail HealthCare
Medical Staff Services
1500 S.W. 10th Ave
Topeka, KS 66604-1353
Phone: (785) 354-6241
Fax: (785) 354-6159

STORMONT-VAIL OBSERVATION/ACTIVITY APPLICATION

Medical Student/PA Student _____
Advanced RN Practitioner Student _____
Other_____ _____

Premed Student _____
Physician _____

Name _____

Address _____

City, State, Zip _____

Telephone _____

Date of Birth_____ (Minimum age 18 yrs)

TB Skin Test Results _____
(Attach Copy of Documentation d)

Health Insurance Company/Policy # _____
(Attached copy of insurance card)

School/Company_____

Address_____

City, State, Zip _____

School/Company Contact_____

State of Licensure (if applicable) _____
(Attach copy)

Professional Liability
Insurance Company: _____
(Attach Copy of certificate

Requested Area for Observation Experience:_____

Reason for the Observation or Activity Experience:_____

Requested Date(s) or Procedure(s):_____
(Note: Surgical observation status is generally limited to one day and general observation status to three days)

Supervising Physician Attestation

I agree to accept supervision of, and responsibility for, the activities and actions of the observer.

_____ _____
Date Supervising Physician

Note: one letter of reference from educational program director or supervising physician must accompany this application.

Observation Attestation:
I understand that I may experience physical or emotional reactions to my observation experience, which could cause me to experience physical and/or emotional injury. I hereby agree to release, indemnify and hold harmless Stormont-Vail HealthCare its medical staff members, employees and agents from all liability related to my observation experience.
I have received and read the guidelines for observation activities in the hospital setting and agree to abide by them.
I also understand the necessity of maintaining and will maintain as privileged and confidential, all information which I may learn about Stormont-Vail HealthCare , including, but not limited to, patient diagnoses, courses of care and treatment, prognosis, personal lives, relationships and concerns, family matters and all information contained in conversations between patients and students, or between patients and Stormont-Vail HealthCare staff or patients and physicians, or between physicians and Stormont-Vail HealthCare staff and/or students pertaining to any patients.
I certify that the information I have given is true, correct, and complete and I agree to the Observation Attestation.

_____ _____
Date Signature of Observer

Approvals

_____ _____
Date Anesthesia Director or Designee (if surgical experience)

_____ _____
Date Hospital Department Director

_____ _____
Date Chair, Medical Staff Department or Designee