

Children's Hospital and Health System, Inc. Administrative Policy and Procedure

SUBJECT: Observers – Job Shadows

POLICY

I. Purpose

The Observer/Job Shadow Program exists to provide students, physicians and other professionals the opportunity to observe the care and services provided at Children's Hospital and Health System (CHHS).

II. Types of Observers

Observers include the following:

1. Students in grades 9-12 and over 13 years of age.
2. Post-high school professional students.
3. Physicians, nurses or other healthcare professionals not on staff at CHW.

Observers exclude the following:

1. Employees of Children's Hospital and Health System.
2. Members of the Medical-Dental Staff of Children's Hospital of Wisconsin (CHW), Children's Hospital of Wisconsin-Kenosha (CHW -K), or Children's Hospital of Wisconsin – Fox Valley (CHW-FV).
3. Individuals on a pre-arranged tour of any of the facilities within CHHS.
4. Students who have been placed at CHW as part of affiliation and program agreements established with their respective colleges or universities.

Note: For information on student placements, see the administrative policy and procedure, titled: "Student Placement Program".

III. Guidelines for Length of Observation

For students, grade 9-12 and over 13 years of age, the guideline for length of observation is less than or equal to one workday.

For post-high school professional students and other healthcare professionals not on staff at CHW, the guideline for length of observation ranges from a few hours on a predetermined day, to as much as 180 hours over 6 months.

These are guidelines. Approvers may extend an observer's time as needed.

IV. Observers Must:

1. Have a site sponsor.
2. Complete and submit all required documents prior to beginning the observation.
3. Define the length of the observation. Use guidelines in section III. Requests for longer observation periods will be evaluated on an individual basis.
4. Be accompanied by their sponsor or sponsor's designee at all times.
5. Obtain and wear an identification badge at all times during the observation. Identification badges are obtained through Security Services for CHW observers.

V. Observers May Not:

1. Conduct a physical exam.
2. Take a patient history.
3. Handle patient equipment.
4. Make recommendations regarding specific patients, provide consultation or make decisions about patient care.
5. Document in the Medical Record or research records.

Approved by the Medical Executive Committee 05/01/2006

Approved by the MEC, CHW-FV 05/03/2006

Approved by the MEC, CHW-K 06/12/2006

PROCEDURE

1. The individual interested in observing contacts the department and/or interested sponsor a minimum of 3 weeks before the observational experience.
2. The sponsor or observer obtains an application packet. The application process should be facilitated through the applicable facility contact listed below:

Physicians

At CHW – Main Campus:	Main Campus Medical Staff Office
At CHW – Fox Valley:	Fox Valley Medical Staff Office
At CHW – Kenosha:	Kenosha Medical Staff Office

Non-Physicians

At CHW – Main Campus:	Educational Services Department
At CHW – Fox Valley:	Fox Valley Medical Staff Office
At CHW – Kenosha:	Executive Director

3. The individual seeking the observational experience works with the sponsor to complete the application packet.

Physicians

Complete sections **I & II for Physician Observers (pages 4 & 5)** and return forms to:

<input type="checkbox"/> CHW-Main Campus Medical Staff Office MS 959 P.O. Box 1997 Milwaukee, WI 53201	<input type="checkbox"/> CHW-Fox Valley Medical Staff Office MS 9944 130 2 nd Street Neenah, WI 54957	<input type="checkbox"/> CHW-Kenosha Medical Staff Office MS 621 6308 8 th Avenue Kenosha, WI 53143-5082
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Non-Physicians

Complete sections **I & II for Non-Physician Observers (pages 6 & 7)** and return forms to:

<input type="checkbox"/> CHW-Main Campus Education Services (C230) P.O. Box 1997 - Suite 230 Milwaukee, WI 53201	<input type="checkbox"/> CHW-Fox Valley Fox Valley Medical Staff Office MS 9944 130 2 nd Street Neenah, WI 54957	<input type="checkbox"/> CHW-Kenosha Executive Director MS 621 6308 8 th Avenue Kenosha, WI 53143-5082
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4. All required documents must be completed and received prior to the observational experience.
5. The individual seeking the observational experience will receive confirmation from the respective sponsor or sponsor’s designee.
6. The sponsor or sponsor’s designee will orient the observer to the items on the **Orientation Checklist (page 8)**, plus any department specific information necessary.

Approved by the Medical Executive Committee 05/2006

PLEASE RETURN FORM TO: (check one)

<input type="checkbox"/> CHW-Main Campus Medical Staff Office MS 959 P.O. Box 1997 Milwaukee, WI 53201	<input type="checkbox"/> CHW-Fox Valley Medical Staff Office MS 9944 130 2 nd Street Neenah, WI 54957	<input type="checkbox"/> CHW-Kenosha Medical Staff Office MS 621 6308 8 th Avenue Kenosha, WI 53143-5082
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**Children’s Hospital and Health System, Inc.
Observer / Job Shadow Agreement Form**

SECTION I: Physician Observers

Observer’s Name: _____ Observer’s Phone Number: _____ - _____ - _____

Observer’s Address: _____

City: _____ State: _____ Zip Code: _____

School/organization: _____

Observation Date(s): From ___/___/_____ To ___/___/_____

HEALTH REQUIREMENTS

1. Has observer had Varicella (chicken pox) in the last month? Yes _____ No _____

If yes, contact an Employee Health & Wellness nurse at 414-266-2190 to confirm a visit date. If no, proceed to requirement #2.

2. Date(s) observer received a negative TB (tuberculosis) skin test or negative chest x-ray within last 12 months: ___/___/_____ (MM/DD/YYYY)

3. Date(s) observer received 2 MMR vaccines ** OR ** a positive Rubella titre & a positive Rubeola (measles) titre: ___/___/_____ (MM/DD/YYYY) and ___/___/_____ (MM/DD/YYYY).

Sponsor: _____ Sponsor Phone Number: _____ - _____ - _____

Location of Observational Experience: CHW-Main Campus CHW-Fox Valley CHW-Kenosha
 Other CHHS Entity (list): _____

Department/Unit/Practice where observation will occur: _____

Reason for observation: _____

F1916E

SECTION II: Physician Observers

AGREEMENT

Children's Hospital and Health System (CHHS) has agreed to allow selected persons to shadow professionals. In consideration of CHHS allowing individuals the opportunity to job shadow at CHHS, the individual hereby agrees to the following:

Privacy/Confidentiality - The individual agrees any patient health information or knowledge acquired or received during the course of the job shadow at CHHS, including but not limited to patient care information and information contained in patient care records, shall be treated as confidential and shall not, unless required by law or otherwise permitted by CHHS, be disclosed or used during or after termination of the individual's placement at CHHS without CHHS's prior written consent.

Release/Indemnification - The individual agrees to and hereby does release, indemnify and hold harmless CHHS, its members, directors, officers, employees and representatives from any and all responsibility and obligation, and agrees not to hold CHHS liable for any or all injuries, losses, damages or expenses which may occur as a result of any act or omission of CHHS, its members, directors, officers, employees or representatives, or which may arise from the individual's participation in the job shadow program at CHHS.

Illness- The Individual hereby forever releases and shall discharge all claims and causes of action whatsoever, present and future, against CHHS, its directors, officers, employees and agents, related to or arising out of any illness, disease or health condition the individual may contract, develop or come into contact with while on the premises of CHHS.

Medical Treatment - CHHS shall provide or refer outpatient treatment to individuals while in the facility for job shadow program placement in case of an accident or illness. However, in no circumstances shall CHHS bear the cost of the emergency outpatient treatment.

Hospital Policy - The individual agrees to conform to all policies and procedures including those relating to safety, patient care and non-discrimination. These policies and procedures include all standards covered by CHHS Code of Conduct, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and Occupational Safety and Health Administration (OSHA) requirements.

Communicable Disease - The individual agrees to disclose if he/she has had contact with others who have Varicella, Severe Acute Respiratory Syndrome, or other communicable diseases that would threaten the safety of patients or staff.

I have completed all of the required elements to participate in this experience. I meet the health requirements as outlined in Section I of this agreement, and I have read the "Observers – Job Shadows" policy; specifically the limitations of the observers and the confidentiality requirements and agree to abide by the policy, and all terms of this agreement.

Observer signature

Date

CHHS Sponsor signature

Date

CHIEF MEDICAL OFFICER, OR DESIGNEE APPROVAL FOR OBSERVATIONAL EXPERIENCE:

Chief Medical Officer/Designee signature

Date

F1916E

Supersedes: 11/2001 Formerly: "Patient Care Observers – Professionals", and "Patient Care Observers – Students over 13 years of age"/CHW, CHW-K, CHW-F, 01/2003, 07/2003 to reflect new Physician-Observer Policy Process Owner: Director of Ed Svcs
Effective: 5/1/2006 Revised: Observers-Physicians combined into this policy
Observers – Job Shadows/CHHS/app

PLEASE RETURN FORM TO: (check one)

<input type="checkbox"/> CHW-Main Campus Education Services (C230) P.O. Box 1997 - Suite 230 Milwaukee, WI 53201	<input type="checkbox"/> CHW-Fox Valley Fox Valley Medical Staff Office MS 9944 130 2 nd Street Neenah, WI 54957	<input type="checkbox"/> CHW-Kenosha Executive Director MS 621 6308 8 th Avenue Kenosha, WI 53143-5082
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**Children’s Hospital and Health System, Inc.
Observer / Job Shadow Agreement Form**

SECTION I: Non-Physician Observers

Observer’s Name: _____ Observer’s Phone Number: _____ - _____ - _____

Observer’s Address: _____

City: _____ State: _____ Zip Code: _____

School/organization: _____

Observation Date(s): From ___/___/_____ To ___/___/_____

HEALTH REQUIREMENTS

1. Has observer had Varicella (chicken pox) in the last month? Yes _____ No _____

If yes, contact an Employee Health & Wellness nurse at 414-266-2190 to confirm a visit date. If no, proceed to requirement #2.

2. Date(s) observer received a negative TB (tuberculosis) skin test or negative chest x-ray within last 12 months: ___/___/_____ (MM/DD/YYYY).

3. Date(s) observer received 2 MMR vaccines **** OR **** a positive Rubella titre and a positive Rubeola (measles) titre: ___/___/_____ (MM/DD/YYYY) and ___/___/_____ (MM/DD/YYYY).

Sponsor: _____ Sponsor Phone Number: _____ - _____ - _____

Location of Observational Experience: CHW-Main Campus CHW-Fox Valley CHW-Kenosha
 Other CHHS Entity (list): _____

Department/Unit/Practice where observation will occur: _____

Reason for observation: _____

Reminder: Sponsor is responsible for notifying applicable Director or Patient Care Manager prior to conducting job shadow experience.
F1916E

SECTION II: Non-Physician Observers

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Observer signature Date

Guardian Signature Date
(If Observer is under 18 years of age)

CHHS Sponsor signature Date

DIRECTOR OR PATIENT CARE MANAGER APPROVAL (if sponsor is a CHHS employee):

CHHS Manager/Director signature Date
F1916E

Children’s Hospital and Health System
Orientation Checklist – CHW Main Campus / Fox Valley / Kenosha

Directions:

- Complete checklist below
- Return signed checklist to facility contact within 24 hours of commencing observation.

Note: Supplemental orientation materials that cover any or all of the checklist items may be used to support completion of the checklist. If you are uncertain about orientation material availability, ask your facility contact, or go to the shared Q drive:

.\Student Orientation\Student Orientation Slide Show.ppt

Introduction to Organization and Roles and Rules of Conduct:

1. Mission of Hospital
2. Role of student/observer, goals/objectives of the observation and any behavioral expectations (examples: attendance, dress code, approach to confidentiality, etc.)
3. Privacy/Confidentiality –Patient Health Information

Safety Procedures:

1. Emergency numbers
2. Safety Conditions
3. External disaster response

Infection Control

1. Standard Precautions
2. Hand-Hygiene

Security

1. Parking
2. ID Badge

Signature indicates “Orientation Checklist” has been covered by the Children’s Hospital and Health System Sponsor/Designee, and Observer reports his/her understanding of material.

Observer’s Signature: _____

Date: ____/____/____

Children's Hospital and Health System, Inc. Administrative Policy and Procedure

SUBJECT: Observers – Job Shadows

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1. Conduct a physical exam.
2. Take a patient history.
3. Handle patient equipment.
4. Make recommendations regarding specific patients, provide consultation or make decisions about patient care.
5. Document in the Medical Record or research records.

Approved by the Medical Executive Committee 05/01/2006

Approved by the MEC, CHW-FV 05/03/2006

Approved by the MEC, CHW-K 06/12/2006

PROCEDURE

1. The individual interested in observing contacts the department and/or interested sponsor a minimum of 3 weeks before the observational experience.
2. The sponsor or observer obtains an application packet. The application process should be facilitated through the applicable facility contact listed below:

Physicians

At CHW – Main Campus:	Main Campus Medical Staff Office
At CHW – Fox Valley:	Fox Valley Medical Staff Office
At CHW – Kenosha:	Kenosha Medical Staff Office

Non-Physicians

At CHW – Main Campus:	Educational Services Department
At CHW – Fox Valley:	Fox Valley Medical Staff Office
At CHW – Kenosha:	Executive Director

3. The individual seeking the observational experience works with the sponsor to complete the application packet.

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**Children’s Hospital and Health System, Inc.
Observer / Job Shadow Agreement Form**

SECTION I: Physician Observers

Observer’s Name: _____ Observer’s Phone Number: _____ - _____ - _____

Observer’s Address: _____

City: _____ State: _____ Zip Code: _____

School/organization: _____

Observation Date(s): From ___/___/_____ To ___/___/_____

HEALTH REQUIREMENTS

1. Has observer had Varicella (chicken pox) in the last month? Yes _____ No _____

If yes, contact an Employee Health & Wellness nurse at 414-266-2190 to confirm a visit date. If no, proceed to requirement #2.

2. Date(s) observer received a negative TB (tuberculosis) skin test or negative chest x-ray within last 12 months: ___/___/_____ (MM/DD/YYYY)

3. Date(s) observer received 2 MMR vaccines **** OR **** a positive Rubella titre & a positive Rubeola (measles) titre: ___/___/_____ (MM/DD/YYYY) and ___/___/_____ (MM/DD/YYYY).

Sponsor: _____ Sponsor Phone Number: _____ - _____ - _____

Location of Observational Experience: CHW-Main Campus CHW-Fox Valley CHW-Kenosha
 Other CHHS Entity (list): _____

Department/Unit/Practice where observation will occur: _____

Reason for observation: _____

F1916E

SECTION II: Physician Observers

AGREEMENT

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Illness- The Individual hereby forever releases and shall discharge all claims and causes of action whatsoever, present and future, against CHHS, its directors, officers, employees and agents, related to or arising out of any illness, disease or health condition the individual may contract, develop or come into contact with while on the premises of CHHS.

Medical Treatment - CHHS shall provide or refer outpatient treatment to individuals while in the facility for job shadow program placement in case of an accident or illness. However, in no circumstances shall CHHS bear the cost of the emergency outpatient treatment.

Hospital Policy - The individual agrees to conform to all policies and procedures including those relating to safety, patient care and non-discrimination. These policies and procedures include all standards covered by CHHS Code of Conduct, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and Occupational Safety and Health Administration (OSHA) requirements.

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Observer signature

Date

CHHS Sponsor signature

Date

CHIEF MEDICAL OFFICER, OR DESIGNEE APPROVAL FOR OBSERVATIONAL EXPERIENCE:

Chief Medical Officer/Designee signature

Date

F1916E

Supersedes: 11/2001 Formerly: "Patient Care Observers – Professionals", and "Patient Care Observers – Students over 13 years of age"/CHW, CHW-K, CHW-F, 01/2003, 07/2003 to reflect new Physician-Observer Policy Process Owner: Director of Ed Svcs
Effective: 5/1/2006 Revised: Observers-Physicians combined into this policy
Observers – Job Shadows/CHHS/app

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Children’s Hospital and Health System, Inc. Observer / Job Shadow Agreement Form

SECTION I: Non-Physician Observers

Observer’s Name: _____ Observer’s Phone Number: _____ - _____ - _____

Observer’s Address: _____

City: _____ State: _____ Zip Code: _____

School/organization: _____

Observation Date(s): From ___/___/_____ To ___/___/_____

HEALTH REQUIREMENTS

1. Has observer had Varicella (chicken pox) in the last month? Yes _____ No _____

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Sponsor: _____ Sponsor Phone Number: _____ - _____ - _____

Location of Observational Experience: CHW-Main Campus CHW-Fox Valley CHW-Kenosha
 Other CHHS Entity (list): _____

Department/Unit/Practice where observation will occur: _____

Reason for observation: _____

Reminder: Sponsor is responsible for notifying applicable Director or Patient Care Manager prior to conducting job shadow experience.
F1916E

SECTION II: Non-Physician Observers

AGREEMENT

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Observer signature Date

Guardian Signature Date
(If Observer is under 18 years of age)

CHHS Sponsor signature Date

DIRECTOR OR PATIENT CARE MANAGER APPROVAL (if sponsor is a CHHS employee):

CHHS Manager/Director signature Date
F1916E

Children’s Hospital and Health System
Orientation Checklist – CHW Main Campus / Fox Valley / Kenosha

Directions:

- Complete checklist below
- Return signed checklist to facility contact within 24 hours of commencing observation.

Note: Supplemental orientation materials that cover any or all of the checklist items may be used to support completion of the checklist. If you are uncertain about orientation material availability, ask your facility contact, or go to the shared Q drive:

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1. Mission of Hospital
2. Role of student/observer, goals/objectives of the observation and any behavioral expectations (examples: attendance, dress code, approach to confidentiality, etc.)
3. Privacy/Confidentiality –Patient Health Information

Safety Procedures:

1. Emergency numbers
2. Safety Conditions
3. External disaster response

Infection Control

1. Standard Precautions
2. Hand-Hygiene

Security

1. Parking
2. ID Badge

Signature indicates “Orientation Checklist” has been covered by the Children’s Hospital and Health System Sponsor/Designee, and Observer reports his/her understanding of material.

Observer’s Signature: _____

Date: ____/____/____