BWH Long Term (Over 48hrs) Clinical Observational Experience Policy:

Statement of Policy/Purpose:

The Brigham and Women’s Hospital takes enormous pride in training and educating the next generation of physicians and healthcare workers. Most such training occurs as part of formal training arrangements such as medical student clerkships, ACGME accredited internships and residency training programs, and ACGME accredited fellowship programs. However, certain BWH Departments also offer non-credit, informal observation experiences for trainees not enrolled in the above entities but who desire to learn or gain basic exposure to the clinical environment. The purpose of this document is to ensure that all trainees, including those pursuing clinical observational experiences, are documented and abide by BWH Hospital policy ensuring no adverse impact on patient care or the academic environment. This policy pertains to experiences where observers are involved with the BWH clinical environment for 48hrs or less.

Clinical Observational Experiences (COE) at Brigham and Women’s Hospital will: (1) provide observers with appropriate educational observations in a closely supervised safe environment, (2) protect the rights and dignity of the BWH patient without adversely impacting clinical care, and (3) maintain the confidentiality and security of protected health information (PHI), and other proprietary or confidential information. COE’s are not training programs, and therefore do not provide BWH credit or any type of certification for trainee skills, level of training, or educational time.

Clinical Observational Experiences (COE’s) at BWH are not affiliated with any Harvard Medical School program or clerkships(s). Participation in a BWH COE will not have a preferential impact on any pending or future training applications. Upon successful completion of a COE, observers will receive an acknowledgement of COE attendance from the offering Department, confirming the observer’s dates of attendance. However, there is no formal credit provided. Prospective observers should also note that it will not be possible for professional or administrative staff to verify observers’ clinical skills based on participation in a clinical observership or provide a grade. Likewise, BWH professional staff will not be expected to write letters of recommendation for clinical observers.

Observer Participation & Limitations:

- The observer may join patient rounds and/or clinic opportunities under the direction of their BWH Faculty Supervisor but cannot ask questions or interrupt workflow. If there is time after rounds/clinic, questions can be directed to the Faculty member or medical team. The observer must note that they are not fulfilling a role as a medical or nursing student. Medical or nursing students (different from clinical observers) are enrolled in a formal training program, and thus may have a direct role in patient care as part of the credentialed medical team.

- The observer can introduce themselves to a patient, but in no way can participate in the care of the patient, documentation of care, or give even the appearance of being a caregiver. Importantly, the observer may not take a medical history, or touch or examine a patient. The observer should not interact with family members of the patient. Observers are not allowed to place medical orders, provide verbal orders, or convey medical recommendations to other patients or other healthcare

Effective 1/01/2023
members. The observers are not hospital employees or members for the professional staff, and may not represent themselves as such.

- The observers’ activities must not interfere with the education or activities of medical students or graduate medical education trainees.
- Clinical observers cannot participate in research* activities. Similarly, Clinical observers cannot publish any works that imply a formal affiliation with BWH.

*Non-employees who expect to participate in research should be onboarded through BWH OSSVS as a Research Trainee.

Observer Participation and Limitations in the Operating Room, PACU, Labor & Delivery:
Access to these locations is granted only by unique circumstance with awareness and approval by the Department Chair overseeing the Faculty Sponsor. In the Operating Room, PACU, and Labor & Delivery, observers must always be in the company of the Faculty Sponsor and/or the designee.

International Observers
- International physicians entering the country on either B1 or Visa Waiver/Business (WB) are welcome to seek observerships. Although the hospital cannot sponsor visas for non-employees, including clinical observers, the Sponsor can provide a formal letter of invitation upon request.

Current BWH Employees
- Current BWH employees not involved in clinical care (e.g. research trainees, research assistants) can apply for long term clinical observation in BWH Departments that will approve employee clinical observations. Note that not all BWH Departments allow clinical observation, and approval from the Chairperson, Vice-Chair of Education, or their delegate must be obtained. The duration of any clinical observation period will be firmly capped at 3 months without exception given the impact longer observation has on the broader education mission and other students. Employees must fully complete their long term observation packet. Departments will then follow this guide to complete the clearance process with the Office of Sponsored Staff.

Harvard Medical School Students
- Harvard Medical Students that are participating in POM or PCE at Brigham & Women’s Hospital may clinically observe within a department so long as they have approval and oversight from a supervising physician who takes responsibility for their observation and participation. Departments will be responsible for tracking and overseeing all efforts during the observation period.
- Harvard Medical Students that are participating in POM or PCE at a different Harvard Affiliated Hospital must contact the department in which they wish to clinically observe (seeking approval), as well as the Brigham & Women’s Hospital Undergraduate Medical Education (UME) Manager. If the student is not already onboarded as a BWH medical student, the UME Manager will complete the onboarding of the student. Note that paperwork for this must be submitted 3 or more weeks in advance of the clinical observation date, similar to onboarding for all HMS students. Departments will be responsible for requesting any additional resources needed to complete the clinical observation inclusive of scrubs and badges. Departments will be responsible for tracking the observation period.

Please note that the BWH Observational Experience Policy is subject to change based on hospital policies.

Process for Applying for an Observational Experience:

Effective 1/01/2023
Persons interested in a clinical observership should complete a ‘BWH Application for Observational Experience’, and ensure all necessary attachments are provided. These documents are then submitted to the sponsoring Department for final approval by the Chair or his/her designee. Once completed, the approved documents are then submitted to the Office of Sponsored Staff (OSS), for final approval.

➢ Step 1: A BWH faculty supervisor must agree to sponsor the clinical observer, and the Department Chair or Associate Chief Nursing Officer (or their designee) from the sponsoring faculty member’s department must approve the observational experience.

➢ Step 2: All application paperwork and necessary supporting documents must be submitted to the Sponsoring Department, for checking and approval:
   - Applicant’s Current CV (resume)
   - Completed COE application and Signed COE Policy & Agreement
   - Partners Confidentiality Statement - signed and dated
   - BWH Occupational Health Form
   - Copy of Applicant’s government issued ID
   - National Practitioner Databank query (NPDB) request – if applicable
   - Copy of health insurance (non-employee visitors must acquire & maintain health insurance for the period of time that they are engaged in BWH-sponsored activities and/or programs)
   - Letter of Good Standing from the applicant’s current hospital/program/school  
   From (and signed by) program director or administrator on company/institution letterhead
   - HireRight Background Check (Sent by Office of Sponsored Staff after successful onboarding)

➢ Step 3: All completed and signed application paperwork and necessary supporting documents must be submitted to The Office of Sponsored Staff Onboarding Portal no later than 3 weeks prior to the first day the observer and the sponsored faculty have agreed to begin the observership. This is a firm deadline
   - Office of Sponsored Staff Onboarding Portal (Email bwhoss@partners.org for access)
   - Click “Add POI Request”. Fill out the POI form in the portal with observers information (pictured below). Start date should be the first date of the agreed upon observership. End date should be the last day of the month in which the observership period concludes.
   - Once POI form is submitted, click “Actions” and “Manage POI Request Checklist” to submit all supporting documentation
   - Once all supporting documentation has been uploaded, go back to the original “Actions” tab and click “Change POI Request Status” from the drop-down menu. In the “Request Status” section of the pop up menu select “Ready for Review” and then click “Save & Close”
   - Some observers may already be in the Onboarding Portal from a previous observership or educational experience. For these circumstances, search for the individual using their last name in the “POI Name” section, click “Actions” and then “Renew POI Request” in the drop-down menu. Follow the steps listed above after clicking “Renew POI Request” to submit your records to the Office of Sponsored Staff.

Step 4: The long-term observer will receive a standard BWH badge with an expiration date aligned with the end of their observership. Coordinators should pick this badge up from the ID office ahead of the scheduled observership.

Effective 1/01/2023
Termination of Clinical Observership Experience:

BWH reserves the right to terminate a clinical observership at any time in the event of observer non-compliance with the terms of the Observership Agreement or if the observer becomes an obstacle to trainee, learning, or patient well-being.

Questions regarding clinical observers at BWH can be directed to Karen Bruynell or Alex McGillivray at the Brigham Education Institute, and Taraye Preston at The Office of Sponsored Staff.
Effective 1/01/2023

POI FORM
To be completed by Manager or Department Administrator

Start Date __________________________

First Name __________________________ Last Name __________________________

Date of Birth (mm/dd/yyyy) __________________________ Gender __________________________ Social Security Number __________________________

Ethnicity __________________________

Address __________________________ City __________________________

State/Country Zip Phone Email __________________________

End Date (approximate) __________________________

License Information (skip this section if it does not apply to you) __________________________

Does the POI hold a work related license? __________

License Type __________________________ License Number __________________________ Expiration Date __________________________

Issuing Agency __________________________ Issuing State __________________________

US Citizen? __________ Work Visa/Authorization Type (include permanent resident) __________________________

I, no, authorized to work in U.S? __________

Work Authorizing Document # __________________________

Expiration Date __________________________

Emergency Contact (optional) __________________________ Phone __________________________

FOR ALL POI’s: __________________________

I understand that before I begin, I will participate in an on-site orientation. I understand I must complete immunization screening and obtain clearance. I certify that the information provided on this application is true and correct. I understand that any deliberate, incomplete, incorrect or false statements may result in dismissal. I understand that all offers to participate in a BWH Sponsored activity are conditional upon receipt of satisfactory CORI background check. I hereby release Brigham and Women’s Hospital and any persons or organizations that provide information from any legal responsibility or liability that may arise from conducting an investigation of my service.

Signature/Date __________________________

FOR PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED PRACTICE REGISTERED NURSES ONLY: I understand that I must be licensed and credentialed in the state of Massachusetts in order to provide any type of medical care or guidance at Brigham and Women's Hospital (BWH). I understand that I must complete a formal BWH credentialing process and be approved for clinical privileges prior to engaging in any clinical activities.

Signature/Date __________________________

HR department (BR# or BD#) __________________________ Department name __________________________

Is the POI being Compensated? __________ Pay Source __________________________

Will the person be practicing medicine &/or assuming clinical duties? __________ Will the person have contact with children? __________

What is the POI’s Role? __________________________

Work Schedule (hours per day & day of the week) __________________________

Please describe duties/responsibilities:

________________________________________________________________________

Access to Partners Network needed? __________________________ Email account needed? __________________________ Is the POI Working Remotely? __________

Primary Work Location (address, building name & floor) __________________________

Requesting Manager/Dept Administrator __________________________ Signature __________________________ Form completed by __________________________

OSSVS/HR Section

POI Type: __________

CORI-Date Submitted __________________________ CORI-Date Received __________________________

OHS Clearance Date __________________________ Orientation Date __________________________ PeopleSoft ID# __________________________

Confidentiality Agreement __________ Type of Volunteer __________________________

POI OSSVS: Revised by BWH Operations 02/10/12
**Clinical Observational Experience (COE) Application:**

**Checklist and Cover Sheet**

This form **must** be completed, submitted and approved before any outside* individual can enter any BWHC facility functioning in the capacity of a learner, an observer, a visiting student/physician, or any other activity whereby such an outside* individual enters an area where healthcare is delivered.

Complete this form completely with necessary attachments and submit to the BEI at least one month prior to any desired rotation start date. Please place all paperwork in the order listed on this form. Do not include any paperwork in this packet that is not listed below.

*Please submit all documents as single-sided document with original signatures.*

<table>
<thead>
<tr>
<th>Clinical Observer Name: __________________________</th>
<th>Current Date: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>BWH Department: ________________________________</td>
<td>Experience Dates: ______________________</td>
</tr>
<tr>
<td>Division/Program: ______________________________</td>
<td>Coordinator Email: _____________________</td>
</tr>
<tr>
<td>Faculty Supervisor: _____________________________</td>
<td>Coordinator Phone: _____________________</td>
</tr>
</tbody>
</table>

*Effective 1/01/2023*
Clinical Observation Experience Policy & Agreement

Clinical Observers are not eligible for clinical privileges

- The observer may join rounds but cannot ask questions or interrupt workflow. If there is time after rounds, questions can be directed to the senior resident.

- The observer can introduce themselves to a patient, but in no way can participate in the care of the patient, the documentation of the care, or give even the appearance of being a caregiver. In particular, the observer may not ask questions, take history, or touch or examine the patient.

- The observer should not interact with ancillary staff and should never be a transmitter of medical information.

- The observer should not interact with family members of the patient.

- The observer should not attend family meetings.

- The observer should not be confused with students, who are participating in a formal training program or under a formal affiliation agreement.

- The observers’ activities must not interfere with the education or activities of medical students or graduate medical education trainees.

- The observers are not hospital employees or members for the professional staff and may not represent themselves as such.

- Observers are not allowed to place medical orders, provide verbal orders, or convey medical recommendations to other patients or other healthcare members.

- Observers cannot participate in research activities.

- Observers cannot publish any works that imply a formal affiliation with BWH.

- Observers cannot suggest or imply that they are acting with authority of BWH.

If an observer is unable to adhere to these guidelines, BWH reserves the right to terminate the observational experience.

__________________________________________  ______________________________________
Clinical Observer’s Signature                      Date

__________________________________________
Clinical Observer’s Name

__________________________________________  ______________________________________
Faculty Supervisor Signature                      Contact Phone Number

Effective 1/01/2023
Clinical Observership Experience Application
BRIGHAM AND WOMEN’S HOSPITAL

This application must be completed for individuals who would like to observe patient care at Brigham and Women’s Hospital. For medical students from other institutions who are interested in participating in the care of patients or seek to receive clerkship credit for this experience, please contact the HMS Registrar’s Office at exchangeclerkship@hms.harvard.edu for more information regarding elective clerkship rotations. For residents and fellows from other institutions who are interested in participating in the care of patients, please contact the Graduate Medical Education office for more information regarding elective rotations. Please submit this application and all required supporting documentation (see checklist) to BWH Office of Sponsored Staff.

Section 1 - To be completed by visiting scholar:

First Name ___________________________ Last Name ___________________________

Date of Birth __________ Gender __________ Social Security Number __________ Ethnicity __________

Home Address ________________________________________________________________

State/Country/Zip Code ________________________________________________________ Email ________________________________________________________________

Phone Number __________ Y/N __________ US Citizen ___________________________

I ____________________________________ (“Clinical Observer”) understand that this observational experience is being made available to me based upon BWH’s interest in training future health care professionals. I understand that this experience is solely for my educational benefit and that my status is that of an observer. I understand and acknowledge that I do not have an employment or volunteer relationship with BWH/HMS and that I will not be providing any services to BWH/HMS during the course of my observational experience.

Clinical Observer’s Signature: ___________________________________________ Date: __________

Effective 1/01/2023
Section 2 - To be completed by BWH Department:

BWH Contact Person/Program Coordinator: ____________________________ Phone number: ________________

BWH Faculty Supervisor: ____________________________ Phone number: ________________

The above-named Clinical Observer would like to apply for an observational experience in the BWH Department of ______________________ in ______________________ (division or program), for the period

from ___________ to ___________ at (hospital) ____________________ (location/ward) ___________% ______

from ___________ to ___________ at (hospital) ____________________ (location/ward) ___________% ______

Educational goals of the proposed observership: ______________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

BWH Signatures:

Faculty Supervisor: ____________________________ Date: __________

Dept Chair/Assoc Chief Nurse Officer or Designee ____________________________ Date: __________
PARTNERS HEALTHCARE SYSTEM
PARTNERS COMMUNITY HEALTHCARE

CONFIDENTIALITY AGREEMENT

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare must assure the confidentiality of its employee, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code [User ID and Password] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. Access to confidential information without a patient care/business need-to-know in order to perform my job—whether or not that information is inappropriately shared—is a violation of this policy. I agree not to disclose confidential or proprietary patient care and/or business information to outsiders (including family or friends) or to other employees who do not have a need-to-know.

2. I agree not to discuss confidential patient, employee, payroll, fiscal, research or administrative 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 make inquiries for personnel who do not have proper authority.

4. I know that I am responsible for information that is accessed with my password. I am responsible for every action that is made while using that password. Thus, I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own.

5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partners' computer systems to unauthorized locations, e.g., home.

6. I agree to log off a Partners workstation prior to leaving it unattended. I know that if I do not log off a computer and someone else accesses confidential information while the computer is logged on with my password, I am responsible for the information that is accessed.

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have the ability to track and monitor access to on-line records and reserves the right to do so. Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare can verify that those who accessed records did so appropriately.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any User ID and/or Password to be issued to me, this form must be completed.

Signature of Employee / Physician / Student / Volunteer / Non-Partners Personnel

Date

Print Name

83288 01/17/06

To Be Filed in Employee’s Personnel Record
BWH Occupational Health Form: The BWH Clinical Observer must complete and comply with ALL infectious control standards at BWH. Long Term observers should complete the attached form and will be approved for compliance by Occupational Health.

Last Name ____________________________ First Name ____________________________ Date of Birth ____________________________

Health Screening Requirements
Directions: Please take this form to your health care provider or Student Health Service for completion.

For Health Care Provider Completion:
All personnel who will work, volunteer, or observe at the Brigham and Women’s Hospital are required to meet the minimal infection control standards on page 2.
- Please plant and read a TB skin test, if this applicant has not had one in the past three months.
- For applicants with a past positive TB skin test, please complete the section labeled “Symptom Review” and obtain a chest x-ray which rules out active TB if one is not on file.
- Either documentation of the measles, mumps, rubella vaccines as required on page 2 is needed or proof of immunity by titer (blood test) is required.

For questions on form completion, call 617-732-6034. Thank You.

<table>
<thead>
<tr>
<th>TB Skin Test (TST)</th>
<th>Date Planted: _______</th>
<th>Date Read: _______</th>
<th>Result in mm: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 within 1 year of start date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#2 TST within 3mos of start date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 3mos of start date (see p.2)</td>
<td>QFT date/result: _______</td>
<td>T-spot date/result: _______</td>
<td></td>
</tr>
<tr>
<td>Symptom Review (Only for applicants who have a history of a positive PPD)</td>
<td>Loss of appetite □ Yes □ No</td>
<td>Fever □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unexplained weight loss □ Yes □ No</td>
<td>Fatigue □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Night Sweats □ Yes □ No</td>
<td>Productive Cough □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chest X-Ray Date</td>
<td>Chest X-Ray Result</td>
<td></td>
</tr>
<tr>
<td>LTBI Treatment Length</td>
<td>□ __________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INH Completion Date</td>
<td>□ __________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>MMR #1</td>
<td>MMR #2</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>Measles #1</td>
<td>Measles #2</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Mumps #1</td>
<td>Mumps #2</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>Varivax #1</td>
<td>Varivax #2</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hep B #1</td>
<td>Antibody Hepatitis B</td>
<td>POS / NEG</td>
</tr>
<tr>
<td></td>
<td>Hep B #2</td>
<td>POS / NEG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hep B #3</td>
<td>POS / NEG</td>
<td></td>
</tr>
<tr>
<td>Td/Tdap</td>
<td>Td</td>
<td>Tdap</td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>Seasonal</td>
<td>Color Vision Screen date</td>
<td>Normal/Abn</td>
</tr>
</tbody>
</table>
### COVID Documentation

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Product Name/Manufacturer and Lot Number</th>
<th>Date</th>
<th>Healthcare Professional or Clinic Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Dose COVID-19</td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
<td>mm dd yy</td>
</tr>
<tr>
<td>2nd Dose COVID-19</td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
<td>mm dd yy</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
<td>mm dd yy</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
<td>mm dd yy</td>
</tr>
</tbody>
</table>

**Print Name Health Care Provider**

**Signature**

**Date**

**Location**

**Telephone**
Infection Control Standards for Health Clearance

Tuberculosis Screening and Chest X-Rays
One of the following is required:
  a. Documentation of 2 step TB testing; #1 within 1 year of start date, #2 within 3 months of start date.
  b. For individuals known to be TB skin test positive, documentation of a chest x-ray report is required which rules out active tuberculosis.
  c. Documentation of a negative QFT or Tspot within 3 months of start date; if positive QFT or Tspot, then documentation of a chest x-ray report is required which rules out active tuberculosis.
  d. For clinical staff who need to be screened annually, QFT or Tspot test accepted only if new hire is from TB endemic country (http://www.who.int/countries/en/) and/or history of BCG vaccine.

Measles, Mumps, and Rubella Immunity Required
One of the following is required:
  a. Documentation of two measles vaccines, two mumps vaccine, and one rubella vaccine or documentation of two MMR vaccines.
  b. Proof of immunity to measles, mumps and rubella by titer (blood test).

Hepatitis B Vaccine
For individuals who may be exposed to blood or body fluids during their experience at BWH:
  a. Documentation of the hepatitis B series and/or
  b. Positive antibody test for hepatitis B.
* BWH will provide Hepatitis B vaccine free of charge to individuals who may be exposed to blood or body fluid during their work.

Chicken Pox Immunity Required
One of the following is required:
  a. Proof of immunity to chicken pox by titer (blood test).
  b. Documentation of two varicella vaccinations.
  c. Documentation of provider verified varicella (chickenpox) disease.

Tetanus
All staff should have documentation of up-to-date tetanus vaccine (Td/Tdap).

Influenza
Massachusetts Department of Public Health requires all health care workers to receive flu vaccine or to sign a declination that it was not received. BWH has a mandatory mask policy for those not vaccinated against seasonal influenza.

COVID-19 Vaccines
All staff, trainees and observers should have documentation of up-to-date Covid-19 vaccines (2 vaccines and a booster).