MARKHAM STOUFFVILLE HOSPITAL CORPORATION	**010.914.914.015 Management of the Observership Program**
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PURPOSE AND SCOPE:

The purpose of this document is 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.

POLICY STATEMENT(S):

It is the policy of Markham Stouffville Hospital (MSH) to accept applications of Observership from individuals who have applied or are considering applying to a health care program (e.g. medicine, nursing, allied health) and from individuals who are currently enrolled in a health care sciences program such as medicine, nursing, allied health and Internationally Educated Health Care Professionals (IEHPs). Individuals must (at the time of application) be a Canadian Citizen or Canadian Resident or hold a valid Canadian Student VISA.

Observers are supervised by individual staff and physicians on a volunteer basis.

It is the responsibility of the observer to find a Sponsor. Thus, the observer must have confirmed a primary supervisor for the Observership who is on Hospital staff (full or part-time) or a member of professional staff at MSH. MSH will not assist observers in finding a Sponsor and will not share personal contact information of physicians or staff members at MSH. All inquiries for contact information can be directed to the public MSH website.

Individuals who have applied or are considering applying to a health care program (e.g. medicine, nursing, allied health) must meet the following criteria to be considered for placement:

- Be a secondary school student who require an observational experience as part of the application process for a post-secondary health care program OR enrolled in a post-secondary educational program seeking an observational experience to enhance their studies
- NOT interfere in any way with the learning experience of students from any of MSH's academic partners.
- Be approved by the supervisor's department chief or manager.
- Be approved by the Director, Interprofessional Practice & Education.

- For this type of individual, the length of Observership is limited to a maximum of five (5) days in one given program or area, for a maximum of fifteen (15) days total over a 12 month period.

Individuals who are currently enrolled in a health care sciences program must meet the following criteria to be considered for placement:

- Be enrolled full-time in an accredited health care sciences program; OR be an IEHP and working towards obtaining college registration in Ontario.
- Be approved by the supervisor's Department Chief, Education Lead, or Manager.
- Be approved by the Director, Interprofessional Practice & Education.
- For this type of individual, the length of Observership is limited to a maximum of four (4) weeks and cannot exceed four (4) weeks over a twelve (12) month period.

Acceptance is granted to observers by the Hospital's departments and programs.

Documentation for academic credit as well as formal/informal feedback or evaluations will not be provided by the Hospital or the Supervisor at any time during or following the Observership.

Observers are strictly limited to the approved date(s).

It is the Sponsor/Supervisor who assumes full responsibility for the Observer during the observation period. The Supervisor must ensure that the:

- They accompany the Observer at all times.
- Observer is wearing an identification badge and accompanied at all times.
- Observer does not participate in health information gathering, have direct patient contact or engage in any aspect of patient care.
- Observer does not access any patient records.
- Observer is not involved in situations in which personal protective equipment is required.
- Observer is aware of the confidential nature of information concerning patients, hospital personnel or other confidential types of hospital information and that all reasonable caution must be exercised in protecting printed or written confidential information from casual observation, unauthorized perusal, or other abuse.
- Observer is introduced to all patients they observe and that verbal consent is obtained from the patient (or substitute decision maker) for the individual to observe.

PROCEDURE:

APPLICATION	
To download a copy of the Observership Application, visit the Interprofessional Practice and Education departmental page on the intranet, located http://intranet.msh.ca/?q=node/246 .	
Applicant	Upon submission of the application, the following documentation (refer to Appendix B) must be submitted by the applicant to Interprofessional Practice and Education (IPE) a minimum of four (4) weeks prior to the scheduled start date of the Observership:

	1. Completed Observer Application (form A) 2. Signed Confidentiality Agreement (form B) 3. Signed Observership Agreement including a witness signature (form C) 4. Completed Observership Offence Declaration Form (form D) 5. Proof of current immunization if required: a. Observers in non-clinical setting there are no specific immunization requirements; b. Observers in a clinical setting 1 day or less there are no specific immunization requirements; c. For students observing in a clinical setting > 1 day, Immunization requirements are the same as for all students at MSH (complete MSH Immunization Record; form E); 6. Completed Health Professional Observership Credit Card Payment Authorization for the non-refundable administrative fee of $50.00 (form F). Fee may be waived on a discretionary basis (ex. for Observership of 1 day or less). The completed application and all required documentation must be received by the IPE office a minimum of four (4) weeks in advance of the observation start date.
APPROVAL / DENIAL	
Director, Interprofessional Practice and Education	If the applicant meets the necessary requirements outlined above, grant final approval. The IPE office will notify both the Sponsor and applicant of the approval.
Observer	Prior to commencing the Observership, attend the Interprofessional Practice & Education office in person and show government issued photo identification (Appendix A) and obtain an ID badge (a $20 refundable deposit will be required to obtain an ID badge).

DEFINITION(S):
Not applicable.

REFERENCE(S):
Not applicable.

RELATED DOCUMENTS:
Not applicable.

RESPONSIBILITY:

Required Endorsements	Sponsor	Approval Authority
Interprofessional Practice and Education	Director, Interprofessional Practice and Education	Medical Advisory Committee

DOCUMENT HISTORY:

Type	Individual/Committee	Date	Outcome
Draft	Policy Coordinator	02/05/2018	New document. Incorporated Policy # 160.901.115.
Approval	Medical Advisory Committee		Approved.
Revise	Policy Advisor & Risk Specialist	22/08/2019	Minor Revision.

APPENDICES:

APPENDIX A:

Accepted Government issued ID (Note: A Health Card is not an accepted form of government issued ID):

- Canadian Passport (currently valid)
- A valid passport issued by a foreign jurisdiction
- Driver's license
- Certificate of Canadian Citizenship
- Birth Certificate issued by a Canadian Province or Territory
- Citizenship Identification Card
- Student Identification Card
- Canadian Permanent Resident Card
- Ontario Photo Card
- Record of Landing (IMM 1000)
- Confirmation of Permanent resident (IMM 5292)
- Citizenship and Immigration Canada – Refugee Protection Claimant Document
- Permanent Resident Card
- Nexus
- Canadian Certificate of Birth Abroad
- Canadian Certificate of Indian or Metis Status
- CANPASS (A Remote Area Border Crossing permit allowing the bearer to cross into Canada at certain remote areas without reporting to a port of entry as long as imported goods are declared)
- Firearm Registration License
- Certificate of Naturalization
- Statement of Live Birth from Canadian Province (Certified Copy)
- Union Card

APPENDIX B: Application for Observership

APPLICATION

A

Applicant to complete:

Personal Information

Name: (First Name)_____(Last Name)_____

Address_____

Email_____

Please indicate which category of Observership you are applying to:

☐ **Individuals who have applied or are considering applying to a health care program (e.g. medicine, nursing, allied health) or**

☐ **Individuals who are currently enrolled in a health care sciences program such as medicine, nursing, allied health Internationally Educated Health Care Professionals (IEHPs):**

To be eligible for an Observership, you must be in 1 of the following categories: (check 1 of the following)

☐ I am a Canadian Citizen ☐ I am a Canadian Resident ☐ I am in Canada on a student VISA

Academic Details

Current Academic Institution _____

Past Academic Instituion (for IEHPs)_____

Current Employer (if applicable) _____

Highest Level of Education (e.g. high school, college, university, etc.)_____

Highest Level of Credentials (e.g.. MD, RN, MSc, etc.)_____

Observership Information

Start Date_____End Date_____

Unit/Department/Service_____

MSH Supervisor Name_____MSH Supervisor Email_____

Please indicate which facility your request for Observership will take place:

☐ Markham Site ☐ Uxbridge Site

Signature approvals to be obtained by applicant:

MSH SUPERVISOR TO COMPLETE (Staff member, Physician, or Midwife)

I agree to supervise this applicant as a student observer and to adhere to the supervisor expectations outlined.

Name_____ Department_____
Signature_____Date_____

MSH MANAGER OR DEPARTMENT CHIEF TO COMPLETE

I approve this applicant as a student observer for the period indicated.

Name_____Department_____
Signature_____Date_____

Signature will be obtained by Interprofessional Practice & Education assistant:

MSH INTERPROFESSIONAL PRACTICE & EDUCATION TO COMPLETE

Approved by:

Name_____
Signature_____Date_____

CONFIDENTIALITY AGREEMENT

B

I acknowledge and agree that:

1. I am aware that Markham Stouffville Hospital has a zero tolerance philosophy on any violation of the security and confidentiality of any information concerning patients, Hospital employees and other confidential business information pertaining to the Hospital (collectively referred to below as 'confidential information').
2. I have an obligation to comply with the Personal Health Information Protection Act (PHIPA) and its regulation.
3. I acknowledge that I have an obligation to keep confidential all information designated as confidential including information that may come to my attention, at any time, and under any circumstances.
4. I will not divulge any confidential information either inside or outside Markham Stouffville Hospital unless required in the normal performance of my duties, as expressly authorized by the Hospital, or as required by law.
5. I will exercise all reasonable care and caution in protecting printed or written confidential information from casual observation, unauthorized perusal, or other disclosure.
6. I understand that I cannot remove confidential records, either on a permanent or temporary basis, from the premises of Markham Stouffville Hospital without specific authorization by the Hospital.
7. I agree to notify Markham Stouffville Hospital at the first reasonable opportunity in accordance with the Privacy Breach Management Protocol and Procedures of an actual or suspected breach of the confidentiality agreement, PHIPA or its regulation, or the privacy policy and procedures.
8. I understand that Markham Stouffville Hospital will conduct random audits to ensure compliance with this agreement.
9. I understand that this document may be revised periodically to reflect changes in the organization and that I may be required to sign a revised agreement.
10. I understand that it is the Hospital's policy that, if I fail to abide by the terms outlined in this agreement, this may result in a report to my health regulatory college, where applicable, and/or disciplinary action, up to and including termination of my observership with the Hospital.
11. I agree that this agreement and the confidentiality obligations contained herein survive the termination of my observership with the Hospital and any breach of the agreement is actionable by the Hospital.

I hereby acknowledge that I have read this document and understand the terms and conditions of this agreement:

Print Name:_____ Signature:_____

Date:_____

C

OBSERVERSHIP AGREEMENT

All Observers Must Read and Complete the Following Information:

I,_____, (the "Observer") acknowledge that I have read, understood and agree to the following terms and conditions:

1. I understand and agree that when on MSH property, I must be accompanied by my supervisor at all times. I have read, understood and agree to comply with all applicable rules, regulations, policies and procedures that govern MSH and will refrain from behaving in any way that is unsafe, inappropriate or in contravention of MSH policies, procedures or expectations. I agree to follow all instructions of my Supervisor or other members of the clinical team and acknowledge that failure to do so may result in termination of the Observership at any time.

2. I agree to conduct myself in a professional, courteous and responsible manner in keeping with the MSH Expect Respect Policy. I agree to wear a MSH Observer Identification Badge at all times. I acknowledge that MSH is a completely smoke-free environment and that smoking is not permitted anywhere on MSH property.

3. Prior to the start of the Observation period, I agree to self-screen myself for communicable diseases and will not enter the Hospital if I answer yes to one or more of the following symptoms: a new cough (not associated with your current illness), fever, shortness of breath, severe headache, unexplained muscle aches, unexplained extreme fatigue, vomiting and/or diarrhea. I agree to leave the hospital if I develop any signs of a communicable illness or otherwise fail the self-screening. Where the Observership will last 1 or more days, I agree to complete a Worker Health Assessment Immunization Record/Respiratory Fit Form.

4. I agree to strictly guard and maintain the confidentiality of any personal health information, or any hospital administrative information, to which I gain access during this experience. I agree to adhere to and sign the MSH Privacy and Confidentiality Agreement and not to, under any circumstance, access financial, human resources and other confidential records of MSH.

5. I understand that as an Observer, I am not considered a member of the staff or an employee, nor am I an independent contractor of MSH and therefore I am not entitled to salary, benefits, reimbursement of expenses or other forms of compensation. Furthermore, I understand that I am not covered under the Workplace Safety and Insurance Board (WSIB) or covered under MSH's liability insurance. I understand that I am not entitled to receive educational credit or certification from the MSH for time spent observing.

6. I agree not to provide any patient care during the Observation period. I understand that patient care includes, but is ***not*** limited to the following functions: interacting with patients or families beyond introductions; taking a medical history; conducting physical examinations; diagnosing or treating a patient's condition; ordering, preparing or administering drugs; performing or assisting in procedures or interventions; obtaining consent; writing notes or orders in a patient's health record, either in electronic or hard copy format; manipulating any equipment used in patient care; accessing health records, either in electronic or hard copy format; and providing health care advice. I further acknowledge that providing medical care to patients in violation of this Agreement may result in civil liability, licensing sanctions, or criminal penalties.

7. I acknowledge that I will respect patient confidentiality and that I will not discuss any patient, his/her medical history, or his/her reason for being at MSH with anyone other than the Supervisor. Under no circumstances will pictures and/or recordings of any nature, including pictures and/or recordings of patients, visitors, staff, physicians, volunteers, records, equipment or facilities, be permitted anywhere in MSH. I acknowledge that I will not access patient charts or patient information, in any format.

8. I understand and agree that there is no guarantee that I will be able to observe all patients and treatments. I understand that I am only permitted to attend selected patients when accompanying my Supervisor and at no other time. I understand that any patient, at any time, may decline to have me observe in their care. I will ensure that each patient verbally consents to my presence during the Supervisor's visit prior to me observing any patient care activities.

9. I will remove myself immediately from the patient area if asked to do so at any time, for any reason, by any member of the MSH staff and/or Professional Staff.

10. I understand that MSH may terminate the Observership at any time and in its sole discretion. I acknowledge that I may be required to leave the premises immediately should the Observation period be terminated by MSH. I understand that no appeal or grievance rights exist to challenge the termination of an Observership.

11. I am aware that as a result of the observation of the Supervisor, I may be exposed to certain risks and dangers inherent in the workplace. In consideration of MSH approving my participation in the Observership, I agree for myself, my heirs, next of kin, executor(s), administrator(s) and personal representative(s) to hereby release and forever discharge MSH, its officers, trustees, principles, directors, employees and agents, as well as the Professional Staff, from any and all actions, claims and demands for damages, loss and injury, howsoever arising which now or may hereafter be sustained by me out of or in consequence of my participation in the Observership. For the same consideration, I agree to indemnify MSH, its officers, directors, employees and agents from any and all claims and demands which might be made against MSH, its officers, directors, employees, professional staff and agents arising out of or in consequence of my participation in the Observership.

12. I acknowledge and understand that under no circumstance may I be permitted to engage in any Observership activities outside of the dates approved by the Hospital (or Interprofessional Practice and Education). I acknowledge that all MSH equipment or property, including scrubs and ID badge, must be returned at the end of the Observership.

I,_____, the Observer, hereby declare that I have read and understand this Observer Agreement in its entirety and hereby agree to be bound by the terms and conditions of this Agreement.

OBSERVER:

Dated_____of_____20_____.

Observer's Name (Print) _____

Observer Signature _____

SUPERVISOR ACKNOWLEDGEMENT:

I have read, fully understand and agree to comply with the terms of this Observer Agreement in my capacity as Supervisor.

Dated_____of_____20_____.

Supervisors Name _____

Supervisor Signature _____

D

OFFENCE DECLARATION FORM

1. I DECLARE that:

   - ☐ I have no convictions under the Criminal Code of Canada up to and including the date of this declaration for which a pardon has not been issued or granted under the Criminal Records Act (Canada).

   - ☐ I have no charges pending under the Criminal Code of Canada up to and including the date of this declaration.

2. I have the following convictions or charges for offences under the Criminal Code of Canada for which a pardon under the Criminal Records Act (Canada) has not been issued or granted.

List of Offences:

Date	Court Location	Conviction	Nature of Offence	Penalty Imposed

I further agree to advise Markham Stouffville Hospital immediately in writing in the event that I am charged with any criminal offence after the declaration has been provided.

OBSERVER:

Dated_____of_____20_____.

Observer's Name _____

Observer Signature _____

Witness Name: _____

Witness Signature _____

IMMUNIZATION RECORD

E

In order to comply with the Communicable Disease Surveillance Protocols for Ontario Hospitals, you must have the following form completed and signed by your physician prior to commencing your observership with the Markham Stouffville Hospital. If you have questions, please call 905-472-7373, X6280

Name:_____ Date of Birth:_____
Please print (dd/m/yr)

Home Telephone No.:_____ Expected start date:_____

Dept.:_____

Tuberculin Skin Testing: 2 Step required. 2nd step must be given 7 to 21 days after 1st test in the opposite arm if the 1st test is negative. If 1st TB skin test is positive a chest X-ray will be required

Date of 1st step test:_____ Result: [ ] negative [ ] positive Induration in mm:_____

Date of 2nd step test:_____Result: [ ] negative [ ] positive Induration in mm:_____

IMMUNIZATIONS

Measles/Mumps/Rubella: 1 MMR after 1st birthday plus an additional measles booster or a 2nd MMR

MMR Date (if available) Measles Booster or 2nd MMR Date: _____

Laboratory Evidence of Immunity (Titres) (Copy of Public Health Lab Results required)

Measles: Date of Titre:_____ Result: [ ] immune [ ] non-immune

Mumps: Date of Titre:_____ Result: [ ] immune [ ] non-immune

Rubella: Date of Titre:_____ Result: [ ] immune [ ] non-immune

VARICELLA
Laboratory Evidence of Immunity (Titres) (Copy of Public Health Lab Results required)

Varicella: Date of Titre:_____ Result: [ ] immune [ ] non-immune
Or
Varicella Vaccine 1st Dose Date:_____ 2nd Dose Date:_____
(2 doses required)

Hepatitis B Immune Status Have you received Hepatitis B Vaccine? [ ] Yes [ ] No Dates: _____ Laboratory evidence of immunity to Hepatitis B (Hepatitis B Antibody Titres): [ ] Yes [ ] No Dates: _____ [ ] immune [ ] non-immune
Influenza Vaccine: Date of last immunization: _____
Tetanus, Diptheria/Pertussis: Date of last immunization: _____

Completed By:

Physician/OHN/RN_____Signature_____

Date_____

Learners must provide documentation of tuberculosis screening, as well as proof of immunity to Measles, Mumps, Rubella and Varicella (Chickenpox) prior to their start date at Markham Stouffville Hospital. Hepatitis B, Tdap/Td and Influenza vaccine status must also be provided.

Measles – Any one of the following is acceptable:
- Documentation of receipt of 2 doses of live Measles virus vaccine (or trivalent Measles-Mumps-Rubella [MMR] vaccine) on or after the first birthday, with doses given at least four weeks apart, OR
- Laboratory evidence of immunity (copy of Public Health Lab results)

Mumps – Any one of the following is acceptable:
- Documentation of receipt of 2 doses of live Mumps virus vaccine (or trivalent Measles-Mumps-Rubella [MMR] vaccine) on or after the first birthday, with doses given at least four weeks apart, OR
- Laboratory evidence of immunity (copy of Public Health Lab results)

Rubella – Any one of the following is acceptable:
- Documentation of receipt of 1 dose of virus vaccine (or trivalent Measles-Mumps-Rubella [MMR] vaccine) on or after the first birthday, with doses given at least four weeks apart, OR
- Laboratory evidence of immunity (copy of Public Health Lab results)

A history of having had Rubella is not acceptable as this disease can be confused with other viruses

Varicella (Chickenpox) – Any one of the following is acceptable:
- Documentation of receipt of 2 doses of Chickenpox vaccine, given at least 4 weeks apart, OR
- Laboratory evidence of immunity (copy of Public Health Lab results), OR
- Diagnosis or verification of a history of typical Varicella (Chickenpox) by a health care provider OR
- Diagnosis or verification of a history of Herpes Zoster (Shingles) by a health care provider

F

HEALTH PROFESSIONAL OBSERVERSHIP
CREDIT CARD PAYMENT AUTHORIZATION FORM

Applicants are required to pay a non-refundable administrative fee of $50.00 to apply for an observership experience at our hospital.

Please provide the following information:

Name: (First Name)_____(Last Name)_____

Department _____

Start Date:_____End Date: _____

Card Type: ☐ American Express ☐ MasterCard ☐ Visa

Credit Card Number:_____Expiry Month:_____Year: _____

Name on card: _____

Billing Address: _____

City:_____Province/State:_____Postal Code: _____

Country:_____

☐ I acknowledge that I will be charged $50.00 on my credit card.

_____ _____

Card Holder Signature Date

(FOR OFFICE USE ONLY)

Processed by:_____ Date: _____