



Title: Confidentiality in Simulation

No.: ADM 8.03

Policy
 Rev.:

Date: 8/1/2015

Areas Affected:

Page 1 of 1

Policy Statement

All students, whether in the BSN program or health system workforce, will maintain confidentiality when attending educational simulations at the Clinical Simulation Center. Confidentiality is essential in the simulation environment; thus, allowing each participant the ability to achieve the learning objectives. Authorization will be obtained from students prior to the release of any simulation photographs or audio/visual recordings in which they appear when used for purposes other than to validate clinical competency for educational purposes.

Procedure

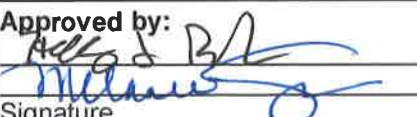
Each student, whether in the BSN program or health system workforce, is oriented to the Clinical Simulation Center. During this orientation, students are given a copy of: 1) the Bon Secours Memorial College of Nursing Simulation Laboratory Guidelines, which include safe practices; 2) the Participation in Simulation Confidentiality Statement, which is a mandatory document that all students must sign prior to participation in simulation activities; and 3) the Participation in Simulation Authorization to Release Photographs and Audio/Visual Recordings, which is an optional document that students may voluntarily sign to authorize release of simulation photographs or audio/visual recordings for purposes other than to validate clinical competency. Students will be asked to sign each of these forms and a copy will be maintained on file at the Clinical Simulation Center for a period of three years.

When photographs or audio/visual recordings are made to validate clinical competency, they are to be used for educational purposes only. The photographs or audio/visual recordings are to be reviewed only by the student, the unit educator/unit supervisor/manager, and simulation staff. Such photographs or audio/visual recordings will be deleted after all parties have completed their review or no more than seven (7) days from the date of the simulation.

When photographs or audio/visual recordings are made for purposes other than to validate clinical competency (for example, to be published and reproduced in professional journals and medical books; to be used at professional meetings; and to be used for any other purpose for which Bon Secours Memorial College of Nursing or its staff members may deem fit in the interest of medical education or research) consent to participate and authorization to release must be obtained. Prior to the taking or release of any such photographs or audio/visual recordings, staff must confirm that the student has signed the Participation in Simulation Confidentiality Statement and Participation in Simulation Authorization to Release Photographs and Audio/Visual Recordings.

Reference Policy # _____

Approved by:


 Signature

Director Clinical Simulation Center
 Provost/VP
 Title

8-1-15
8.1.15
 Date

Approval History:

BSHSI Legal Department 12/3/14
 CSC 3/19/15
 Policy Committee 4/20/15

Participation in Simulation
Confidentiality Statement

I understand that confidentiality is essential to the learning process with simulation.

Therefore, I agree to the following:

1. I agree to not discuss the events of the simulation(s) or the debriefing(s) with anyone other than the students and faculty who participated with me in this/these simulation(s). I hereby agree not to disclose the events, discussions, and/or materials used in the simulated clinical experience.
2. I understand that all information regarding the case(s) for which I have been trained is the confidential property of Bon Secours Memorial College of Nursing, and I agree that I will not disclose to any third party any information about the case(s) or information about the students whom I have seen during any project.
3. I consent and authorize the professional staff and such assistants, photographers, videographers and technicians to take still photographs and audio/visual recordings, including video tapes, CD-Rs and DVDs, of my participation in simulations for educational use to validate my clinical competency.
4. I understand that if I am in the simulation lab for the purpose of validating clinical competency, any visual recording is for educational use only. The visual recording will be reviewed by me, my unit educator/unit supervisor/manager, and simulation staff only. The video recording used to validate clinical competencies will be deleted after all parties have completed their review or no more than seven (7) days from the date of the simulation.
5. I acknowledge that if I breach this contract, I may be excluded from any further simulation experiences and may be subject to disciplinary action.

I have read, understand, and agree to abide by the above Confidentiality Statement.

(Signature)

(Print Name)

(Date)

**Participation in Simulation
Authorization to Release Photographs and Audio/Visual Recordings**

I hereby voluntarily authorize Bon Secours Memorial College of Nursing to obtain and disclose personally identifiable information from my educational record in the form of simulation photographs and audio/visual recordings as follows:

1. I permit and authorize the professional staff and such assistants, photographers, videographers and technicians to take still photographs and audio/visual recordings, including video tapes, CD-Rs and DVDs of my participation in simulations for educational and non-educational use.
2. I grant to Bon Secours Memorial College of Nursing, the irrevocable, perpetual, unrestricted royalty-free right, license and permission to copyright in its own name, and to use, re-use, publish, reproduce and distribute, any and all simulation photographs and audio/visual recordings, distorted or modified, without restriction through any medium, including, but not limited to, website publishing, illustration, art, education, promotion, advertising, or trade.
3. I authorize the unrestricted modification or retouching of such photographs or audio/visual recordings, and the publication of information relating to my case(s), either separately or in connection with the publication of the photographs or audio/visual recordings taken of me.
4. I permit such photographs or audio/visual recordings to be published and reproduced in professional journals and medical books; to be used at professional meetings of any kind; and to be used for any other purpose for which Bon Secours Memorial College of Nursing or its staff members may deem fit in the interest of medical education or research.
5. Although I have given permission to the publication of all details, photographs, and audio/visual recordings concerning my simulation case(s), I understand that I will not be identified by name unless I provide specific authorization.
6. I understand that I have the right to revoke this release at any time, but acknowledge that such revocation will only apply to those photographs or audio/visual recordings that have not yet been released by Bon Secours Memorial College of Nursing.
7. This authorization will remain in effect from the date it is executed until revoked by me, in writing, and delivered to Bon Secours Memorial College of Nursing.

I have read and understand the above Authorization to Release Photographs and Audio/Visual Recordings.

(Signature)

(Print Name)

(Date)

This form is intended to comply with the Family Educational Rights and Privacy Act (FERPA) governing disclosure of student educational records.