	Regulatory Compliance Policy	No. COMP-RCC 4.62
	Title: SCRIBES IN THE HOSPITAL PROVIDER BASED SETTING	**Page:** 1 of 5
		Effective Date: 11-30-17
		Retires Policy Dated: 03-02-15
		Previous Versions Dated:

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to define the use of scribes by physicians/providers in the hospital provider based setting to ensure medical record completion fully and accurately reflects a patient's care and is in accordance with federal, state, accreditation, and Tenet requirements.

III. POLICY:

Scribes are present during a physician/licensed independent practitioner's ("physician/provider") performance of a clinical service and document, on the behalf of the physician/provider, the services and observations of the physician/provider as directed, without applying any clinical insight or interpretation. Tenet permits the use of scribes in its hospital provider based setting facilities, although such Tenet Facilities will not employ, or otherwise pay for, scribes. The physician/licensed independent provider is ultimately responsible for all documentation, and must verify that the scribed note accurately reflects the services provided and is completed at the point of care.

IV. PROCEDURE:

A. Credentialing:

Each scribe must be credentialed by the Tenet Facility. Credentialing may be through the medical staff process or the Human Resource process that meets accreditation and regulatory requirements. Scribes must meet the following minimum criteria:

1. Possess a High School Diploma or GED

2. Successful Completion of a medical terminology course[1]

3. Have a job description or similar document outlining the qualifications and responsibilities (see Attachment A for sample job description)

[1] Individuals who hold a valid health care license are deemed to have met this criterion.

B. Scribe Responsibilities

1. Scribes must complete all required Tenet Facility orientation and training, including any required electronic health record (EHR) training.

2. Scribe entry should be created in the EHR. It may also be handwritten or dictated if the physician note functionality is not available in the Tenet Facility EHR. The scribed note must accurately reflect the services provided as dictated by the physician/provider on a specific date of service. Scribed documentation must include the following elements:

   a. The name of the scribe and a legible signature (if handwritten)

   b. The name of the physician/provider rendering the service

   c. The date and time the service was provided

   d. The name of the patient for whom the service was provided, as well as a secondary patient identifier, such as a medical record or account number (unless otherwise indicated on the documentation form or automatically populated by an EHR)

   e. The date and time of the scribe note, unless automatically generated by an EHR

3. Scribes must document that they are scribing while the physician/provider is performing the service and authenticate the note with their name and discipline. Notes completed by a scribe must begin with the following: "(Scribe's Name) scribing the following service on behalf of Dr. XXX…."

4. Scribes must notify the physician/provider of any EHR alerts. Alerts must be addressed to the physician/provider.

5. Scribes using EHR must create notes under their own password/access which has been assigned within the scribe role after attending an approved orientation class for the Tenet EHR. Scribes may not create notes under a password/access assigned within any other role, for example as a medical student. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.

6. Scribes must not provide services for anyone other than their supervising physician/provider. A "supervising physician or licensed independent provider" is a specified individual for whom the scribe is authorized to provide services through the Human Resource Office or Medical Staff Office.

7. Scribes must document in compliance with all federal, state, and local laws, as well as with internal policies and procedures, including the Medical Staff Rules & Regulations.

8. Scribes shall not provide clinical services of any kind, including but not limited to assisting in medical procedures, providing instructions to patients or their family, and entering orders in the EHR or relaying provider verbal orders to the clinical staff. Additionally, scribes shall not respond to clinical documentation queries directed to their supervising physician/provider.

9. A scribe can be authorized to provide other services at the Tenet Facility, according to his or her training, experience and license or certification. In no event may an individual serve as a scribe and in another role at the Tenet Facility during the same period.

D. Physician/Provider Responsibilities

1. The supervising physician/provider is ultimately responsible for the content of the documentation. The physician/provider must authenticate each scribed note. Authentication cannot be delegated and is to be performed immediately following completion of scribed documentation in the medical record.

2. The authentication must include the following:

   a. Affirmation the physician/provider was present during the time the encounter was recorded;

   b. Verification that the information was reviewed;

   c. Verification of the accuracy of the information;

   d. Any additional information and/or revisions to the note needed; and

   e. Authentication including the date and time.

Examples of notes:

- "The above service was scribed by (Scribe's Name) on my behalf and I attest to the accuracy of the note…Signature MD Date/Time;" or

- "I performed the above scribed service and the documentation accurately describes the services I performed. Signature MD Date/Time."

3. Physicians/providers must not use signature stamps to authenticate scribed notes.

4. Physicians/providers must authenticate all scribed notes before the physician/provider and scribe leave the patient care area.

5. Physicians/providers must document in compliance with all federal, state, and local laws, as well as with internal policy, such as Medical Staff Rules & Regulations for timeliness of a medical record completion.

6. All documentation recorded by scribes must be authenticated upon completion (prior to leaving patient care area per above) by the supervising physician/provider and in all events before it is finalized in the EHR.

E. Responsible Person

The Tenet Facility's Chief Executive Officer is responsible for ensuring that all individuals adhere to the requirements of this policy and that these procedures are implemented and followed at the Tenet Facility and that instances of non-compliance with this policy are reported to the designated Compliance Officer.

G. Auditing and Monitoring

Audit Services and the Comprehensive Clinical Audit teams will audit compliance with the policy. Each Tenet Facility with a scribe service must conduct a focused review of the service for the first six months the service is in place, or the first six months following the effective date of this policy, whichever is later, to confirm compliance with this policy. Based on the results of the focused reviewed, the Tenet Facility will determine the frequency of ongoing review to be conducted as part of its record review activities assessing the quality and content of the medical record. The focused review and ongoing monitoring must include reviews to verify scribes perform within their job description, do not enter orders and have their work properly authenticated.

H. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

All other individuals whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures including the Medical Staff Bylaws, Rules and Regulations.

V. REFERENCES:

- COMP-RCC 4.03 Health Information Management Operations, Hospital Chart Completion, Documentation and Security

- EC.PS.04.04 Activity Logs and User Monitoring Standard

- The Joint Commission Frequent Asked Questions, Use of Unlicensed Persons Acting as Scribes, Revised July 12, 2012

VI. ATTACHMENTS:

- Attachment A Sample Position Description

Position Description Sample
Scribe – Non-Registered Nurse; Non-Tenet Employee

Position: Scribe - Non-Registered Nurse; Non-Tenet Employee

Reports To: Directly to Supervising Physician/Provider;

Position Qualifications - Requirements:

- High School Graduate or GED
- Completion of a medical terminology course (individuals who hold a valid health care license are deemed to have meet this criterion)

Position Qualifications – Preferred Requirements:

- College degree or enrollment in a college program including health or medical related courses
- Computer aptitude, including functions of the electronic health record (EHR)
- Certified Medical Scribe Specialist (CMSS) certification

General Role Description: The role of the scribe is dependent upon the physician practice. The core responsibility of the scribe is to capture accurate and detailed documentation of the physician/provider – patient encounter in a timely manner. Scribes are not permitted to make independent observations, decisions, or translations while capturing or entering information into the health record or EHR. The scribe is limited to recording interactions as dictated by the physician/provider. This position is a clerical role and does not involve direct patient care at any time.

Key Role Responsibilities:

- Accompany the physician/provider upon patient interview and examination.
- Document physical examination findings and procedures as performed and dictated by the physician/provider.
- Document the results of laboratory and radiology studies, and the physician/provider interpretation of the results, as dictated by the physician/provider.
- Document the correct time of patient care related activities including physician /provider-to physician/provider communication, family communication, and re-examination of the patient.
- Assist and remind physician/provider to review all completed scribe documentation, make any necessary amendments, and sign the chart.
- Ensure completion of the medical record in collaboration with the supervising physician/provider contemporaneous with the delivery of the patient care service.
- Maintain confidentiality and privacy of information in accordance with governing HIPAA regulations and organizational policies.

Position Description Sample
Scribe – Non-Registered Nurse; Non-Tenet Employee

This position description reflects the general duties considered principle functions of this position as identified and shall not be considered as a complete description of all of the work requirements and expectations that may be inherent in the position.

I, the undersigned, hereby acknowledge that I have received and read this position description, and understand the content. I also acknowledge and understand I can only function dependently under the direction of my supervising physician/provider and that I may not be involved in direct patient care at any time.

_____
Printed Name of Individual

_____
Signature of Individual

_____
Date