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FACILITY: Sacred Heart Hospital	**MANUAL(S): Medical Staff**
TITLE: Use of Scribes	**ORIGINATING DEPARTMENT: Medical Staff**
SUPERCEDES: n/a	**POLICY NUMBER: none**

I. POLICY:

The use of scribes to support the providers in the documentation of patient care functions is permitted. .

For the purpose of this policy, a scribe is defined as an individual who is present during the provider's performance of a clinical service and documents on behalf of the provider everything said during the course of the service. This definition makes it clear that the provider is rendering the service while the scribe is recording only information cited by the provider. Scribes may not enter orders, nor submit orders for co-signature.

II. PURPOSE:
To provide guidelines for the use of scribes by the provider.

III. GUIDELINES/PROCEDURES

1. Scribes will not be funded by Sacred Heart Hospital
2. Ancillary staff including, but not limited to, nurses or medical assistants, secretaries or other staff may serve as scribes.
3. Residents and medical students may not serve as scribes while serving in the capacity of a resident or student.
4. The provider must be present with the scribe for scribing to occur and the patient must consent to the presence of the scribe.
5. Scribes do not act independently or record their own observations or impressions.
6. Individuals serving as a scribe must review the hospital's policy on the use of scribes and sign the scribe agreement. (Attachment A)
7. A scribe will be credentialed in accordance with the Clinical Assistant Policy, and all documentation related to a Scribe's credentialing will be maintained as outlined in the policy.
8. A scribed note must accurately reflect the service provided on a specific date of service. The billing provider is ultimately responsible for the content of the scribed note.
9. A scribe's entry can be hand-written, dictated or created/typed in the electronic medical record (EMR).
10. Documentation of a scribed service must include the following elements:
    a. A personal, dated note from the scribe that:
        i. Identifies them as the scribe of the service
        ii. Attests the notes are written/recorded contemporaneously in the presence of the provider who performed the service
        iii. Identifies the provider
    b. Signature of the Scribe (dated/timed)
    c. Co-signature of the provider (dated/timed)

Example of a compliant scribe statement: "I (scribe's name) am personally scribing in the presence of Dr. (physician's name)."

11. Individuals can only create a scribe note in the EMR if they have their own password/access to the EMR. Documents scribed in the EMR must clearly identify the scribe's identity and authorship of the document – in both the document and the audit trail. The provider must cosign all documents captured by the scribe in a timeframe consistent with the medical staff bylaws.
12. Providers are required to document in compliance with all federal, state and local laws as well as with hospital policy.
13. All individuals working as a scribe must be processed by the People Services Department in accordance with the Clinical Assistant Policy, and all documentation related to a Scribe's credentialing will be maintained as outlined in the policy.
14. A photo ID will be issued and must be worn while providing scribe services.
15. User setup for scribes in the EMR is conducted by the Information Systems Department. Users set up as scribes will only have access to the applications needed to perform the job.

Reviewed & Concurrence by:	**Revised**	**New**
Medical Executive Committee: November 16, 2012		**December 1, 2012**
Medical Executive Committee	**May 19, 2017**	