

## Tip# 26: The Proper Use of Scribes

**The Risk:** As the use of electronic health records (EHRs) has become widespread, documentation practices and workflow patterns have changed significantly and have added to a growing clinical and administrative workload. The use of this technology has increased the amount of time necessary to complete medical record documentation and order entry.

One way that physicians have chosen to address these issues is through the use of scribes. Scribes originated in the fast-paced clinical setting of the emergency department (ED) as a way to reduce the time physicians needed to spend documenting care in an electronic format. The use of scribes has expanded from these roots in the ED to numerous other clinical settings. Scribes perform EHR data entry under the direct supervision of a licensed professional, freeing the physician or other provider to spend more time directly interacting with the patient.

As unlicensed members of the healthcare team, the recruitment, training and supervision of scribes is paramount in managing their use in all clinical settings. Whether you are currently using scribes in your practice, or are considering employing them, the following recommendations may be useful in evaluating your program or determining strategies for implementation.

### Recommendations:

1. Use documentation policies for your organization that comply with regulatory requirements. In addition, practices should monitor federal, state and regulatory changes to maintain compliance with these guidelines.
2. Develop a written job description for scribes that outlines required qualifications and competencies, including proficiency with your EHR system and medical terminology. Clearly delineate job responsibilities.
3. Provide orientation that includes, but is not limited to, HIPAA, privacy regulations, organizational policies, and patient rights.
4. Scribes should not perform any clinical functions or provide any direct patient care (unless they are otherwise a licensed healthcare provider such as an LPN or RN.)

This includes:

- acting independently;
  - touching patients;
  - handling bodily fluids or specimens;
  - translating for a patient;
  - interpreting any information; and
  - conducting other duties while acting as a scribe.
5. Scribes should be assigned their own unique user ID/password credentials to access the EHR system. All entries to the record made by a scribe must be while logged in with their own password and user ID. In the event a licensed clinical staff member functions as a scribe, they must have two separate user IDs and passwords and use them accordingly.
  6. Introduce the scribe to the patient and give the patient the opportunity to decline having the scribe present during the examination.
  7. The primary responsibility of the scribe should be to document the clinical encounter, including the history of present illness, a review of systems, the physical exam, and the assessment and plan, as presented by the provider. Scribes may also create pending orders as dictated by the provider. Providers must review and complete all medical orders.
  8. All information entered into a medical record by a scribe must include:
    - the name of the patient and the provider providing care;
    - the date and time; and
    - authentication.
  9. Providers must review the scribe's documentation and verify the entry. An attestation statement should include:
    - affirmation of the provider's presence during the time the encounter was entered;
    - confirmation that the provider reviewed the information and verified its accuracy; and
    - authentication, including date, time, name and credentials.
  10. Perform regular audits/assessments of the scribe's documentation and provide constructive feedback for performance improvement, as indicated.

## References

1. [https://www.jointcommission.org/standards\\_information/jcfaqdetails.aspx?StandardsFaql=1908&ProgramId=46](https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaql=1908&ProgramId=46)
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