



How you want to be treated.

SPH Emergency Department Scribe Pilot Project



Table of Contents

Scribe Program Information.....	3
Background.....	3
Goals of the Project.....	3
Purpose of the Study.....	4
Scribe Duties.....	4
Procedures.....	6
Scribe Policies and General Information.....	6
Dress Code.....	6
Parking.....	7
Payroll Information.....	7
Schedule Policy.....	7
Absence Policy.....	8
Trainees.....	8
Security.....	8
Phone System.....	9
Cell Phone Policy.....	9
Meal Break Policy.....	9
Communication Forum.....	9
Scribe Documentation Form.....	9
ED Addendums.....	9
Scribe Meetings.....	10
Program Evaluation.....	10
Computer Systems/Information Systems.....	10
ED and Flow.....	11
Appendix I.....	12
Lab Descriptions.....	12
Appendix II.....	15
Approved Abbreviations.....	15

Scribe Program Information

Background

The limited supply of emergency physicians (EP) in the face of increasing demands for emergency care is creating a serious patient care problem. Emergency Department (ED) scribes can help improve patient care.

In emergency rooms across the country, a doctor can take up to half of his/her time dealing with documentation of a patient's visit. This added paperwork lengthens patients' emergency room stays and reduces the overall number of patients a doctor is able to see within his/her shift. The job of the ED Scribe is basically to take care of all documentation and required paperwork for the doctor during ED visits, allowing the physician to focus more closely on the patient and to see more patients during his/her shift.

Scribe programs have been shown to benefit EP's and their patients tremendously, expediting the ED process by as much as 30-40%.

Scribes are often students who are interested in pursuing medicine as a career. Scribes assist the physicians with clerical duties associated with patient care to help improve productivity. Their roles are diverse and may include documenting the history/physical, procedures, collating investigation reports, and old records as well as, help in preparing discharge information.

Goals of the Scribe Project

- Increase and improve quality of doctor patient interaction. The EP can keep their attention focused solely on the patient rather than the keyboard or paper chart. Mitigates the negative effect of computerization of health care that can detract from human interaction.
- Improve productivity of EP's by reducing the clerical workload. By having an assistant, the EP's can see more patients. This in turn reduces time to physician, length of stay and flow targets. Scribes can improve workflow by removing much of the burden of documentation and other clerical duties.
- Improve flow of the department by helping with clerical documentation tasks and tracking test results, etc.
- Enhance workplace satisfaction
- Increase patient satisfaction
- Improve quality of documentation
- They are, as Bukata puts it, a physician's "third arm."
- Provide the scribe with an invaluable real-time/real-world exposure to emergency medicine. This is especially of interest to prospective students of medicine or ER as a specialty

Scribe Program Information Continued

Purpose of the Study

1. To study the impact of scribes on performance indicators in the ED.
 - a. Physician productivity
 - b. ED length of stay for patients
 - c. Patient satisfaction
 - d. Physician/staff satisfaction
2. To study and explore electronic documentation templates and the use of tablet devices at the bedside.

Scribe Duties

1. Generate encounter documentation:
 - i. Scribes accompany the physician as he/she examines and interviews patients and then records the physician's observations and comments either on paper or in an electronic medical record (EMR) depending on what the hospital uses.

All information is recorded in the presence of a physician. Documentation components include:

1. History and physical exam is documented ideally as it is being performed by the EP.
 2. Transcribe key test results and interpretation of the results as directed by the EP.
 3. Record physician's consultations with family members, paramedics and specialist consultants.
 4. Document procedures and treatments performed by the physician.
 5. Record physician impression and treatment plan.
 6. Document patient discharge instructions and follow-ups.
2. Gather relevant information for physician review:
 - i. Scribes may gather information (i.e., laboratory results, faxed radiology reports, medical records) and other data for review by the EP as requested.
3. Assist in generating and collating EP specific documents:
 - i. ED Discharge summary documentation and associated materials (patient information handouts)
 - ii. Help coordinate with the Unit Clerk to book outpatient appointments.

Scribe Duties Continued

4. Coordinate communication:
 - i. Provide patients with updates about waits and delays as instructed by the EP. Scribes may not give medical advice, communicate medical information or care plans of any kind directly with the patient or patient's family/friends.
 - ii. The scribe may communicate to the RNs that orders have been written or the discharge paperwork is on the chart - **but under no circumstances can any orders be given by the Scribe.**
 - iii. Scribes can make and answer calls for the MD under their direction but cannot take any medical data (lab values, radiology, clinical information) from other doctors/consultants or family/friends.
5. Improve Flow: Scribes can help with the flow of patients by proactively loading the provider with prioritized information and assist the EP with sequencing of work if requested. These activities include:
 - i. Check on progress of investigations: x-rays, lab etc. and notify physician when tests are complete and ready for review. For example: Imaging should be reviewed by the EP within 30 minutes of test completion.
 - ii. Notify the physician when an ECG has been completed and assist the physician in reviewing the ECG within 10 minutes of test completion. Document that the ECG has been reviewed in the [investigations section] on the Scribe Documentation Form.
6. Scribes DO NOT:
 - i. Sign or give verbal orders.
 - ii. Examine or directly interview a patient
 - iii. Make physical contact with or solicit information from patients, administer medication, relay orders between physicians and nurses, or enter anything into a chart that has not been reviewed and approved by a physician.
 - iv. Assist with any clinical work such as cleaning wounds, setting up suture trays etc.

Remember the role of the scribe is to assist the physician to do his/her work as effectively and efficiently as possible. In addition, scribes should adhere to all privacy and confidentiality requirements of the hospital.
7. Assist in the clerical duties associated with the Discharge Process:
 - i. Scribes may collect printed discharge information sheets from the printer under the EP's direction.
 - ii. Scribes may communicate with the Unit Clerk to arrange booking of follow-up appointments.

Scribe Duties Continued

- iii. Scribes can collate the ED Discharge Summary, follow-up appointment slips/ instructions and give them to the physician or place on the patient chart as directed by the EP.
- iv. Scribes **may not** disposition any patients.
- v. Scribes should document carefully discharge information given to the patient by the physician.
- vi. Scribes should document the time of patient discharge as defined when the patient leaves the care space.

Procedures

1. Each scribe will work with one physician for the entirety of his/her shift.
2. Physician Assignment:
 - a. Scribes will be assigned to work with:
 - i. 4pm Acute shift (week days)
 - ii. 11am Fast Track shift (weekends)
3. Please sign in at the beginning of your shift in the ED Scribe Pilot Binder. Payroll will be based on the sign in sheets.
4. Please read any updates in the memo section of the ED Scribe Pilot Binder before the start of your shift.
5. Introduce yourself to the physician that you are working with. The schedules with physician assignments will be posted in the ED in the EP work room.
6. Introduce yourself to the Clinical Nurse Leader and the Unit Coordinator in the unit area that you are assigned.
7. Please keep notes and provide feedback about your shift in the Shift Comments section in the ED Scribe Binder. This is a pilot research project and we will need to continually look for innovative ways to improve documentation, efficiency and flow.

Scribe Policies and General Information

Dress Code

Scribes have a required dress code for professionalism at all times while working a shift in the ER. Please dress business casual as you would to a family medicine office rotation including your lab coat. You may NOT wear denim, sweat pants or scrubs. You must wear closed toe shoes and your shoes should be comfortable.

Your Providence ID badge is considered part of our dress code and should be worn at all times when at SPH for work. It is important for hospital staff, medical staff and patients and their families to be able to properly identify you as part of the ER team.

Parking

There is no designated parking for ER Scribes. You may park in the underground if spots are available. Parking rate for the underground lot is \$4.75 with valid Providence staff ID.

Payroll Information

Scribes are paid every two weeks through direct deposit. The scribe pay rate is \$15/hour. The workweek is from Sunday to Saturday. We use timesheets for clocking in and out. In an 8 hour shift you should take a 30 minute meal break, preferably when the EP is taking their break.

Schedule Policy

All schedules will be released on the 15th of each month for the coming month. Shifts will be granted on a first come, first served basis. However, ED Scribes are allowed to work a maximum of two shifts per month, only. Special requests will be allowed should an ED Scribe be unable show up for a shift, and the shift must be filled. In this circumstance, approval from the Scheduler must be given. Currently, there will be 5 weekday shifts from 6:00 PM – 12:00 AM, and 2 weekend shifts from 11:00 AM – 7:00 PM. Further on in the project, there may be 2 additional weekend shifts added to the schedule. We will notify the scribes by email if any shifts are added.

To sign-up for a shift, you must go to:

<https://www.familymed.ubc.ca/emergency/login.php>

and log-in to the ED Scribe Schedule. Shifts will either say “session is available”, or “session is full”. If the “session is available”, click on the icon and fill in the necessary information. If the “session is full” this shift has been taken and you can not sign up for that shift. It is important that all assigned shifts are covered for the success of the research program. Once you have signed up for a shift it is mandatory that you show up for your shift on the specified date and time.

Absence Policy

An absence from work is any change in your schedule that results in your shift being uncovered. This may be due to illness or any other unscheduled absence (not related to illness). If you are unable to show up for your shift it is your own responsibility to find a replacement. If you find a replacement, you must contact the Scheduler to notify them of the shift change and who will be taking your shift. If you cannot find a replacement, you will be expected to cover your shift. All shift changes must be done within 24 hours notice. There are no excused absences and there are no exceptions to this policy.

Consequences for absences are as follows:

- 1st absence - no penalty
- 2nd absence - verbal warning
- 3rd absence – termination

For further inquiries or questions about the schedule or the absence policy, please contact the Scheduler.

Scheduler Information:

Nicole Smith, Chief Scribe
nikks@interchange.ubc.ca
778-829-6110

Trainees

There will be a multitude of learners on rotation in the emergency department such as medical students, International Medical Graduates (IMGs), residents etc. It is their first priority to learn on their rotation. The scribe must not interfere with the learning of these trainees. The scribe will work directly with the staff physician and the patient's that he/she sees. The trainees will be seeing patients under the supervision of the staff physician.

Security

You need to have your picture taken and obtain a hospital name badge from the Protection Services Department. This is located on the fourth floor of the Comox building. Wear your name badge at all times in the Hospital. It will be needed for entry / exit to certain areas. If you lose your ID badge, please notify your Chief Scribe and inform the security desk in the ED immediately so they can arrange to get a replacement badge for you.

Phone System

The telephone manual is available in the physicians' office. Dial 9 to obtain an outside line. Telephone calls that come in will be "parked" to a particular 2 digit "local". If you are being paged to answer a physician-call, dial 692 followed by the # you are asked to respond to. Long distance calls are allowed for official business by dialing the hospital operator (0) and asking for a long-distance line.

Cell Phone Policy

Please be clear on our policy regarding cell phones - scribes are not use cell phones on the floor.

Meal Break Policy

Scribes should take their meal breaks at times that are convenient and agreed to by the provider. This will most likely be when the provider takes his/her break. You do not need to sign out and sign back in for this break, but do check with your provider first.

Signature below acknowledges understanding of the above policies, and agreement to abide by these. I further understand that these policies may change from time to time, and that the Providence Health Care Scribe Program will give you such notice as is possible to all employees of those changes.

Communication Forum

In order to facilitate communication between scribes and the project leads, we will be using a discussion forum on the SPH website. The URL for this site is: www.sphemerg.ca. Everyone will be assigned their own unique login name and code for accessing this site. Once logged in, the ED Scribe Program link is on the left of the page where you can access posts and forums. Resources and new information will be updated on this site so please visit it regularly to view updates.

Scribe Documentation Form

To help increase ease and efficiency in scribe documentation, designated Scribe Documentation forms will be provided in the emergency room. This form should be filled out as you accompany the attending physician in the patient interview. This form should be added to the patients chart with a patient label and the attending physician's signature.

ED Addendums

Notifications and updated information will be placed at the front of the Scribe Sign-In Binder, located in the Emergency Room. Please review new information before starting each shift. These notifications will also be posted on the SPH ED Scribe website at: <http://sphemerg.ca/>

Scribe Meetings

Meetings to address and explore the Pilot Scribe Program's effect in the SPH Emergency Room will be held during the second and fourth months of the program, as well as after the pilot has been completed in six months. Attendance at these meetings is crucial for the success of the program and attendance is therefore mandatory. Meeting minutes will be emailed to each Scribe for review and reference.

Program Evaluation

Over the course of the pilot project you will be expected to complete surveys. These surveys will help evaluate the project and your perception of the Scribe position impact on ER flow efficiency.

Please complete one survey per month. Surveys as well as a deposit envelope for the completed surveys will be available in the ER department where the Sign-In binder is located.

Separate surveys will also be available for you to provide to the attending physician on at least one of your shifts per month. Please have the physician fill out the survey and return it to the same deposit envelope as the Scribe surveys.

Computer Systems / Information Systems

PCIS

The ED information system used at the Providence Health Care is called Sunrise Clinical Manager. You will need to complete the online training course in order for you to get a login and password to the system. The two main applications we use are:

- Sunrise Clinical Manager (SCM)
- ED Manager model of SCM

Pharmanet

All prescriptions dispensed within British Columbia are stored on the Pharmanet system. The Registration clerks usually generate a pharmanet record for all acute side patients. Both the Unit Coordinators and Registration clerks have access to this system. A physician may direct you to request the pharmanet from the Unit Coordinator.

Excelleris/Pathnet

Outpatient laboratory results may be accessible on the Pathnet system. The Unit Coordinator usually has access to this database. A physician may direct you to locate recent outpatient lab results.

Computer Systems/Information Systems Continued

CareConnect

Regional database that contains encounter information for all regional facilities. Lab, radiology, consultation reports from VGH, LGH, Richmond can be located on this system. Most physicians have access to this system.

ED and Flow

Flow is critical to maintaining the function of an emergency department (ED). When flow is slowed and stopped, the ED cannot fulfill its mandate of efficiently seeing new patients. Critical time targets:

EP Key performance	Target	Accountability
< CTAS Fractile Response Times (Time to MD)	<ul style="list-style-type: none"> • CTAS 1: Immediate • CTAS 2: 15 minutes • CTAS 3: 30 minutes • CTAS 4: 60 minutes • CTAS 5: 120 minutes 	Physician in charge (PIC)
Department Key	Target	
Emergency Department Length of Stay for Discharged Patients	<ul style="list-style-type: none"> • Acute: < 4 hrs • Fast-Track < 2 hrs 	PIC and CNL
EDLOS for Admitted patients	<ul style="list-style-type: none"> • < 10 hrs 	PIC/CNL/clinical coordinator
Laboratory STAT Blood work turn around time (Order to Result File)	<ul style="list-style-type: none"> • < 60 minutes 	PIC/CNL/Lab supervisor
Radiology:	<ul style="list-style-type: none"> • Plain Film: 30 minutes from order to completion. • Urgent CT (non-oral contrast): Order to Interim Report < 90 minutes • Urgent US (Order to Interim Report) < 90 minutes 	PIC/CNL/Radiology supervisor
Consult Times:	<ul style="list-style-type: none"> • Consult to decision < 2 hours 	PIC/CNL/ Specialist Attending Physician
Inpatient Transfer Time:	<ul style="list-style-type: none"> • From admission decision to inpatient transfer < 2 hours. 	PIC/CNL/Admitting Team/Clinical Coordinator

Appendix I

Lab Descriptions

Lab Panels - Blood

ABG: Arterial Blood Gas

pH

pCO2

pO2

*Must have interpretation of results to be billed

BCP: Basic Cell Profile

WBC

HGB

HCT

PLT

*Circle "normal" or "normal except"

CBC: Complete Blood Count

Same as BCP but includes a differential of the WBCs

Segs (neut)

Lymph

ono

Eos

Baso

Bands

*Only record % not #

Chem 7: Basic Metabolic Profile

Gluc

BUN

Creat

Na

K

Cl

CO2

Ca

Anion Gap

GFR

*Circle "normal or "normal except"

Cardiac Enzymes

CK or CPK

Troponin

Appendix I

Lab Panels - Blood, continued

Coagulation

PT (INR included)

PTT

BNP - used to r/o CHF

LP Panel: Lumbar Puncture panel

WBC

RBC

Lymph

Polys

Gluc

Pro

Gram Stain (found under microbiology results)

Liver Panel: Liver Function Tests (LFT's)

ALB

Alk Phos

AST

ALT

TBili

Lipase - used to r/o pancreatitis

ETOH: Blood Alcohol Level

Drugs of Abuse

Urine (UTox)

Amphetamines

Barbiturate

Benzodiazepines

Opiates

Cannabinoides

Cocaine

PCP

Serum (STox)

ASA

Acetaminaphen

ETOH

ED Chest Pain Protocol

EKG

CBC

Chem 7

CK

Troponin

CXR (Portable)

Appendix I

Lab Panels - Urine

UA: Urinalysis

WBC

RBC

BAC

*Circle "normal" or "normal except"

Cultures

BCx Pending (Blood)

UCx Pending (Urine)

WCx Pending (Wound)

CSFCx Pending (CSF)

Cell Counts

Can be ordered individually for body fluids obtain by centesis procedures (paracentesis, arthrocentesis, etc.

Record:

WCB

RBC

Polys

Lymph

And any other results the provider would like to be included.

RH Factor (+ or - of blood type)

RSV (will be + or -)

Misc Labs

D-Dimer - r/o Blood Clot

Acetone - r/o DKA (**will be + or - and will include a ratio**)

Drug Levels for Seizure Medications

Dilantin (Phenytoin)

Tegretol (Carbamazepine)

Phenobarbitol

Depakote (Valproic Acid)

Appendix II

Drug Delivery Devices

HHN - Hand Held Nebulizer (Breathing Treatment administered by RT)

MDI: Metered Dose Inhaler (Given to pt by nurse with teaching and spacer)

Approved Abbreviation Listing

q.....	Every	COPD.....	Chronic Obstructive
OD.....	Once Daily		Pulmonary Disease
EOD.....	Every other day	CAD.....	Coronary Artery Disease
BID.....	Twice daily	DVT.....	Deep Vein Thrombosis
TID.....	Three times daily	#.....	Fracture
QID.....	Four times daily	tx.....	Treatment
Q6H.....	Every 6 hours	dx.....	Diagnosis
HS.....	Night time	Hgb.....	Hemoglobin
h.....	Hour	WBC.....	White blood cell
D.....	Day	PTT.....	Partial thromboplastin
N.....	Night		time
PO.....	Orally	CR.....	Creatinine
PR.....	Per Rectum	K+.....	Potassium
I&O.....	In and Out	KCl.....	Potassium Chloride
DAT.....	Diet as Tolerated	INR.....	International Normalized
CF.....	Clear fluids		Ratio
FF.....	Full fluids	BUN.....	Blood Urea Nitrogen
AAT.....	Activity as tolerated		
Neb.....	Nebulizer		
sc.....	Subcutaneous		
IM.....	Intramuscular		
IV.....	Intravenous		
td.....	Transdermally		
CVA.....	Cerebral Vascular		
	Accident		
CHF.....	Congestive Heart Failure		

