

Rounding with Scribes: Employing Scribes in a Pediatric Inpatient Setting

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Using scribes to document patient encounters for physicians offers both benefits and challenges. A pediatric hospital recounts its experience adding scribes to its inpatient rounding teams.

The use of scribes to assist providers with documentation is gaining popularity for reasons that include increased pressures on providers, the need to improve patient throughput, and the challenges of electronic health records, which in many cases decreases provider productivity.

Implementing a scribe program has many challenges, and it is not a cost-effective answer in every setting. However, scribes can offer significant improvements in the timeliness of documentation and patient and provider satisfaction.

Children's Hospitals and Clinics of Minnesota learned these lessons when it chose to employ scribes as part of its daily inpatient rounding team.

A Beginning in Rapid Process Improvement

The initial decision to use scribes at Children's resulted from a Lean Rapid Process Improvement (RPI) design session. The RPI goal was to increase the number of discharges from medical-surgical units before noon, improve the communication of the med-surg team, seamlessly include residents into the hospitalist rounding process, and increase parent and patient satisfaction.

The RPI leadership team developed goals and brainstormed possible solutions. A subsequent weeklong meeting involving physicians and nurse practitioners, Lean fellows, nurses, residents, HIM staff, and health unit coordinators analyzed the options.

As part of the planning, participants considered several options to improve the communication of the med-surg team. In the current-state process, hospitalists and hospital-based general pediatricians rounded in an unorganized manner; that is, they had no schedule for seeing patients. Instead they responded to requests from nursing staff to see new patients or patients in need of emergent evaluation. The hospitalists in particular were often running between two med-surg units on different floors in a helter-skelter fashion.

The majority of documentation on these patients occurred after 5 p.m. when the evening physicians came on board. Consequently, the providers often could not connect with the patient's primary nurse, nor were the parents available when they visited the patient. Any plans for the patient were left to the end of the day and enacted either on the evening shift or the next day.

Participants discussed several options for improving the timeliness of documentation: the use of scribes or residents to chart daily notes as well as the use of provider-entered notes directly into the electronic health record. They heard from the medical director of a local emergency physician group, who presented his synopsis of how scribes were used in his emergency department. The next phase was analysis of options.

Weighing the Benefits of a Scribe Program

Children's did employ hospitalists who dictated inpatient progress notes. The HIM department was asked to compare transcription expenses to scribe costs.

To determine transcription cost, HIM staff determined the average cost of a transcribed inpatient progress note and the average number of inpatient progress notes per day. An inpatient progress note would not be completed on the day of discharge. To determine the number of daily progress notes, staff used the following calculations:

$$\text{Average daily census (23.2) x Days in year (365) = Annual patient days (8,468)}$$

$$\text{Annual patient days (8,468) / Avg. length of stay (3.36) = No. of discharges (2,520)}$$

$$\text{Annual patient days (8,468) - No. of discharges (2,520) = No. of progress notes per year (5,948)}$$

$$\text{No. of progress notes per year (5,948) / Days in year (365) = No. of progress notes per day (16)}$$

To determine scribe costs, HIM staff determined the hourly rate, the number of scribes required, and the hours per day they would work.

At the time of the initial decision, scribe costs were less than the transcription expense. However, it should be noted that since the implementation of the scribe program, transcription productivity has increased 35 percent due to background speech recognition technology. Thus transcription expenses are now less than scribe expenses.

Children's did consider the possibility of transitioning current transcriptionists to scribes; however, the majority of the transcription staff was not interested. The transcription staff is entirely home-based, with a majority living 30 miles away from the facility. Many were not interested in driving to work on a daily basis. In addition, some stated they were not sure if they were up to the physical demand of being on their feet for up to five hours without a break.

Thus having determined that a scribe program was its best option, Children's next needed to decide whether it would employ scribes or contract them. Ultimately, it was more cost-effective to employ the scribes.

Implementing the Program

Without any experience using scribes, Children's contracted with a local physician-owned scribe program to implement its own program. A lead scribe from this staff assisted Children's HIM staff with interim staffing, recruitment, and training of new hires.

Recruitment was fairly easy because of a medical school in close proximity. Many pre-medical students were aware of scribe programs at other hospital emergency departments. Children's sought pre-medical students who had completed a bachelor's degree, had a GPA over 3.4, and had taken coursework in anatomy and physiology, organic chemistry, and medical terminology.

Additional features of successful candidates included either healthcare-based employment or volunteer service. Generally these are requirements for medical school, so most candidates had the necessary background.

Besides a typical interview and transcription test, applicants were required to submit a secondary application in which they answered a series of questions. These questions helped determine the candidate's writing skills, reasons for interest in the job, ability to manage multiple priorities, and their timelines for medical school application.

Additionally, candidates needed to be fully aware of the physical, mental, and social requirements for scribes. The rounding process is intense. Scribes stand for the entire process, which averages four to five hours in length. There are no breaks.

Scribes also must be fully alert to all conversations in the room. The provider, resident, nurse, parent, and patient all share pertinent data that the scribe must capture accurately. Being a scribe requires commitment to the job, and no-absence attendance is essential. It is critical for scribes to be on time, and they must show up for every shift, even if there is 12 inches of snow on the ground.

Training Scribes

Before working on patient care units, scribes at Children's must attend mandatory hospital employee orientation and complete privacy and compliance training. A session with a coding manager is also required. It is critical scribes understand that they can only record the portions of a physical examination and review of systems that were actually completed. In addition, scribes are provided with a list of commonly used medications, provider names, and medical terms.

Actual scribe training is completed on the job. Scribes-in-training typically follow an experienced scribe for about a week. They watch the process, read the notes, and learn the electronic health record system.

After a week they begin typing the notes while a trained scribe simultaneously takes notes. The senior scribe communicates corrections with the new hire. After the provider signs the report, the scribe-in-training is expected to review the report and make note of the physician's changes.

This process continues for several more weeks until the new hire's accuracy is sufficient. The physician reviews all the notes, makes corrections, and then signs off on them. The scribe and provider work closely to ensure accuracy of the notes. The provider may bring significant changes to the scribe's attention. The provider in all cases retains full responsibility for the accuracy of the documentation.

The Scribing Process

The process for rounding begins about an hour before the team converges. The rounding team consists of the provider, resident(s), the nurse, interpreter(s) or social worker(s) as required, the patient, the parent(s), and the scribe.

The resident initiates the process by pulling together the census of patients to be seen that morning. The resident coordinates the schedule and communicates it to the nursing staff. The nurse is responsible for bringing in social workers or interpreters if needed and communicating with the parents an approximate time when the team will arrive in their rooms.

A template designed for the scribe process ensures consistency and provides a standard format for compiling different data inputs. The template for daily progress notes has headings as well as age-appropriate normal exams. It can pull in critical data from elsewhere in the EHR, such as laboratory data, medication lists, and vital signs.

The scribes begin their day one hour prior to the start of rounds, preparing templates for each of the patients who will be seen. The templates are filled out with as much known information as possible, such as a brief patient identification statement, medications, diagnostic and lab results, and vital signs. This information is obtained from a review of the existing medical record and previous notes. This step saves significant time during rounds and allows the scribes to better keep up with the rounding team.

Each note also clarifies the scribe's participation. The following statements are placed at the top of each note:

I, [scribe name], am serving as a scribe to document services personally performed by [physician name], MD, based on my observation and the provider's statements to me.

I, [physician name], MD, attest that [scribe name] is acting in a scribe capacity, has observed my performance of the services, and has documented them in accordance with my direction.

After the notes are prepped the scribe joins the rounding team, enters the patient room, and uses a computer on wheels to record the review of systems, physical exam, plan of care, and any other relevant data in real time.

The scribe is encouraged to interrupt the rounding team to clarify statements or to ask them to speak louder so that he or she can accurately capture all pertinent information. The rounding team is aware of the format of the notes and is encouraged to present information in the same format, minimizing guesswork on the part of the scribe.

The goal is for the scribes to have the note complete after they leave the patient room. If there are notes that need revision before being submitted to the physician for signature, the scribe may stay after rounds to complete the notes. Seasoned scribes may need only 15 minutes after rounds, while scribes with less experience may need one hour.

All notes must be submitted to the physician for signature before the scribe leaves for the day. In addition, the physician must sign the reports before leaving for the day. Scribes are not allowed to enter orders.

Program Challenges

Children's program presented many challenges, which can be grouped into four categories.

People

Generally most providers were open to working with scribes and understood that the scribes' work would reduce the providers' time on the job. However, this sentiment was not universal.

Some providers are challenged to change the way in which they conduct examinations. In order for the scribe to take notes while in the patient room, providers must verbalize their review of systems, physical examination, and summarization of results and plan. Some providers are uncomfortable speaking out loud in front of patients and prefer the anonymity of writing down notes and dictating after the fact.

However, open communication with the scribe offers additional benefits. It opens communication with everyone in the room, helping residents learn, bringing immediate understanding of the care plan to the nurse, and opening up communication to the most important people in the room-the patient and the family.

Process

Initially Children's followed the direction of the physician-owned scribe program contracted to implement the program and used a standard template with defaulted phrases for the review of systems and physical exam. It was discovered early on that the contracted interim scribes were documenting a full review of systems and physical examination for each visit.

A coding manager accompanied the scribes to validate that this level of service was actually taking place. It was determined that after the initial admission examination, the providers were performing focused examinations; that is, reviewing one or two systems and examining only those parts of the body that resulted in admission. The coding manager met with the scribes and communicated to the providers that only those elements that were reviewed could be documented to avoid fraudulent claims.

Technology

The computers on wheels the scribes used to create notes in real time worked well with the exception of battery life. When the computers were fully charged, batteries lasted about five hours, which was generally sufficient.

However, scribes shared unit-based computers at first, and during pediatric surge period (generally November to March) the computers were in such frequent use that they could not always be fully charged before the scribes needed them. At times the batteries ran out during rounding, and the scribes had to either locate a charged computer or plug-in, power-up, and sign-in at each patient encounter. This was a struggle during the intense, nonstop rounding process.

Consequently Children's purchased computers on wheels solely for use by scribes to ensure they would be fully charged before rounding began.

Regulatory

In May 2011 the Joint Commission published an FAQ titled "Use of Unlicensed Persons Acting as Scribes." It wrote that it "does not endorse nor prohibit the use of scribes," but it does have expectations for their use. (The FAQ may be found at www.jointcommission.org/standards_information/jcfaq.aspx.)

In response to the expectations outlined, Children's enacted a formal improvement process for its scribe program. The coding manager began rounding with scribes at regular intervals to ensure that they are documenting only what is occurring and are not acting outside of their job description.

The scribes now audit completely the physician's timeliness in signing reports. The date and time of the physician's signature are logged in daily spreadsheets. These spreadsheets are then forwarded to the medical director on a weekly basis. Any issues of late signatures are brought to the medical director's attention for follow-up.

The Results

The overall rounding program did not meet the original objective of increasing the number of discharges by noon. However, the other results are significant.

The providers involved with the program are very happy with the quality of the notes, and they are particularly pleased that they no longer need to stay and dictate for several hours each evening. The notes are more succinct and complete, because providers do not have to remember details hours after the patient examination. The care team is very satisfied with the timeliness of communicating information in real time. The parent response is overwhelmingly positive. Concerns about who was in charge of the case and what was going on have been eliminated.

Implementation of a scribe program has significant challenges. However, if it is a cost-effective or cost-neutral solution, Children's experience has shown that scribes can improve timeliness of documentation and improve patient and provider satisfaction.

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