Using Scribes to Document Clinical Care

Electronic health records (EHRs) have significantly changed documentation processes and workflow patterns in healthcare. Although these systems offer opportunities for better information management, streamlined and secure data sharing, enhanced care coordination, and improved patient safety — both in practice and promise — they also have created new challenges and frustrations for healthcare providers.

Common complaints associated with EHRs include information overload, administrative burden, and disjointed provider-patient encounters — all of which contribute to ongoing concerns about clinician burnout.

An article in the *Annals of Family Medicine* states that “Among the largest contributors to burnout is a growing clerical workload. For every hour physicians provide direct face time to patients, 2 more hours are spent on EHR and desk work.”

One way that healthcare providers and organizations are addressing the clerical burden of EHRs is by using scribes to support documentation of clinical care. Scribes are typically nonlicensed personnel who enter information in electronic or paper records under the direct supervision of a physician or other licensed healthcare provider. Scribes also might assist with EHR navigation, data retrieval, and coding. Research suggests that scribes might improve provider satisfaction, boost efficiency, and help providers interact more directly with patients, fostering greater trust and patient engagement.

However, introducing scribes into clinical practice requires careful planning and consideration of potential risks. The strategies presented in this publication can help healthcare providers and organizations develop and implement policies for using scribes to support documentation of clinical care.
1. Include information specific to scribes in organizational documentation policies. Make sure policies adhere to state and federal laws, accrediting agency and third-party payer requirements, and professional guidance.

2. Develop written job descriptions for scribes that detail required qualifications, experience, and training. Job descriptions and employment contracts also should clearly delineate scribes’ responsibilities, required competencies, and expectations for productivity.

3. Make sure scribes are proficient with the organization’s EHR system and have individual security rights to access the system. Healthcare providers should advise scribes about how to respond to EHR alerts and notifications that occur during patient encounters.

4. Do not allow scribes to conduct any form of clinical practice, such as clinical decision-making, assessment of a patient’s current illness or symptoms, physical evaluation, or entering orders for tests or medications.*

5. Introduce scribes to patients during clinical encounters, and explain their role in documenting care and facilitating better provider-patient interactions and communication. Understand and comply with patients’ right to refuse the presence of scribes in the exam room.

6. Review all scribe-generated documentation to ensure accuracy and completeness. Correct any information that is inaccurate or does not thoroughly represent the care provided.
Include a statement in the documentation that (a) verifies that the treating clinician provided the services that the scribe documented, (b) explains that a scribe (include the scribe’s name) documented the provision of care, and (c) confirms that the clinician reviewed the documentation for accuracy and completeness.

Provide a signature and date/time to confirm review and approval of all scribe-generated documentation. Ensure scribes also sign off on all documentation if required by organizational policy. (Note: Some accrediting agencies and third-party payers require scribes to sign documentation.)

Ensure review and appropriate signoff of scribe-generated documentation occurs within the timeframe stipulated in the organization’s documentation policies.

Provide orientation and ongoing training for scribes that cover federal and state privacy regulations, organizational documentation policies and standards, patient rights, etc.

Conduct routine assessment of scribes’ competency and review of performance. Audit scribe-generated documentation for compliance with organizational documentation and privacy/security policies.

Offer scribes constructive feedback and measurable goals for performance improvement. Consider including key indicators related to scribe functions in organizational quality improvement plans.
Monitor for changes in federal and state laws, accreditation and payer requirements, and professional guidance related to the appropriate use of scribes.

Ensure healthcare providers know how to independently navigate and operate the EHR system in case a scribe is not available.

* Some scribes are licensed healthcare professionals who can perform clinical duties commensurate with their licensure if permitted by organizational policy. However, the American Health Information Management Association (AHIMA) recommends avoiding having one individual simultaneously filling multiple roles during clinical encounters. ⁴
Endnotes


4 The American Health Information Management Association, Using medical scribes in a physician practice.