POLICY STATEMENT:

It is the policy of Texas Tech University Health Sciences Center (TTUHSC) Ambulatory Clinics to define the use of scribes in a clinical setting and to provide a framework for proper documentation of clinical services when a physician or other practitioner (collectively referred to as “provider”) has elected to utilize the services of a medical scribe.

SCOPE:

This policy applies to all TTUHSC Ambulatory Clinics operated through its Schools.

PROCEDURE:

1. **Duties.** A scribe is a documentation assistant that records in “real time,” facts and events that occur between a patient and a provider. The scribe enters information into the electronic medical record (EMR) or chart at the direction of the provider. An individual acting as a scribe shall not, in any manner, correct, interpret, clarify or otherwise enter anything other than the exact wording or directions of the provider, or patient/guardian. The scribe must not interject his/her own observations or impressions. The provider is ultimately responsible for all documentation and must verify that the scribed note accurately reflects the service provided. Documentation of scribed services must clearly include the following:

   a. Name of the scribe and legible signature;
   b. Name of the provider rendering the service;
   c. Date and time the service was provided;
   d. Name of the patient for whom the service was provided;
   e. Authentication of the scribe.

2. **Reference.** The person employed as a scribe must make a third-person reference in the documentation that indicates they are scribing while the billing provider is performing the service and authenticate the note with their name and discipline. All notes created by a scribe must begin with the following:

   “I, _________, am scribing for and in the presence of, Dr. _________."

3. **Provider Notes.** The provider notes should also include the following:

   a. Confirmation that the provider was present during the time the encounter was recorded;
   b. Verification that the information was reviewed.; verification of the accuracy of the information;
   c. Any additional information needed;
   d. Authentication, including date and time.
4. **Provider Review.** The provider performing the service must review the information as it is scribed and notate his/her review of the information and may comply with above requirements using the following attestation statement:

   I, Dr. _________, personally performed the services described in this documentation, as scribe by _________ in my presence, and it is both accurate and complete.”

5. **Non-Eligible Scribes.**
   
a. Residents are prohibited from performing scribed services as a matter of best practice at TTUHSC.
   
b. Medical students functioning as a student on clinical rotation are prohibited from performing scribed services.

   (*Note: Non-physician providers with billing priviledges may act as scribes but may not be the most cost-effective choice as a long-term practice.)

**APPROVAL AUTHORITY:**

This policy shall be recommended for approval by the Joint Ambulatory Policy Committee to the Council of Deans.

**RESPONSIBILITY AND REVISIONS:**

It is the responsibility of the Joint Ambulatory Policy Committee to review and initiate necessary revisions based on collaboration and input by and through Quality Improvement/Performance Improvement, Risk Management and the Office of Institutional Compliance.

**RIGHT TO CHANGE POLICY:**

TTUHSC reserves the right to interpret, change, modify, amend or rescind this policy in whole or in part at any time to reflect changes in policy and/or law.

**CERTIFICATION:**

This policy was approved by the Council of Deans on March 12, 2015.