SAINT LUKE'S HEALTH SYSTEM
ACCOUNT SPECIFICS

Platform:	eScription
Institution/Site Code:	slhs
Software Versions:	ESMT: Version 10.12 eMon: Version 10.12
Info/Resources:	ES SAMPLE SITE: https://SLHS.escriptionasp.com/Downloads/Labor-1.0.0/ Log in with your EditScript login ID/P
Customer Links:	http://www.saintlukeshealthsystem.org/
Doc Find Link:	www.saint-lukes.org

Version/Change Record

Version	Date	Responsible Person	Description of Version/Change
1.0		Implementation Team	Customer Approved Final Version w/GoLive. Enter Name of Customer approving, date and time.
1.1	11/21/13	Chris Randolph	Addition of WTs
1.2	11/25/13	Chris Randolph	Change of acct name to Saint Luke's
1.3	12/05/13	Chris Randolph	Add Doctor Link
1.4	12/11/13	Chris Randolph	Add Doctor Link
1.5	1/3/13	Chris Randolph	Signing Clinician Changes
1.6	1/9/14	Chris Randolph	Signing Clinician changes and addition of WT to list
1.7	1/17/14	Tiffany Higgins	Update WT 12 mandatory pend reason
1.8	1/21/14	Chris Randolph	Update Wt mandatory pend reason
1.9	1/23/14	Chris Randolph	Added to type as dictated under Latin Acronyms
2.0	2/18/14	Chris Randolph	Update for No dictations

TABLE OF CONTENTS

All subjects are listed in alphabetical order and are hyperlinked. Simply click on a subject to find the information.

NOTE: Utilize the AHDI Book of Style for any format information not contained in this document.

ABBREVIATIONS/ACRONYMS

Transcribe all abbreviations and/or acronyms as dictated. Do not expand unless they are dictated in their expanded state.

EXCEPTION: Expand all acronyms/abbreviations *related to the diagnosis* under **ANY** diagnosis, assessment, or impression heading, to include but not limited to, PREOPERATIVE DIAGNOSIS, POSTOPERATIVE DIAGNOSIS, DISCHARGE DIAGNOSIS, ADMISSION DIAGNOSIS, etc. Common lab and radiologic abbreviations do not need to be expanded.

> Example under DIAGNOSIS heading:
> Dictated: COPD. Awaiting results from CT lung, CBC.
> Transcribed: Chronic obstructive pulmonary disease. Awaiting results from CT lung, CBC.
> Example under IMPRESSION heading:
> Dictated: EKG evidence of MI
> Transcribed: EKG evidence of myocardial infarction.
>
> Example under PLAN heading:
> Dictated: Continue IV fluids
> **Transcribed: Continue IV fluids.**

Clinicians often use abbreviations as complete words, such as "sat" for saturation, "vfib" for ventricular fibrillation, or "tox" for toxicity. These should be expanded to their expanded forms.

OP NOTES: On operative notes, dictators will often want to have the PREOPERATIVE DIAGNOSIS text copied to the heading POSTOPERATIVE DIAGNOSIS by dictating: "Postoperative diagnosis, same." **Do NOT transcribe the word "same"** Copy verbiage from PREOPERATIVE DIAGNOSIS and type the entire contents after the POSTOPERATIVE section.

For all other Latin acronyms not listed above: When the speaker dictates "q." separate "q." from the rest of the phrase with a single space.

Correct	Incorrect
q. noon	q.noon
q. day	q.day or q.d.

Otherwise, write exactly what you hear the speaker say, even if there is an equivalent abbreviation. **Type as dictated!!!**

Example: If speaker says q. 4 hours, this does not need to be shortened to q.4h.

Clinician Dictates	Correct	Incorrect
as needed	as needed	p.r.n.
twice a day by mouth	twice a day by mouth	b.i.d p.o

Standard Acronyms

Write acronyms, which are combinations of letters and numbers, in the usual manner:

- S1
- L4-5
- CA-125 (Write “cancer antigen 125” if clinician speaks it as such)
- FESO4
- 2D (Write “two dimensional” if clinician speaks it as such)

Transcribe vertebral spaces literally, using a hyphen: “L5-S1”, “S1-2”

- Use the ampersand (&) as part of an acronym.

Correct	Incorrect
CTA&P	CTA and P
H&H	H and H
H&P	H and P

JCAHO Prohibited Abbreviations

All of the JCAHO required AND optional do-not-use entries will be expanded. See list below.

U (unit)	Write "unit"
IU (International Unit)	Write "International Unit"
Q.D., QD q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Write "daily" Write "every other day"
Trailing zero (X.0 mg)*** (see note below)** Lack of leading zero (.X mg)	Write X mg Write 0.X mg
***Exception to above: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.**	
MS MSO_4 and $MgSO_4$	Write "morphine sulfate" Write "magnesium sulfate"
ug (for microgram)	Write "mcg"
h.s., H.S., Q.H.S., q.h.s.	Write out "half-strength" or "at bedtime"
T.I.W. (for three times a week)	Write "3 times weekly" or "three times weekly"
S.C. or S.Q. (for subcutaneous)	Write "Sub-Q", "subQ", or "subcutaneously"
D/C (for discharge or discontinue)	Write "discharge" or "discontinue"
cc (for cubic centimeter)	Write "mL" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears) O.S., O.D., O.U. (Latin abbreviation for left, right, or both eyes)	Write: "left ear", "right ear" or "both ears" Write: "left eyes", right eyes" or "both eyes"

ALLERGY STATEMENTS

Uppercase for positive allergy statements; lowercase otherwise.

Example:
ALLERGIES: No known drug allergies.

ALLERGIES: PENICILLIN CAUSES A RASH.

CAPITALIZATION OF DEPARTMENT NAMES

Do not capitalize any department names, not even emergency room/department.

CC vs. mL: See JCAHO abbrev list. If dictated as cc, transcribe as mL.

CONTRACTIONS

Transcriptionists should expand contractions when they are spoken unless in a direct quote.

Examples:
Dictated: He's a vegetarian.
Transcribed: He is a vegetarian.
OR
Dictated: The patient was murmuring, "I'm a diabetic."
Transcribe: The patient was murmuring, "I'm a diabetic."

DATES

When a full date is dictated, which would include Month, Day & Year, such as January 27, 2010 or "the 27th of January, 2010, dates should be transcribed with padded numerics, forcing 4-digit year, in format xx/xx/xxxx ex: 01/27/2010.

If only Month and year, i.e., January of 2010, transcribe as January 2010.

If only Month and Day, i.e., January 27th, transcribe as January 27th or "17th of January", transcribe as dictated, NOT forcing numerics as above.

DATE OF BIRTH

SLMG Office Notes - enter the DOB in the DOB field. For the Employee Health (WT56), the DOB field should have the date of incident.

FACILITY NAME

Saint Luke's (NOT St. Luke's)

FORMATTING INSTRUCTIONS

AUTO-NUMBERING

No. Turn off auto-formatting feature.

FORBIDDEN CHARACTERS

Do NOT use the following characters. They are not accepted in the electronic interface: Pipe **|,** Caret **^,** Backslash **\,** or Tilde **~**

SPECIAL FORMATTING

Do NOT use bold, underline or italicize as requested by speaker. Do NOT change any of the special formatting that is part of a normal template you have pulled into your document.

TABS: Do not use TABS.

TIME FORMAT

Times may be spoken in many ways. It is important that they be formatted as uniformly as possible.

Use the hour:minute format and use military hour time if the provider dictates as such. Note, there is no colon in military time, i.e., 1900, not 19:00.
If dictated, add “a.m.” and “p.m.”
Never include the word o'clock when talking about time. Use o'clock only if dictator is referring to anatomy, i.e., "...a lesion at the 8 o'clock position.)

Provider dictates:	Transcriptionist types:
I saw the patient at one fifteen.	I saw the patient at 1:15.
... quarter past one.	... 1:15.
... one fifteen p.m.	... 1:15 p.m.
... thirteen fifteen.	... 1315.
... thirteen hundred fifteen.	... 1315.
... around one o’clock.	... around 1:00.
... around thirteen hundred hours.	... around 1300.

VERBATIM VS. NON-VERBATIM

Verbatim. Small changes to grammar are expected, but keep to verbatim as much as possible. Any obvious discrepancies in dictation should be corrected or, if in doubt, should be flagged and pended to client for verification.

HEADINGS

You MAY use the "&" in headings for this account.

Do NOT use **"/"** as any part of headings, i.e.,

CORRECT:
LABORATORY TESTS PROCEDURES & RESULTS:

PAST FAMILY AND SOCIAL HISTORY:

INCORRECT:

PAST FAMILY/SOCIAL HISTORY:

Heading followed by colon and 2 spaces with text immediately following on the same line as heading.

SOCIAL HISTORY: The patient denies history of alcohol use.

Double space between headings

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

Subheadings: Drop-down format

Note: This example is for Exam AND Review of Systems.

PHYSICAL EXAMINATION:
HEENT: Unremarkable.
SKIN: Warm and dry.
HEART: Normal

Do **NOT** abbreviate headings, i.e.,

INCORRECT: GI:
CORRECT: GASTROINTESTINAL

Do not type any text that the clinician dictates which repeats the meaning of the heading. Example: DICTATED: Past medical history. The patient's past medical history i s significant for asthma. TRANSCRIBED: PAST MEDICAL HISTORY: Significant for asthma.

EMPTY (UNUSED) SECTIONS/HEADINGS

Delete any section or heading for which the dictator does not dictate information.

VAGUE SECTION HEADINGS

If speaker dictates “HISTORY,” expand to “HISTORY OF PRESENT ILLNESS” or PAST MEDICAL HISTORY”, PAST SURGICAL HISTORY as appropriate.

HEADER AND FOOTER INFORMATION

Do not repeat information in text that already appears in the header such as DATE OF BIRTH.

LISTS

For any lists

Do not enumerate lists of items unless dictator explicitly requests so.
Instead, enter the sequence into a comma-separated list, as you would when listing a series of words in a sentence.

Example:
PAST MEDICAL HISTORY: Diabetes mellitus, hypertension and hypercholesterolemia.

Listen for the following common phrases that a clinician uses to ask you to enumerate a list such as "Number two", "Number Next", "Next" or "Next item."

Enumerated lists will have the number, a period and 2 spaces. Do NOT use tabs.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Diabetes mellitus.

NUMERICS

Quantities: Write all quantities as Arabic numerals with the following exceptions:
Examples:
The patient has had 2 mammograms within the past 3 years.
But
Two small cysts were removed.
And
There was another one on the left side.
I observed hundreds of particles.

Numeric Units: Separate the number from its unit with a space. Example 5 mg

Numeric Ranges: Identify numeric ranges by placing a hyphen between both numeric values

Example:
The patient will return for followup in 3-4 months.

Frequencies or number of times: Indicate frequencies or number of times by placing the 'x' abutted to the number.

Example:
The patient was alert and oriented x3.

Dimensions: Indicate dimensions by using the 'x' with spaces, as follows.

Example:
CORRECT: The lipoma was 2 x 3 cm in size.
INCORRECT: The lipoma was 2x3 cm in size.

OB/GYN: When dictated as words, use commas to separate OB/GYN histories.

Example:
The patient is gravida 1, para 2.
When dictated as an abbreviation, leave a space.
Example:
The patient is G1 P2.

Roman Numerals vs. Arabic Numerals:

- Use Roman numerals for "grades" of conditions and diseases
  Example "Grade II/VI systolic murmur"
- Use Roman numerals for "stages" of conditions and diseases
  Example "Stage II cancer"
- Use Roman numerals for cranial nerve numbering
  Example "CN II-XII"
- Use Arabic numerals for "types" of conditions or diseases
  Example "diabetes mellitus type 2"

LABORATORY DATA AND VALUES

Platelets: Transcribe platelets as dictated, i.e., 236 or 236,000. No need to expand if not dictated.

Trailing zeros: Please see JCAHO Abbreviation List. Trailing zeros in laboratory values are acceptable to transcribe if dictated.

PATIENT NAME

If the clinician dictates the patient's actual name, transcribe as dictated. Do NOT change to "the patient."

If a sentence begins with "patient" leave as dictated. Do NOT insert the article "the" if not dictated.

NOTE: Any other identifying information, such as family names, phone#s or room #s, is completely fine to transcribe as dictated.

WORK TYPES

ACUTE CARE WTs		
WORKTYPE	TAT	THESE BUSINESS ENTITIES ONLY
Clinic STAT (5015)	2	CRIT (R)
Code Blue Note (14)	2	SLC (C)
Emergency Department Admit (48)	2	SLELS (S)
Outpatient PreOp H&P (5002)	2	SLH (L)
PreOperative History and Physical (1)	2	SLMG (99)
Transfer Discharge Summary (5)	2	SLNB (B)
Abdominal Transplant Clinic Procedure (160)	8	SLNS (V)
Delivery Note (10)	8	SLS (J)
Echocardiogram (20)	8	
Electroencephalogram (16)	8	
Electromyogram (17)	8	
History and Physical - CRITTENTON (90)	8	
History and Physical (3)	8	
History and Physical Update (2)	8	
Hospitalist History and Physical (31)	8	
Inpatient Operative Note (7)	8	
Neonatal Progress Note (136)	8	
OB Progress Note (135)	8	
Operative / Procedure Note (8)	8	
Progress Note (115)	8	
Somatosensory Evoked Potentials Study (18)	8	
Consult Sign-Off Note (26)	12	
Consultation (4)	12	
CV Surgery Eval and Mgmt Report (124)	12	
Emergency Department Discharge (49)	12	
Hospitalist Consultation (34)	12	
Interval Summary (129)	12	
Partial Dictation (9999)	12	
Radiation Oncology Note (106)	12	
Abdominal Transplant Clinic (60)	24	
ADDENDUM (100)	24	
Anderson Country Con/Op/Prog Note (75)	24	
Anderson County Clinic (76)	24	
Anderson County Discharge Summary (77)	24	
Anderson County H & P/ER (2074)	24	
Anderson County H&P_ER (5074)	24	
Cardiovascular Consultants Discharge Summary (29)	24	
Cardiovascular Consultants Preliminary Discharge Summary (30)	24	
Cardiovascular Procedure (21)	24	
Cesarean Section Surgery Note (138)	24	

Discharge Summary - CRIT (96) 24
Discharge Summary (9) 24
Employee Health Summary (56) 24
ENT Clinic (132) 24
Heart Failure Clinic (121) 24
Hospitalist Discharge Summary (39) 24
Letters - CRIT (91) 24
Liver Transplant Clinic Note (161) 24
Neurosurgery Clinic Report (84) 24
Nursing Home Visit (11) 24
OB Discharge Summary (139) 24
Oncology Specialists (65) 24
Pain Clinic Office Note (15) 24
Psychiatric Evaluation or Consult (94) 24
Psychological Assessment (35) 24
Psycholological Evaluation CRIT (92) 24
Psychosocial Assessment (70) 24
Psychosocial Assessment TToms (32) 24
Rehab History and Physical (43) 24
Rehab Outpatient Plan Progress Note (5117) 24
Rehab Plan Progress Note (66) 24
Rehabilitation Initial Evaluation (42) 24
Rehabilitation Medicine (12) 24
Rehabilitation Therapy Discharge Note (40) 24
Renal Transplant Clinic (61) 24
Rheumatology Clinic (133) 24
Short Stay Summary (19) 24
Sleep Study (37) 24
SLCC General Letter (22) 24
SLCC Nuke Medicine (13) 24
SLMG Letter (98) 24
SLMG Office Note (99) 24
SLNI Office Note (118) 24
Spiritual Assessment (119) 24
Sports Medicine Clinic (134) 24
Saint Lukes Endocrinology and Diabetes Center Office Note (104)
Thoracic Clinic (117) 24
Treatment Review Summary (95) 24
Valve Clinic (116) 24
Vein Clinic Note (127) 24
Vein Clinic Procedure (128) 24
Weston Radiology Overreads (74) 24
Women's Health Care Clinic (53) 24

WORKTYPE SPECIAL INSTRUCTIONS:

Partial WT Dictation (WT9999) – NEVER change WT or ADT / Visit # / Account #. Do not add CCs. Transcribe verbatim.

All Other WTs - There could be more than one visit to choose from – choose ONLY the 10 digit acct #

WORKTYPES TO BE PENDED TO CLIENT:

PEND TO: SLHS_Discharge Summary MED LIST Pend (for all BEs EXCEPT ACH, HMC, and WMH):

Cardiovascular Consultants Discharge Summary (29)
Discharge Summary – CRIT (96)
Discharge Summary (9)
Hospitalist Discharge Summary (39)
Short Stay Summary (19)

PEND TO: SLHS_Verify Visit/Encounter:

Rehabilitation Medicine (12)

Worktype 118 (clinic note):

Do not Search for patient info; these are free flowing text fields and name/info should be phonetically inputted into demographics.

SLCC General Letter (22)/SLCC Nuke Medicine (13):

These are "NO ADT" dictations (they will not be associated in eScription to a patient registered in Epic and/or will not be sent as transcribed document from eScription to Epic) they will come into eScription as:

Name: Person Unknown
MRN: Unknown
Account Number: Unknown.

For Nuke Med dictation, the MT will be able to edit the name field in EditScript and enter whatever is appropriate.
For General Letters, the Admin will be listen to the dictation in EditScript, but then typing the text directly into an MS Word document. As such, they will not enter any identifying information for the dictation into eScription.

PENDING RULES and UPLOAD PROTOCOL
Non-DSP MT

NOTE: *Please do not include personal notes or opinions in pend notes. Keep all comments direct, professional, and to the point.*

Pend all notes to QC with note as follows:

#	Pending Reason
1	NTS_NonDSP

ADDENDUMS

Change WT to **ADDENDUM** and transcribe **Addendum** as first line of text and pend as below.

#	Pending Reason
1	NTS_NonDSP
2	SLHS_Addendum

BLANKS

Pend all notes to QC with note as follows:

#	Pending Reason
1	NTS_NonDSP

CARBON COPIES:

Add CC dictated by creating a new contact with all provided information. Pend to:

#	Pending Reason
1	NTS_NonDSP

INCOMPLETE DICTATIONS

If dictation is incomplete, transcribe "DICTATION ENDS HERE" as last line of text and pend to

#	Pending Reason
1	NTS_NonDSP
2	SLHS_Incomplete Dictation

NO DICTATION

Pend as below

#	Pending Reason
1	NTS_No Dictation/Cancelled

RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to NTS for discrepancies that cannot be resolved with complete confidence/competence.
2. Type comments that are pertinent to the dictation. Example: "This is a re-dictation."
3. Omit comments that are NOT pertinent to the dictation. Example: "This is the third time I have dictated this chart! I won't dictate it a fourth time!" If in doubt, pend to NTS.

SIGNING CLINICIAN

If you receive an MTI, change it based on what the MTI states. If they don't receive an MTI, then don't change the signer.

If you are unsure of speaker or signing clinician, pend as:

	#	Pending Reason
	1	NTS_NonDSP

Please always follow MT instructions regarding surrogate speakers if one exists for the dictation you have open!

MULTIPLE REPORTS ON 1 DICTATION

Transcribe/Speech Edit and Pend To:

	#	Pending Reason
	1	NTS_NonDSP

WRONG WORKTYPE

If job uploads with wrong work type, change to correct the worktype. Pend to:

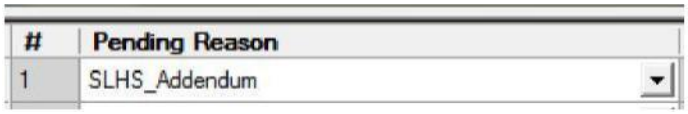
	#	Pending Reason
	1	NTS_NonDSP

The information listed below in this document pertains to MTs/QCs who have been granted Direct Send Privilege status. If you are not yet DSP'd, please follow pending rules and upload protocol instructions that are outlined above.

PENDING RULES and UPLOAD PROTOCOL
ALL DSP MTs & QCs

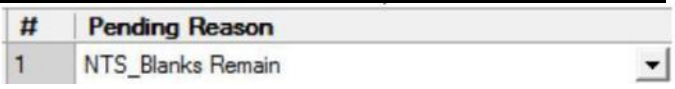
NOTE: *Please do not include personal notes or opinions in pend notes. Keep all comments direct, professional, and to the point.*

ADDENDUMS
Change worktype to **ADDENDUM** and transcribe **Addendum** as first line of text and pend as below.



BLANKS
2 or less blanks may be uploaded directly to client without pending.

MTs: For more than 2 blanks pend to QC as below.

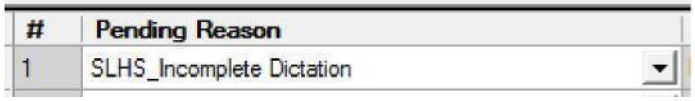


QCs: You may upload to client with 2 or less blanks. If more than 2 blanks, please pend to customer as below.

Stats with blanks: After QC review, change blanks to 4 underscores and upload directly. **A stat dictation will be a priority 2.** Please always check the priority of your dictation in your EditScript header.

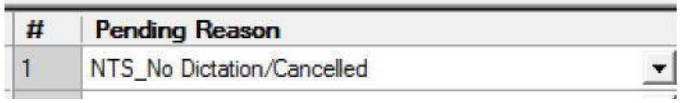
CARBON COPIES:
Add CC dictated by creating a new contact with all provided information. Then upload directly. Do NOT pend to client only for the reason of CC not found.

INCOMPLETE DICTATIONS
If dictation is incomplete, transcribe "DICTATION ENDS HERE" as last line of text and pend to client as



NO DICTATION:

MTs PEND AS:



QCs: WT 999 (was named "999 NOT APPLICABLE") I have renamed to "**999 VOIDED DICTATION**". This is the WT that should be assigned to any dictation that is a **null**

dictation meaning it should not be transcribed or distributed as a valid report. For example, the recording is abandoned by clinician, s/he only partially dictates the report, s/he instructs MT in the dictation to cancel the dictation, etc. If there is any question by the MT that this dictation should be voided, then pend it to SLHS to verify. When it is confirmed that this is not a valid report, then the WT should be updated to **999 VOIDED DICTATION** and the status set to "Unsigned" so that it is no longer in any Transcription or Pending queues and hit Save (not Save and Distribute).

MULTIPLE REPORTS ON 1 DICTATION:

Transcribe/Speech Edit and pend to:

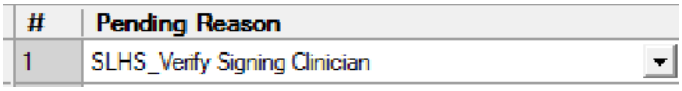
RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to SLHS for discrepancies that cannot be resolved with complete confidence/competence.
2. Type comments that are pertinent to the dictation. Example: "This is a re-dictation."
3. Omit comments that are NOT pertinent to the dictation. Example: "This is the third time I have dictated this chart! I won't dictate it a fourth time!" If in doubt, pend to customer.

SIGNING CLINICIAN

If you receive an MTI, change it based on what the MTI states. If they don't receive an MTI, then don't change the signer.

MTs should pend to NTS to verify and after QC review, pend to client as



WRONG WORKTYPE

If job uploads with wrong work type:

Change worktype and upload directly. Do not pend.