ST. FRANCIS HOSPITAL
ACCOUNT SPECIFICS

Platform:	eScription
Institution/Site Code:	sfhmc
Software Versions:	ESMT: Version 9.14 eMon: Version 9.14
Info/Resources:	ES SAMPLE SITE: https://sfhmc.escriptionasp.com/Downloads/Labor/ Log in with your EditScript login ID/PW
Customer Links:	http://www.stfranciscare.org/

Version/Change Record

Version	Date	Responsible Person	Description of Version/Change
1.0	10/12/11	Implementation Team	Alison Nicklas
1.1	03/30/2012	Bethanne Tuel	Ampersand Sign
1.2	04/12/2012	Lisa Wise	Font
1.3	05/10/2012	Lisa Wise	DOS – Pain Management Reports
1.4	05/27/2012	Lisa Wise	Punctuation
1.5	06/20/2012	Lisa Wise	Service Area Codes
1.6	08/06/2012	Lisa Wise	List Format for Diagnoses
1.7	11/05/2012	Bethanne Tuel	QC Blanks/Underscores
1.8	12/11/2012	Sydniee Schuster	Removed Font type as it is not necessary to change font
1.9	04/23/2013	Bethanne Tuel	No Dictations
2.0	06/10/2013	Bethanne Tuel	Demographics/Visit ID
2.1	09/24/2015	Bethanne Tuel	Added Work Types for JMMC Go Live

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.
- Do not abbreviate unless dictated as an abbreviation.

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. Do not expand these short-hand indicators. Assume that, if the clinician wants you to expand any acronym or abbreviation, they will speak them in their expanded form.

OP NOTES: On operative notes, if speaker uses the word "same" for Postoperative Diagnosis, transcribe as "Same." **Do NOT copy the Preoperative Diagnosis to Postop Diagnosis.** Leave the word “same” as the entire contents of the POSTOPERATIVE section.

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

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.

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-L5
- 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”

- Do not use the ampersand (&) as part of an acronym.

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

Capitalize all department names.

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.

DEMOGRAPHICS

Do not ever change a populated visit ID to a T visit. If unsure if populated visit ID is correct, leave as is and pend to client SFH: Please verify visit ID.

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 **\,** Tilde ~, or Ampersand &

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

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

CORRECT:
LABORATORY TESTS PROCEDURES AND RESULTS:

PAST FAMILY AND SOCIAL HISTORY:

INCORRECT:
LABORATORY TEST/PROCEDURES & RESULTS:

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:
Do **NOT** abbreviate headings, i.e.,
INCORRECT: GI:
CORRECT: GASTROINTESTINAL

REVIEW OF SYSTEMS, MEDICATIONS, PHYSICAL EXAMINATION: List meds at left margin (see Lists). List subheaders at left margin with no line after header.

MEDICATIONS:
Zoloft
HCTZ
Lasix.

REVIEW OF SYSTEMS:
CONSTITUTIONAL:
HEENT:
RESPIRATORY:

PHYSICAL EXAMINATION:
VITAL SIGNS:
HEENT:
CHEST:
HEART:
EXTREMITIES:

If HPI and PMH are dictated in sentence and paragraph form, put them in paragraph.

When a doctor dictates PAST MEDICAL HISTORY in paragraph-type form, then it would stay in paragraph.

EXAMPLE:
PAST MEDICAL HISTORY: In 10/2011, the patient came into the hospital with pneumonia. He also has a history of diabetes and hypertension. This we would leave in a paragraph.

If speaker says PAST MEDICAL HISTORY: Hypertension, diabetes, pneumonia, CHF….
we would type it flush with the left margin, not with numbers unless he/she dictates numbers or says next, etc.

EXAMPLE:
PAST MEDICAL HISTORY:
Hypertension.
Diabetes.
Pneumonia.
CHF

CANCER REPORTS: In the physical exam, when the Cancer Center doctors ask for a new line, please go ahead and make a new line. Some of them would like to see the different parts of the physical on a separate line.

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

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 is 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.
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.

MEDICATIONS:
1. Aspirin.
2. Atenolol.

DIAGNOSES:
1. Acute renal failure.
2. Anemia.

If items are dictated in list form without number, list them flush at the left margin without numbers.

MEDICATIONS:
Aspirin.
Atenolol.

DIAGNOSES:
Acute renal failure.
Anemia.

If more than 1 diagnosis is given, list them at the left margin. Do not use paragraph form.

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 the word “to” between both numeric values
Example:
The patient will return for followup in 3 to 4 months.

Frequencies or number of times: Indicate frequencies or number of times by using the word "times"
Example:
The patient was alert and oriented times 3.

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, with no space.
Example:
The patient is G1P2.

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.

PAIN MANAGEMENT REPORTS

If the clinician is dictating a letter, the DOS is the date of dictation if not dictated.

If the clinician is dictating a followup or initial visit, these are tied to the visit ID entered, which would be the DOS.

PATIENT NAME

If the clinician dictates the patient’s actual name, type “the patient.” Each occurrence of a patient’s name in the document will be replaced with the phrase “the patient”.

If a sentence begins with "patient" leave as is. Transcribe 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.

PUNCTUATION

You can use a period or omit the period when typing Dr.

Example: Dr Smith

SERVICE AREA CODES

This is a list of the Service Areas for both clinics at SFH.

Clinic Service Area Plan

Service Area Code	Service Area Description
BPED	BURGDORF PEDI
BPPS	BURGDORF PEDI PSYCH
BSUR	BURGDORF SURGERY
BPOD	BURGDORF SURG PODIATRY
BMED	BURGDORF MEDICINE
BCAR	BURGDORF MED CARDIOLOGY
BPUL	BURGDORF MED PULMONARY
BEND	BURGDORF MED ENDOCRINOLOGY
BINF	BURGDORF MED INFEC DIS
BNEU	BURGDORF MED NEUROLOGY
BWLK	BURGDORF MED WALK-IN
BNEP	BURGDORF MED NEPHROLOGY

APCU	GENGRAS ADULT PC UNIT
MED	GENGRAS MEDICINE
GCAR	GENGRAS MED CARDIOLOGY
GPUL	GENGRAS MED PULMONARY
GEND	GENGRAS MED ENDOCRINOLOGY
GID	GENGRAS MED INFECTIOUS DISEASE
GGI	GENGRAS MED GI
GMPR	GENGRAS MEDICAL PRE-OP
GDEY	GENGRAS MED DIABETIC EYE
SUR	GENGRAS SURGERY
GURO	GENGRAS SURG UROLOGY
GENT	GENGRAS SURG ENT
GORT	GENGRAS SURG ORTHOPEDICS
GCOL	GENGRAS SURG COLORECTAL
GDRM	GENGRAS SURG DERMATOLOGY
GSPR	GENGRAS SURGICAL PRE-OP
PSS	GENGRAS ADOLESCENT
PED	GENGRAS PEDIATRICS
GPPS	GENRAS PEDI PSYCH

WORK TYPES

WORKTYPE
Anesthesia Pain Center
BH Discharge Note Clinician
BH Discharge Summary Psychiatrist
BH Progress Note
Breast Health Center Follow-up
Breast Health Center New PT
Cancer Center Follow-UP
Cancer Center New Pt
Cardiac Catheterization
Cardiology PTCA
Consultation
Cyberknife
Detox Discharge Summary
Diabetes Center
Discharge Summary
Echocardiogram
EEG
Electrophysiology
Emergency Admit
Emergency Physician Report
Endoscopy
History and Physical
Holter Monitor
Jaycee Center BH
Neurophysiology
Operative Report
Peripheral Intervention
Progress Note
Psychiatric Admission Note
Psychiatric Evaluation
Pulmonary Function Test
Radiation Consult
Radiation Therapy
Rehab Discharge Summary
Transfer Summary
Sleep Study
Stress Test
Transition of Care Note

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:

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: FOR REVIEW

ADDENDUMS

Transcribe **Addendum** as first line of text. Pend to:

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: FOR REVIEW

BLANKS

Pend all notes to QC with note as follows:

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: FOR REVIEW

CARBON COPIES:

Add CC dictated by creating a new contact with all provided information if not located in the database. Pend to:

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: FOR REVIEW

INCOMPLETE DICTATIONS

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

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: FOR REVIEW

NO DICTATION

Pend **exactly** as below
NO DICTATION

QC: After verifying the job is a no dictation or hang-up, pend as below.
SFH: No dictation

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 QA.

SIGNING CLINICIAN

If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be blank. The MT should fill this in based on who the speaker states they are dictating for. If the speaker does not dictate a signer or if the signer cannot be found then the MT/QC should pend the document as below:

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: FOR REVIEW

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:

Offshore NTS_IN: Split Dictation
Onshore NTS_US: Split Dictation

WRONG WORKTYPE

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

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
Transcribe **Addendum** as first line of text and pend to customer as
SFH: Addendum

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

MTs: For more than 2 blanks, pend to QC.
QCs: After review, upload directly. DO NOT change the number of underscores. Leave as 5 underscores and DO NOT pend to customer for any blanks.

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

HEADER CHECK
Pend notes to QC for any discrepancy or header checks as follows:
Offshore NTS_IN: Header check please.
Onshore NTS_US: Header check please.

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

NO DICTATION
Pend **exactly** as below
NO DICTATION

QC: After verifying the job is a no dictation or hang-up, pend as below.
SFH: No dictation

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 QA.

SIGNING CLINICIAN

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Pend to client as such: **SFH: No signing clinician dictated.**

WRONG WORKTYPE

If job uploads with wrong work type:

MT/QC: Change worktype and upload directly. Do not pend.