VANGUARD – VALLEY BAPTIST
ACCOUNT SPECIFICS

Platform:	eScription
Institution/Site Code:	vbhs
Software Versions:	ESMT: Version 9.4 eMon: Version 9.4
Info/Resources:	Using present database Log in with your EditScript login ID/PW
Customer Links:	http://www.valleybaptist.net/foundation/index.htm

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		Pre GoLive	Correction to Headings and Blanks

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, 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 paste the entire contents after the POSTOPERATIVE section, adding anything additional after the word "same."

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-S2”

- 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

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.

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

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, 2 spaces with text immediately following on the same line.

SOCIAL HISTORY: The patient denies history of alcohol use.

Double space between main section 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 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.
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 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 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, 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" always insert the article "the". Do NOT begin sentence with "Patient…"

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

WORK TYPES

WORKTYPE
Discharge Summary
Consult
History & Physical
Operative Note
Inpatient Progress Note
Short Stay
Delivery Note
Dialysis
Procedure
Echocardiogram
Foot Care Institute
Wound Care Center
ED Assessment
EEG
Exercise Stress
Lexican Stress
Rest Stress
Resting MUGA Right Ventricular First Pass
Resting Thallium with Delay
Brwns Psych Eval (Inpatient)
Brwns Psych Progress Note (Inpatient)
Psychiatric Consult (Inpatient)
Psych Discharge Summary
Psych Evaluation (SIOP)
Pysch Progress Note (SIOP)
Behavioral Health H&P (EC Inpatient)
Behavioral Health Progress Note (EC Inpatient)
Behavioral Health Psych Eval (EC inpatient)
Behavioral Health Psych Discharge Summary (EC inpatient)
IBH Clinic DS (Outpatient)
IBH Clinic Evaluation (Outpatient)
IBH Clinic Progress Note (Outpatient)
Preop H&P
Neonatal
Transfer 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. 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

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 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: FOR REVIEW
Onshore NTS_US: FOR REVIEW

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

Offshore NTS_IN: FOR REVIEW
Onshore NTS_US: 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 upload directly. Do NOT pend for addendums.

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

MTs: For more than 2 blanks pend to QC.
QCs: You may upload to client with 2 or less blanks. If more than 2 blanks, please pend to client as:
VBHS: Blanks remain.

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.

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

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

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

RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to VBHS 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 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.

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

WRONG WORKTYPE

If job uploads with wrong work type:

Change worktype and upload directly. Do not pend.