Medical Scribe experience

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What is a Medical Scribe?

-A trained medical information manager who specializes in charting physician-patient encounters in real time during medical exams

- An unlicensed individual hired to enter information into the EHR at the direction of a physician or licensed independent practitioner.

That is.. if this Rona thing goes away

What are the benefits of having a scribe?

- Timely, accurate documentation
- Well-phrased EHR note
- Legal liability
- Physicians can be fully engaged with the patient
- Quality of life for the physicians
- Patient and physician satisfaction increases

SOAP

- The method used in charting the patient's stay through the clinic/ED must follow a logical progression
  - The most common method is to consider the chart to have four generalized sections:
  - Subjective
  - Objective
  - Assessment
  - Plan

Subjective

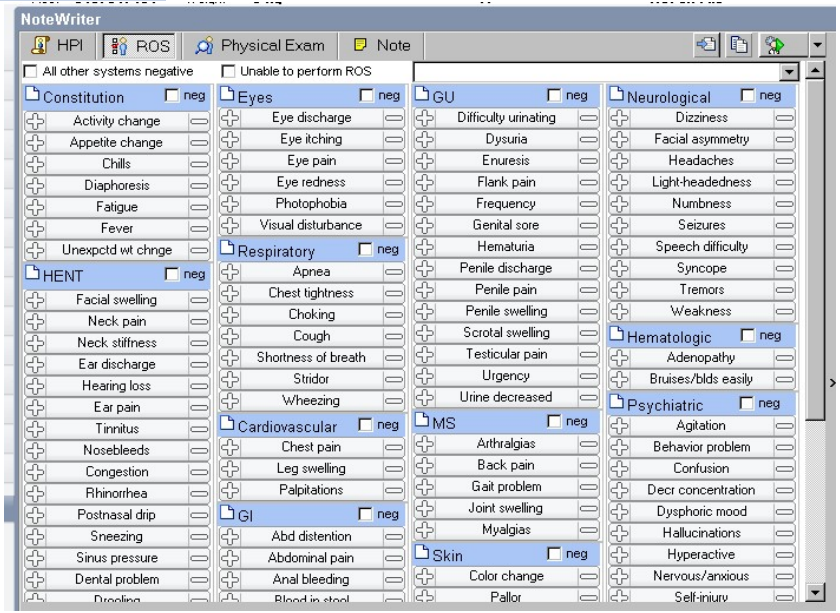
- The Subjective portion includes:
- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past medical history (PMHx)
- Family history (FHx)
- Social History (SHx)

Subjective example

Pt is a 39 y.o. male with past medical h/o HTN who presents to the ED with acute, burning, substernal chest pain onset 2 hours ago while he was sitting in his recliner at home. He states that the pain has been constant since onset, intermittently radiating to his L arm. His wife noted him to be diaphoretic and became concerned, prompting his presentation at this PM. Additionally, he also c/o SOB and nausea but denies emesis. He denies any prior h/o ACS, MI or similar chest pain. No reported aggravating factor and has tried no pain medication PTA to the ED. He denies fever, chills, cough, dizziness, palpitations, extremity weakness/numbness/paresthesia, abdominal pain and any other sx at this time.
Family hx: HTN – mother, HTN, DM & MI (age 43) – father.
Social hx: Denies tobacco usage, illicit drug abuse or EtOH abuse on a regular basis.

Adult ROS

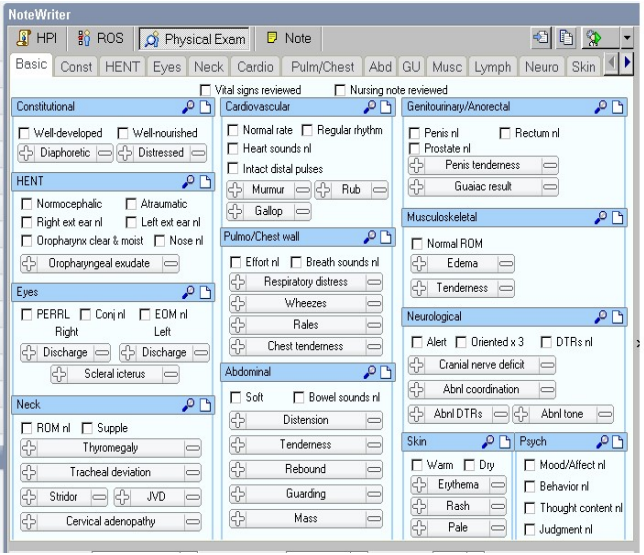
- A Review of systems is an inventory of body systems obtained through a series of questions to identify signs and/or symptoms which the patient maybe experiencing or has experienced

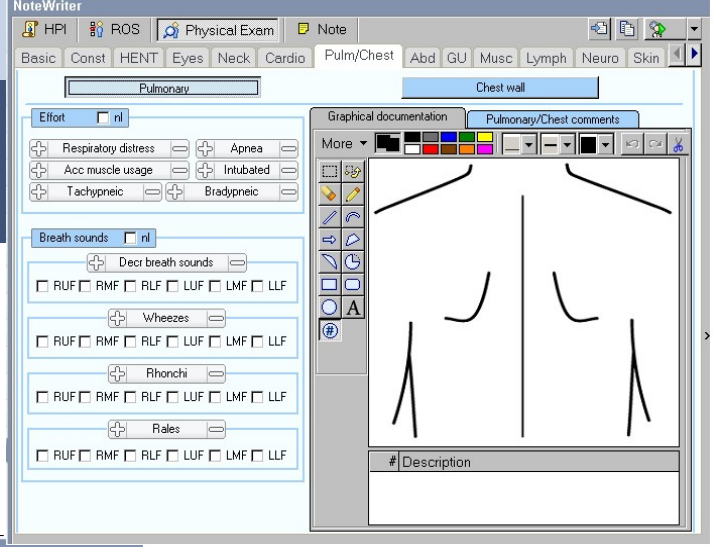


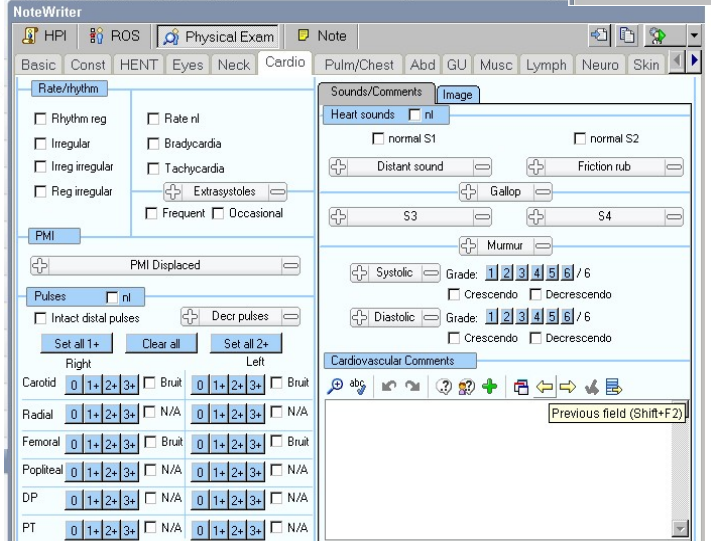
Objective

- Physical Examination (PEx)
  - Information elicited through observation, palpation, percussion and sucultation
- Medical Decision Making (MDM)
  - Documented under “Progress notes” and contains differential diagnosis, progress notes and attending MDM

Physical Exam Template examples







Progress note and attending MDM

- Progress note example:

Re-eval at 1400 – Pt states that her nausea have resolved. Pex: Abdomen is soft and non-tender, normal bowel sound. Pt will be discharged and f/u with her PCP as needed.

- Medical Decision Making (MDM):

A)Subjective: Reviewed and agree with HPI

B)PEx- GI: abdomen soft and non-tender

C) A: UTI vs kidney stone

D) P: Labs, CT abd/pelvis to rule out kidney stone

Assessment and Plan

- Diagnosis: The physician's impression of the patient after combining the information from the subjective and objective.

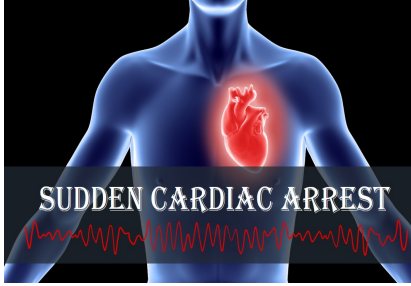
  Examples: Atypical chest pain, kidney stone, UTI etc.

- Plan: How the physician manages the patient's care after the final diagnosis has been identified and can discharge or admit the patient based on their diagnosis.

Typical ED scenarios

- 37 y.o. male presented to the ED with lymphadenopathy and anxiety. He was recently treated with STD but G/C done on 3/23 was negative. His PE demonstrated posterior cervical lymphadenopathy and he was diagnosed with lymphadenopathy of head and neck. He was subsequently discharged with RTER precautions for worsening sx.
- 50 y.o female past medical h/o HTN, HIV and ESRD presented to the ED with atraumatic R-sided lower back pain ongoing for the past week which did not improve with the intake of Tylenol. She denied any recent indulgence in strenuous activities and also denied h/o back problems. During her stay at the ED, she had a XR spine lumbar done which was negative for any acute disease. She was diagnosed with acute r-sided low back pain with R-sided sciatica and was subsequently discharged on Robaxin.
- 56 y.o. female presented to the ED with intermittent episodes of constant “burning” chest pain for the past week with associated burping due to indigestion. She was taking Pepsid with mild relief. She denied any prior h/o MI or PE or any other cardiac problems. Her CXR demonstrated no acute infiltrates and thoracic spine dextroscoliosis and her EKG was also within normal limits. During her stay at the ED, she was provided with H2 blockers with significant improvement in her sx. Her troponin was negative, heart score was low, and, therefore, she was subsequently diagnosed with atypical chest pain. Afterwards, she was discharged with rx for Maalox, Mylanta and GI referral.

Higher acuity patient 1: Cardiac arrest patient



HPI: 58 y.o. male with past medical h/o CHF, MI, HTN and HLD presented to the ED with witnessed cardiac arrest. Downtime was known to be approximately 25 mins. Initial rhythm was noted to be v-fib. En route to the ED, pt was placed on LUCAS, provided with 300 amiodarone, epinephrine x 2 and was shocked x 3 but he remained asystole.

Physical Exam (PEx):

Constitution: Pt is in acute distress. Backboard and face mask in place. Active CPR with LUCAS device. HENT: Vomit in the mouth. Eyes: Pupils dilated. Cardiovascular: No pulse Pulmonary: No spontaneous respirations Abdomen: Distention. Musculoskeletal: R tibial interosseous line Neurological: Unresponsive, GCS 3.

Medications/procedures performed in the ED:

Pt was provided with epi x 2 and bicarb x 2 and was subsequently intubated but he remained asystole.

Diagnosis: Cardiopulmonary arrest

Disposition: Pt expired

Higher acuity patient 2: Psych patient

HPI: 35 y.o male presented to the ED with SI. She also c/o anxiety and took Xanax PTA to the ED with no significant relief. She mentioned that she has been undergoing a lot of stress recently due to her currently living conditions and relationship problems which has led to the "back and forth SI." She endorsed h/o bipolar disorder and is currently only compliant with Lithium. She was previously f/u by Healing Touch but always transitions between different psych facilities. She denied HI, hallucinations, SOB, cough, recent travel, sleep disturbances.

Physical Exam:

Attention and perception: She is inattentive. Mood and affect: She is depressed (tearful). Speech: Speech is delayed. Behavior: Behavior is withdrawn. Though content: Suicidal. No homicidal ideation. Judgement: Inappropriate

Diagnosis: Bipolar disorder, current episode depressed, severe, without psychotic features.

Disposition: Transferred to Behavioral Health Unit for psych evaluation.

Re-evaluation: Shortly after disposition, pt became lethargic. She was provided with Narcan with no improvement in her condition. Therefore, she was subsequently placed on the monitor. Her O2 stat dropped to the 80s and therefore she was placed on a nasal canula. Physician suspected possible AMS due to excessive alcohol and benzo intake.

Higher acuity patient 3: Stroke patient

HPI: 62 year old woman with a past medical history of multiple TIAs, subarachnoid hemorrhages, seizures, and type 2 diabetes mellitus presents to the ED with new onset weakness and altered mental status in the last 24 hours. The patient states that she got up in the morning to use the restroom, and she was staggering like she was “drunk” or “drugged.” The patient’s niece, who lives with her, said that the patient’s speech was slowed and she was more confused than her baseline. The patient does have some baseline left sided weakness and facial nerve palsy from previous cerebrovascular events, however she is normally able to perform ADLs.

Physical Exam: General: somnolent. Oriented to person and place. HEENT: PERRLA. EOMI. No oral lesions, no lymphadenopathy. CV: Regular rate and rhythm, no murmurs. Pulmonary: Clear to auscultation bilaterally. GI: Normal bowel sounds, soft, non distended. Moderate tenderness over left abdomen and flank. Extremities: No swelling, good peripheral pulses. Neuro: Left facial droop. Strength 4/5 in LUE and LLE and 5/5 in right. No sensory deficits. Speech is slowed. Coordination is slowed. Unable to complete assessment of attention due to mental status.

Labs and Studies: CBC: WBC 4.4, Hb 12.2, Plts 179. BMP: Na 130, K 4.6, Cl 99, Bicarb 25, BUN 18, Cr 1.08, Gluc 519, Ca 9.9, Phos 2.8. LFTs: TP 7.7, Alb 4.1, Tbili 0.3, ALT 13, AST 15, AlkPhos 110. Lipids: TC 305, TG 202, HDL 44, LDL 221. Thyroid: TSH 16.04, free T4: 0.57. UA: glucose >500. CT Head: no acute ischemic or hemorrhagic event

Diagnosis: Weakness/AMS: Differential diagnosis for the patient’s current complaints is widespread and includes CVA, encephalitis, hyperglycemia, hypertensive encephalopathy, hypothyroidism, seizure, and phenytoin toxicity. No acute changes on head CT rules out a stroke and the patient is not demonstrating any signs of infection (no fever, no elevated WBC, no headache/neck pain). The leading consideration at this point would be related to missed doses of medications, given lab valves of glucose and thyroid hormone, or perhaps

Benefits of being a medical scribe

- Great opportunity to shadow physicians
- Helps decide early-on if one wants to pursue medicine in the future
- Provides the opportunity to earn money while shadowing
- Avenue to learn medical terminologies, differential diagnosis and medical decision-making procedures
- Gain insight regarding EMR navigation, IPAC (X-ray) & EKG interpretation
- Provides the opportunity to empathize with patients
- Enhanced typing speed and efficiency
- Instills a sense of responsibility and teamwork
- Develop strong relationships with physicians, nurses and other

Thank you!

Any questions or comments?