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| **Scanning Documents** | | | | |
| **Purpose** | This procedure provides instructions for SCANNING DOCUMENTS in the clinical document folder in the Electronic Medical Record (Cerner / PowerChart).   * Part One provides instructions for scanning **ORDERS**. * Part Two provides instructions for scanning **REPORTS**. | | | |
| **Policy Statements** | This procedure applies to all laboratory staff responsible for scanning documents. | | | |
| **Materials** | **Materials/Equipment** | | **Documents/Forms/Records** | |
|  | * PC with Cerner – PowerChart * Scanner | | * Final reference laboratory report(s) * Complete provider’s laboratory order(s) * Flow Cytometry tables * Pathology report(s) | |
| **Procedure** | Follow the activities in the table below for SCANNING DOCUMENTS. | | | |
|  | **Part One: SCANNING ORDERS** | | | |
|  | **Step** | **Action** | | **Related Document** |
|  | 1 | Review the orders before scanning. All orders are required to have the following information:   1. Patient’s name and other identifiers as defined by Children’s Hospitals and Clinics of Minnesota so the order can be properly matched to the patient. The criteria for identifying the patient are the same as those for laboratory specimen labeling, Section 2, part A: [630.00 Laboratory Specimen Labeling](http://khan.childrensmn.org/manuals/policy/600/033257.asp) 2. Date of service 3. Provider’s signature or name 4. Diagnosis | | [630.00 Laboratory Specimen Labeling](http://khan.childrensmn.org/manuals/policy/600/033257.asp) |
|  | 2 | Find the patient in Cerner. Check in the patient’s medical record under Notes – External Lab Orders to be sure the document has not already been scanned. If the document has not been scanned, scan it according to Step 3.  **NOTE:** It is important to scan the order into the correct encounter. | |  |
|  | 3 | If the report has not been scanned, scan it by clicking on the “Scan” icon. On the scanning screen, in the drop down menu for “TYPE”, select “External Lab Orders”.  The default date of service is always today’s date – to change this, type a new date or select one from the dropdown list.  Enter the time as 00:00.  If there are additional orders from the same day, the following scanned orders should be entered with a time of one minute added to the previous. (ie. 00:01, 00:02, 00:03, etc) | |  |
|  | 4 | Place the document face down and top down in the scanner. Click **Scan.** | |  |
|  | 5 | Before submitting the document to the electronic chart, review the scanned image to verify it is:   1. Complete – All pages were scanned in the correct sequence. 2. Correctly identified – The document identifiers match the patient, and the document type and date are correct. 3. Legible – All pages and information can be read.   If the document does not meet these criteria, cancel and rescan the document. | |  |
|  | 6 | If the document is acceptable, click “Sign”. This will place the document in the patient’s electronic medical record (EMR).  **NOTE:** When signing the document, the scanner’s name will be referenced to it. To view the document in the PowerChart Clinical Documents window, click “Yes” when prompted. If not, click “No”. | |  |
|  | 7 | File the order for verification by a second staff member. | |  |
|  | 8 | After verification by a second staff member, the paper copy can be shredded. | |  |
|  | **Part Two: SCANNING REPORTS** | | | |
|  | 1 | All reports of testing results from reference labs (unless interfaced with Children’s LIS) must be scanned into the patient’s EMR in PowerChart.  Review the reports before scanning. The report must meet the following criteria:   1. Patient’s name and other identifiers as defined by Children’s Minnesota so the report can be properly matched to the patient. The criteria for identifying the patient are the same as those for laboratory specimen labeling, Section 2, part A: [630.00 Laboratory Specimen Labeling](http://khan.childrensmn.org/manuals/policy/600/033257.asp) 2. The report has a status of FINAL REPORT. 3. The patient’s name, medical record number (MRN), accession number, and collection date/time all appear on the report (if not, write the information on the report). 4. Ordering Physician | | [630.00 Laboratory Specimen Labeling](http://khan.childrensmn.org/manuals/policy/600/033257.asp) |
|  | 2 | Find the patient in Cerner. Check under “Notes” to be sure the report has not already been scanned.  If the report has not been scanned, scan it by clicking on the “Scan” icon.  On the scanning screen, in the drop down menu for “TYPE”, select the correct folder for the report.  **Types of Folders:**   1. Anatomic Pathology Reports - scanned 2. Blood Bank Reports – scanned 3. Chemistry Reports – scanned 4. Coagulation Reports – scanned 5. Cytogenetics Reports – scanned 6. DNA Testing Reports – scanned 7. External Lab Orders 8. Flow Cytometry Table 9. Hematology Reports – scanned 10. Micro Reports – scanned 11. Miscellaneous Reports – scanned 12. Miscellaneous Fluids Reports – scanned 13. Serology/PCR Reports – scanned 14. Toxicology Reports – scanned   **Author:**  The scanner defaults as the author.  For Cytogenetics and DNA reports Change the author to the ordering provider**.**  **Date and Time:**  Enter the collection date/time of the report.If there are additional reports from the same date and collection time, the following scanned reports should be entered with a time of one minute added to the previous. (ie. 00:01, 00:02, 00:03, etc)  **Subject:**  Type the name of the reference lab in the Subject field. See the “Reference Laboratory Abbreviations List” for standardized nomenclature.  **EXCEPTION:** For reports from the University of Minnesota Cytogenetics Laboratory containing “aCGH – Comparative Genomic Hybridization Array”. Enter “**aCGH**” in the Subject field  If unable to determine into which folder the report should be scanned, check Sunquest MIQ, Results, the Scanning Folder spreadsheet, or with a supervisor as appropriate. | | Scanning Folders Spreadsheet  Reference Laboratory Abbreviations List |
|  | 3 | Be sure all pages are in the correct order. Place the report face down, top down in the scanner. Click “Scan”.  When all pages of the document have been scanned, review the scanned image to be sure it is:   1. Complete – All pages were scanned in the correct sequence. 2. Correctly identified – The document identifiers match the patient, and the document type and date are correct. 3. Legible – All pages and information can be read. 4. Final – The report is final.   If the scanned document does not meet these criteria, click “Cancel” and rescan as appropriate. | |  |
|  | 4 | If the document is acceptable, click “Sign”. If the ordering provider is the author, click “Submit”. | |  |
|  | 5 | After the report is scanned, attach all pages together, and file the report to be verified by a second staff member. | |  |
| **Procedure Notes** | 1. Orders and results are discarded in a secure Shred It after the second reviewer has approved the scan. 2. Original copies of reports for external providers will be appropriately mailed.  Before turning the computer on, ensure the scanning device is powered up, then power up the computer.  1. If problems cannot be corrected by rescanning, contact a supervisor or LIS department. 2. If two documents are scanned in for the same date and time the second scan will overwrite the first scan. In this situation the first document will need to be marked by clicking the red “X” and rescanned with the time indicated to be one minute later. (ie. 07:22, 07:23,etc.) 3. If a report or order has been scanned incorrectly (i.e. wrong date/time or wrong patient), select the incorrect report, click the red “X,” and enter the reason for marking the report/order. To have the report permanently removed from PowerChart, e-mail the information to Health Information Management (HIM):   Kristi Lundgren, HIM Manager at [Kristi.Lundgren@childrensmn.org](mailto:Kristi.Lundgren@childrensmn.org)  AND  Mary Benesh, HIM Supervisor at [Mary.Benesh@childrensmn.org](mailto:Mary.Benesh@childrensmn.org)  Notify the Technical Specialist of Support Services or LIS with questions.   1. All reports from Flow Cytometry are scanned into the “Flow Cytometry Tables.” To scan these, follow the directions on the red folder containing these reports. 2. A second lab staff member reviews all scanned orders and reports to ensure that the order, result, scanning folder, and collection date/time are correct. The reviewer should correct any errors appropriately and file the documents. | | | |

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| **Historical Record** | **Version** | **Written/Revised by** | **Effective Date** | **Summary of Revisions** |
| 1 | Dawit Getachew | 10/24/22 | Modified step 8 of Scanning Orders. Manual requisitions can be shredded after scanning to patient charts instead of keeping them for 2 years |
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