Policy Statement

Phone Notes and Flags shall be used appropriately as communication tools in the EMR.

Reason for Policy

The purpose of this policy is to provide guidance regarding the appropriate use of the phone notes and flags as communication tools in the electronic medical record (EMR).

A. Definitions

1. Phone Notes are encounter forms that record information in a patient’s chart that is received outside of office visits. Phone notes may be generated in response to a call from a patient or 3rd party or from the clinic/office.

2. A flag is a brief non-patient-related message you can send to another user on the EMR system database. A flag does not become a part of the medical record and therefore, there is no permanent record of a flag in the chart.

3. An entry is a block of text in a Phone Note entered by a single user. A phone note may include multiple entries by multiple users and may have more than one entry by the same user. Each phone note entry must be signed by the individual user (also called “dot signing”) before it is routed to another user.

4. Document is the term used to describe the entire compilation of entries that may comprise one Phone Note.

Who Should Read This Policy

Rutgers RWJMG faculty and staff

Related Documents

Contacts

Office of the Dean, Rutgers RWJMS (732-235-6300)
6. **The Policy**

Phone Notes and Flags shall be used appropriately as communication tools in the EMR.

A. Procedure

1. **Phone Notes**
   i. Phone Notes are used to document healthcare-related encounters with patients or with 3rd parties on behalf of a patient (for example, medication pre-authorization requests with insurers).
   ii. Non-healthcare-related telephone encounters, such as when a patient calls asking for directions or to inform us that they are going to be late for their appointment do not necessitate the use of a Phone Note.
   iii. Healthcare-related encounters that deal with a single issue/problem may occur over a period of time and may involve multiple communications between/among the healthcare team.
      a. When taking calls from patients, users should check to see if a Phone Note already exists for the issue/problem.
         1. If the Phone Note exists and is unsigned, the previous note should be continued. A new phone note should not be created.
         2. If the Phone Note has been signed, it can be appended to document the additional information and routed to an appropriate user.
         3. If the patient is calling about a new and different issue, a new Phone Note should be created.
   i. All entries should be “Dot Signed” before routing. (Dot-signing is accomplished by typing “.s” and then the <space> key. It activates a macro that inserts the name of the currently logged-in EMR user, followed by the current date and time). If a user works on a Phone Note more than once, each entry should be dot-signed even if the entries are consecutive in the note.
   ii. If the text box in the Phone Note is full, the note should be continued in the body of the document (by closing the form and typing below the existing text).
   iii. Once any entry is made in the body of the document, additional entries should be typed into the body of the note following all previous entries in order to ensure that entries are documented in the order in which they were made.
   iv. If the patient is requesting to be called back, the user should ask which phone number to use and document this number in the note. Users should not assume that the phone numbers already in the chart are correct.
   v. Before routing a note to another EMR user, **the author of a Phone Note should document clearly what action is expected from the recipient of the note** (e.g. approve a medication renewal, answer a question, call in a prescription, mail a lab order).
   vi. Signed status of a phone note indicates that all actions have been completed and all issues raised in the note have been resolved. It may be removed from the nursing desktop and should not be routed back to the Provider. If additional action or approval is needed from the provider, then the note should not be signed. Therefore:
      1. Phone notes should be kept “on hold” (unsigned and open for additional input) until all actions are completed.
      2. Phone Notes should be signed by the person who completes the last necessary action at the time it is completed.

2. **Flags**

   i. Flags CAN be used for:
      1. Non-patient-related questions, for example, “Can you help me customize my name list in the EMR.”
      2. Reporting a problem – “I’m getting labs that belong to another doctor.”
      3. Asking registration staff to update contact information
      4. Notifying another provider that you have seen a patient

   ii. Flags SHOULD NOT be used for:
      1. Documenting a patient phone call
      2. Asking someone to call a patient
      3. For anything related to orders for a patient.
iii. Converting Flags to Phone Notes
   1. If a flag is used inappropriately, for communications, it must be converted into a Phone Note. *(Having a need to convert a Flag to a Phone Note always indicates that someone used the flag incorrectly.)*