

Dictation Best Practices

Rationale

The American Association for Medical Transcription (AAMT) is actively engaged in offering our professional expertise to address the impact of problem dictation as it relates to documentation errors and critical flaws affecting patient safety, the potential for sentinel events, the effects on turnaround time, and the resulting increased cost.

Patient Safety

AAMT has defined 2 specific flaws: (1) critical flaws that impact patient safety and (2) major flaws that involve document integrity. In an AAMT Quality Assessment Study, of 220 records reviewed, 38 critical flaws were detected. Of those critical flaws affecting patient safety, 53%, were caused by the dictator's medical word misuse. Furthermore, throughout this study, the dictator's speed and poor articulation were cited as being the most frequent causes of problematic dictation.

Recognition of the importance of clear dictation often comes from those at the front lines of patient care. In a memo to the medical staff at Caldwell Memorial Hospital, Geoffrey Burbridge, M.D., Chairperson, Medical Record Committee writes:

*"Another patient safety goal focuses on legibility. Legibility of handwriting has long been identified as a problem. With increases in technology, inaudible dictation has fallen into this same category. **Illegible handwriting and inaudible dictation both are records of patient care/findings that are incomprehensible by others.** Poor dictation can result in the omission of very important words such as "no" or "non", as in "there is (no) malignancy identified", or large amounts of phrases and or words that cannot be transcribed due to the dictation being inaudible, garbled, or loud background sounds over-riding the voice."*

Lest anyone believe that poor documentation, and its potential impact on patient safety, are limited to only one small geographic location:

"Patients in the United States reported higher rates of medical errors and more disorganized doctor visits and out-of-pocket costs than people in Canada, Britain and three other developed countries, according to a survey released on Thursday. Thirty-four percent of U.S. patients received wrong medication, improper treatment or

incorrect or delayed test results during the last two years, the Commonwealth Fund found.”¹

Document Integrity

Document integrity is perhaps of greatest importance to the dictator when the patient's record is used as a legal document. An example of the medical record as a witness is shown in a Wisconsin Appeals case, *Kagenkord v. State*, 100 Wis.2d 452, 302 N.W.2d 421 (1981). This particular case was an appeal to a conviction for physical child abuse or shaken baby syndrome. The appellant raised the issue that during the course of the trial the state read portions of medical records pertaining to the admission of the child to various hospitals, and denied her the right to confront the witness by simply accepting the medical record.

According to the Wisconsin Supreme Court:

“We hold only that hospital records bear such an unusual indicia of reliability and trustworthiness that, in circumstances where the evidence is clinical and nondiagnostic and there is no articulated reason that there is any inaccuracy or irregularity in the entries in the record, such records satisfy the confrontation clause.”²

Clearly the courts consider some portions of medical records to be so trustworthy that there is no need to bother with the plaintiff's constitutional right to confront the witness (the witness being the record). Dictators may not get the chance to explain themselves in the clinical and nondiagnostic areas, and may indeed find themselves having to explain their dictation in the nonclinical and diagnostic areas. In one court case evaluated by this group, the use of a particular prepositional phrase was raised in the sentencing of a felon involved in slitting someone's throat. Grammar and properly quoting the patient does make a difference legally.³

¹ Susan Heavy, *Us Leads Way in Medical Errors, Common Dreams*, November 23, 2005.

² *Id.* At 478, 302 N.W.2d at 434.

³ *Cain*, 958 S.W.2d at 408-409.

Turnaround Time

The continuing effort to reduce turnaround time is seen in all healthcare facilities. Yet, unaddressed problematic dictation can consume up to 33% more resources in labor-related time. Studies in various transcription departments have generated statistics that reveal serious implications to turnaround time due to dictators. Poor dictation can double and triple the time spent in the combined efforts by Medical Transcriptionists (MTs) and Quality Editors to resolve dictation problems. Departments have reported that turnaround time can be increased by 12 to 24 hours, not only for the affected report, but others as well. Poor dictation can be caused by issues such as medical word misuse and incorrect verbiage, to the effects of speed, accent, articulation, volume, background noise, poor equipment, insufficient information, incorrect information, poor grammar, and style. As one transcription supervisor of a 540-bed hospital reports: "One miserable dictator can greatly impact everyone's turnaround time. For example, if a physician dictates poorly on several reports, the extra time spent (as much as 3-4 times the normal) multiplied by several reports can mean that 20-30 other reports that might have been completed cannot be done. So it does not only impact the poor dictator's reports, but it will impact others who may have been great dictators who will now wait that extra time before their reports are done."

Costs

The silent partner of increased turnaround time is the increased cost of extra staff necessary to address the results of poor dictation. Again, from the transcription supervisor of the 540-bed hospital:

"... the equivalent of one full time equivalent (FTE) would be necessary to address 'holds.' Depending on who that FTE is would greatly impact the cost. If the supervisor or a transcriptionist has to waste time on addressing the problem, the cost would be even more significant than a clerk."

The same is found by the departments cited above: *"We've had to add about .75 QA FTE per 8 MT FTEs to take care of blanks. These blanks are almost universally caused by poor dictation."*

From another: *"One FTE for our QA staff is necessary for the workload to review areas left blank in reports due to MTs not being able to decipher a word or words in reports. Therefore, I attribute 25% of our QA cost to be directly due to poor dictation."*

When we have these types of added costs in departments where qualified MTs are stymied by the results of poor dictation, we are adding significantly to the overall healthcare costs related to documentation.

Transition to Speech Recognition and the EHR

The traditional transcription environment is not the only one that will be improved by better dictation practices. As the healthcare system rapidly moves toward adoption of EMRs and ultimately the EHR, widespread attention has now turned toward automating technologies such as speech recognition to create greater efficiencies in data capture and documentation. Speech recognition vendors consistently cite a low percentage of qualified users as a chief concern in assisting clients in adoption and implementation of this technology. For SR solutions to be both efficient and cost-effective, there must be a high degree of recognition on the part of the speech engine to produce a draft at or above the 96% minimum accuracy threshold that would justify even using the technology as a solution. For this reason, transition from traditional transcription to a speech-recognized documentation process *must* be facilitated by high quality dictation being delivered to the speech engine. Clear, articulate dictation will best ensure the efficacy of that technology, either alone or as part of an EMR/EHR system.

Conclusion

Facilities who seek to address concerns related documentation turn-around, quality, and cost, would be well served by taking a close look at the correlation between poor or questionable dictation to these key concerns. This often-overlooked factor in the documentation process can have a measurable impact on all of these areas, and making better dictation practices a priority should be a key concern of any facility that is focused on cutting costs in documentation while preserving documentation integrity and promoting patient safety.

The *Dictation Best Practices Tool Kit* is designed to assist facilities in addressing this issue – to begin to adopt and implement policies and training practices that will promote high quality dictation and ensure the best documentation outcomes.