Southern Transcription Services
ERROR DEFINITIONS / QA GUIDELINES

October 2008

I. PURPOSE OF QUALITY ASSURANCE AUDIT

A. To promote transcription of documents that are clear, accurate and complete to support patient care by providing caregivers timely and correct documentation.

B. To promote minimal variation in transcription practices regardless of where transcription occurs.

C. To ensure the accuracy, integrity, and quality of patient information, and to support code assignment.

D. To clearly communicate quality expectations to all STS employees.

II. QUALITY REFERENCES

Quality references are based on, but not limited to, the following:

- AHDI (AAMT) Style Guide.
- Southern Transcription Services Style Guide
- Facility specifications

III. REVIEW GUIDELINES

A. QUALITY

A quality audit provides a formal opportunity for an account manager to help an employee understand where improved performance is expected, and to provide written record of each counseling session. The following will apply:

- Verbal Warning – 1st Offense
- Written Warning – 2nd Offense
- Final Written Warning – 3rd Offense
- Suspension – 4th Offense

A quality goal of at least 98.1% is set for each transcriptionist. A transcriptionist who falls below 98.1% must stay on the review until they have maintained the 98.1% or above for one month.

The quality audits are performed on a voice-to-text platform.

In addition to yearly reviews, quality audits can be performed at any time the facility or account manager deems necessary.

B. METHOD

Report selection will be random and from any and all work types that the employee transcribes.

Documents created from templates or “normals” which are complete reports/text are excluded from review e.g., doctor says, “use my normal lap chole."

Blanks: There may be times when it is necessary for a transcriptionist to leave a blank in the document. For this reason, the transcriptionists will not receive error points for blanks.

Reports returned from physicians, HIM Coders, or any other source with errors identified will be used.

Errors will be categorized and tallied on the quality review report. The following formula is used:

Total number of lines - total error score / by total number of lines = total accuracy score

For example a report with 1 Critical Error (2pts) and 1 Major Error (1pt) would score as follows: 100-3 = 97%

C. QUANTITY

A minimum of 1000 lines typed by each transcriptionist will be reviewed by the Account Manager.

D. REPORTING AND FEEDBACK

Transcriptionists will have the opportunity to challenge quality review findings with resolution based on expert resources such as Stedman’s, Dorland’s, the AHDI Book of Style, or the STS Style Guide.

IV. GUIDELINES

This section is devoted to determining what constitutes an error and the definition/example of the error. The evaluation of errors is based on two main principles:

- The consequences of a particular error or omission to patient care; deemed “CRITICAL ERROR”; “MAJOR ERROR”; “MINOR ERROR”
- The integrity of the report that may be affected by a particular error or omission and how that reflects upon the transcriptionist, the healthcare provider and the facility.

Criteria and Weights: The Quality Assurance Staff will score reports utilizing the error definitions and associated weights outlined below. Examples are provided to assist in identifying the appropriate error category/definition.

CRITICAL ERRORS (2 POINTS EACH)

- **Compromising Patient care**: Any error that has the potential to compromise patient care including but not limited to: any medical or English term(s) or phrases or the omission of the same, nonsensical text or verbiage, inappropriate abbreviations and incorrect numerical values.

- **Identification Error (critical)**: Any error associating the patient information with another patient, or other patient resulting in the patient information going to another physician (potential HIPAA violation).

- **Incomplete dictation**: Transcriptionist error.

- **Noncompliance:** These errors result in not following STS Style Guide, STS website, STS protocols or reference materials named in the STS contract.

Error:	Transcribed	Dictated
Incorrect Lab Value	TSH .33	TSH 3.3
Incorrect Vital Sign	BP: 128/90	BP: 182/90
Incorrect Drug	Zantac	Xanax
Incorrect Dosage	25 mg	250 mg
Incorrect administration	b.i.d.	t.i.d.
Creative transcription affecting patient care	• Aseptic guidewire was inserted. • MT sella syndrome • CNS	• The guidewire was inserted. • Empty sella syndrome • C&S
Omitted transcription affecting patient care	Urine creatinine was 0.3, low	Urine creatinine was 0.3, low suggesting incomplete collection.
DO NOT USE ABBREVIATIONS	U QOD	Unit Every other day
Inappropriate word expansion	60-year-old bowel movement	60-year-old black male
Dictation signed off w/o completing transcription (Non-Technical)		
Inappropriate use of physician “normal” / macro Failure to delete text from a normal, routine or work type if directed to do so	ROS: use my normal (typed in report) Lower GI normal inserted	(Should be expanded to include dictators ROS or should be flagged for follow up at facility) “insert upper GI normal”
Inappropriate use of report type	Transcribed an H&P	Doctor dictated a Consult
Incorrect dictating physician / incorrect courtesy copy	Steven Jones, MD (orthopedic)	Stephen Jones, MD (infectious disease)

Error:	Transcribed	Dictated
Incorrect patient name (HIPPA), choosing the wrong patient causing the incorrect patient information to be tied to the chosen patient.	Jones, Edward - MRN 0293040 pt 62 year old.	Jones, Edward - MRN 92454 pt 30 year old.
Noncompliance STS Protocol(s)	See Examples Below for correct transcription protocol:	See Examples Below for what is dictated by the physician:
	• **NO KNOWN DRUG ALLERGIES** • DIAGNOSTIC DATA	• No know drug allergies. • Laboratory Data:

MAJOR ERRORS – (1 POINT EACH)

- **Document Integrity**: Dictation that is transcribed differently than dictated without significant impact on the medical meaning, but compromises the integrity of the report.

- **Padding Lines**: An error where text has been inserted that was not dictated either inadvertently or for financial gain.

- **Identification error (major)**: Any error causing the patient to be linked to the wrong date of service, wrong exam, or not properly linking patient exams.

Error:	Transcribed	Dictated
Creative nonsensical	• He has grandchildren • Hospitalist consult • She lived in a women's shelter • To optimize the urine	• He has grown children • Hospice consult • She worked in a women's shelter • To alkalinize the urine
Insertion of text not dictated (padding lines)	• Removed K wire and then passed and docked the dilator • Heart: Regular rate and rhythm. • The wound was closed with a buried interrupted simple skin closure	• Removed the K wire then docked the dilator • Heart: Regular rate. • The wound was closed with a buried interrupted subcuticular and interrupted simple skin closure
Incorrect exam # / account # / missed link	• DOS 05/15/05 Emergency Room report for patient account # 123456 • Transcribed on CT of the abdomen without linking the CT of the pelvis	• DOS 05/16/05 Day Surgery for patient account # 678910 • Doctor dictates a CT of the abdomen and pelvis

MINOR ERRORS – (.25 POINTS)

- **Grammar and Spelling Errors:** Includes subject-verb agreement, incorrect gender pronouns, incorrect verb, and the wrong part of speech. This also includes misspellings, capitalization and typographical.

Error:	Transcribed	Dictated
Mispelling Inconsequential Medical misspelling (if incorrect word is used throughout the report it is only counted once)	• Costal Chondritis	• Costochondritis
Inconsequential English misspelling (if incorrect word is used throughout the report it is only counted once)	• Plurale	• Plural
Incorrect Words (sound-alikes & medical versus English)	• Principal • Assistance • Plural	• Principle • Assistants • Pleural
Capitalization	lipitor	Lipitor
Incorrect Grammar Incorrect verb tense Incorrect subject/verb Incorrect preposition Incorrect gender pronouns Typographic errors (inconsequential)	*There is a visible scar* *Findings was normal* 2 CM from the umbilicus She presents today *She ahs been sick*	*There was a visible scar* *Findings were normal* 2 CM for the umbilicus He presents today *She has been sick.*

COMMENT ONLY ERRORS – (0 POINTS EACH)

- **COMMENT ONLY ERROR:** Misplaced commas that do not alter the meaning of the sentence and improper use of colons or semicolons. This also includes insertion of small words not dictated that do not alter the meaning of the sentence or integrity of the document.

Error:	Transcribed	Dictated
Punctuation Errors	November 16, 2005	November 16 2005
Creative transcription	The wound was closed with a #1 Vicryl suture.	The wound was closed with #1 Vicryl suture.