SUBJECT: Quality assurance for medical transcription

PURPOSE: To assure quality documentation for our customers with opportunities for education and improvement in the transcription process.

Transcribed documents are a vital and necessary component to the healthcare record. Transcription accuracy therefore should be monitored regularly to ensure quality documentation and to ensure that medical transcriptionist professionals receive timely and consistent feedback. Attention to quality should reflect an understanding that even minor errors in the record potentially can create health risks for a patient, and can diminish the credibility and perceived competence of the healthcare provider.

RATIONALE: The patient record is the only real evidence of care provision in any healthcare facility. To ensure an accurate and complete record, all items and services should be documented by the healthcare professional at the time of care. More generally, accurate and complete healthcare documentation involves a partnership between the patient, the healthcare provider and the documentation team.

A valid quality assurance process ensures that medical transcription practices are as consistent and accurate as possible. Whether an MT is the transcriptionist of the document or is an editor of the same, human judgment will always be involved in this process. The degree of accuracy and consistency that can be achieved depends on the experience and skill of the MT coupled with the acoustical quality of the dictation and the organization, focus, and language proficiency of the author.

PRINCIPLES OF QUALITY: When a document is reviewed (i.e., audited) for quality, key principles in establishing quality assurance criteria for that document are:

- The transcribed report should be reviewed against the actual dictation. Reading the report without listening to the dictation does not provide an accurate comparison of the transcription to the dictation.
- The review should apply industry-specific standards as provided by current resources and references. When evaluating style, punctuation, or grammar, *The Book of Style for Medical Transcription* is the industry standard. See Attachment A.
- The review should encompass attention to risk management issues and the documentation standards of accreditation and healthcare compliance agencies.
- Accuracy scores (ratings) should be quantified with the use of a numeric calculation that weights varying degrees of error against the length of the report. MMSC recommends the following quality goals:
  - 100% accuracy with respect to critical errors, defined as ones that potentially could compromise continuity of care, such as medical word misuse or omitted dictation, incorrect patient demographics;
  - 98% accuracy with respect to major errors; ones that compromise the integrity of the document without risk to patient care, such as misspellings or incorrect English words(s), some demographics errors and formatting errors, omitted words or unnecessary creative transcription; and
  - 95% accuracy with respect to all errors in the report, including minor errors that compromise neither patient care nor document integrity but represent an area of recommended improvement to the transcriptionist, such as capitalization, punctuation, and other minor style and grammar errors. See Attachment B for examples.
HEALTH INFORMATION MANAGEMENT POLICY & PROCEDURES
POLICY NUMBER: HIM 740
SUBJECT: Quality assurance for medical transcription

Page 2

- The reviewer (or the review process) should provide timely and consistent feedback to the medical transcriptionist in order to eliminate repetition of errors.
- All measurements, standards, and benchmarks should be disclosed to the medical transcriptionist and should be set forth in written guidelines by the healthcare provider or transcription service.

PURPOSE: Ongoing feedback, education, and performance improvement should be the goal of any quality assurance program. The scope of the program should not be limited to merely the correction of errors, but should focus on developing a transcriptionist's experienced judgment, including the ability to discern client/chart-ready documents from those that could benefit from additional review. Attention to quality must also include a commitment to the ongoing professional development and continuing education of the medical transcriptionist as a means of ensuring overall continuous quality improvement.

APPLICATION OF PRINCIPLES: The application of these principles and the development of a quality assurance program that incorporates them should be set by organizational policy. MMSC recommends the following considerations in doing so:

1. **Frequency:** Random review by periodic sampling of transcribed reports should be performed to ensure ongoing compliance with quality standards. Reports transcribed by medical transcriptionists who are new to an organization should undergo review on a regular basis until competency and judgment have been consistently demonstrated.

2. **Delineation:** Clear qualification and quantification of errors should be established for the purposes of document evaluation.

3. **Accuracy:** Transcriptionists should strive to ensure that every document is 100% accurate prior to delivery to the healthcare provider, as noted above. It is important to reiterate that hitting these targets should be the goal in transitioning a transcriptionist through any comprehensive quality assurance program. These targets are not likely to be achieved overnight, and they should not be used to penalize a relatively new or inexperienced transcriptionist, or even an experienced transcriptionist who is new to the quality assurance process or in a new work setting. Rather, these goals should be established as the standard to which all transcriptionists ultimately will be held. It also should be understood that despite every attempt to develop an objective evaluative tool for QA, review is inherently subjective and some flexibility in that regard should be incorporated into the process. Also, some allowance should be made in situations where the dictation is of poor sound quality. Finally, MMSC recognizes the inherent trade-off between speed and accuracy and strives to set productivity standards that are reasonable and of comparable national benchmarks.

4. **Purpose:** Ongoing feedback, education, and performance improvement should be the goal of any quality assurance program. The scope of the program should not be limited to merely the correction of errors, but should focus on developing a transcriptionist's experienced judgment, including the ability to discern client/chart-ready documents from those that could benefit from additional review. Attention to quality must also include a commitment to the ongoing professional development and continuing education of the medical transcriptionist as a means of ensuring overall continuous quality improvement.

5. **Accountability:** Reviews will take place as determined following initiation of the QA process. The reviewer will select a sample of documents in a random rotation so that every transcriptionist has a variety of authors and report types reviewed each quarter, a minimum of five reports per transcriptionist. The reports to be reviewed will be printed and the dictation listened to for comparison. The same error appearing consistently in a review will be counted the first time only. Again, ongoing feedback, education, and
HEALTH INFORMATION MANAGEMENT POLICY & PROCEDURES
POLICY NUMBER: HIM 740
SUBJECT: Quality assurance for medical transcription

Page 3

performance improvement are the goals of the quality assurance program, not just the correction of errors.

CATEGORIES / GUIDELINES

<table>
<thead>
<tr>
<th>Error</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical:</strong></td>
<td></td>
</tr>
<tr>
<td>Wrong or omitted medical term/ dosage / indices</td>
<td>5</td>
</tr>
<tr>
<td>TES screen (wrong demographics/originator)</td>
<td>5</td>
</tr>
<tr>
<td>Carbon copy (missed/wrong)</td>
<td>5</td>
</tr>
<tr>
<td><strong>Major:</strong></td>
<td></td>
</tr>
<tr>
<td>Omitted words / unnecessary creative transcription</td>
<td>1</td>
</tr>
<tr>
<td>Wrong report type</td>
<td>1</td>
</tr>
<tr>
<td>Wrong English word(s)</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Minor:</strong></td>
<td></td>
</tr>
<tr>
<td>Grammar/ punctuation</td>
<td>0.25</td>
</tr>
<tr>
<td>Typographical / spelling errors</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Blanks are NOT considered an error as it is better to leave a blank than to guess or leave out altogether. **Unless there is a pattern of blanks being used by transcription rather than researching an easily found answer (such as a lab value or medication that is in the CPSI system and not a guess). If the correct answer can be found in less than 5 minutes, it may be considered as an error if there is a pattern associated with the transcriptionist.**

Originated by: Health Information Management
Effective date: 1/12

Authorization:

Review date:
Revision date:

REFERENCES:
*References / sources used in the development of this QA Program include:

Association for Healthcare Documentation Integrity (AHDI)
   Statement on Quality Assurance for Medical Transcription
Amphion Medical Solutions
Mercy Medical Center – Cedar Rapids
Theresa L. Leppert, RHIT, CMT / Kaplan University
WahlTek Professional Services
Wheaton Franciscan Healthcare / Covenant Medical Center

February 2009
ATTACHMENT A: Quality assurance for medical transcription
Guide to various reference materials used in the QA process

- *Stedman’s Medical Dictionary*
- *Stedman’s Medical Speller*
- *Stedman’s Word Books*
- *Health Professions Institute Word Books*
- *Vera Pyle’s Current Medical Terminology, Eighth Edition, Health Professions Institute*
- *Webster’s II New College Dictionary*
- Credible Internet websites
- Articles published on Quality Standards
- Other credible reference materials
ATTACHMENT B: Quality assurance for medical transcription
Defining Critical and Major Errors with examples

Critical Error – 5 points:

- A critical error is one that potentially could compromise continuity of care, such as a medical word misuse, omitted medical term, incorrect medication.

  “With treatment of her underlying [blood pressures] (dictated blood sugars) the patient improved significantly.”

  “Patient was started on [alprazolam] (dictated lorazepam).”

  “The patient [was started on] (dictated was not started on) Coumadin when the Lovenox was discontinued.”

- Correct patient demographics as well as correct “Originator” are critical information.

  If Dr. Smith dictates a Discharge Summary on patient John Doe for the skilled stay and the TES is filled out with Dr. Jones with demographics for John Doe’s acute stay these would be considered critical errors.

  Dr. McCune dictated H&P but it is transcribed Dr. McCarville as originator.

Major Error – 0.5 to 1 point:

- A major error is one that compromises the integrity of the document without risk to patient care, such as omitted dictation, some demographics errors, and formatting errors, incorrect English word usage.

  Dictated: “FAMILY HISTORY: Unable to report.”

  Transcribed: FAMILY HISTORY: [No blank marker was placed and nothing was transcribed – omission of words. Would be OK to leave blank for unclear dictation and not be counted an error.]

- Report is dictated as a History and Physical report (01) but is transcribed on a Progress Record (032) template.

Minor Error – 0.25 point:

- Minor: does not compromise patient care or document integrity but is recommended by standard expectations communicated in Transcription Tips, such as capitalization, punctuation, style and grammar
## Quality assurance for medical transcription

### Attachment C: MMSC TRANSCRIPTION QUALITY REVIEW FORM

<table>
<thead>
<tr>
<th>Transcriptionist</th>
<th>Job #:</th>
<th>Total Minutes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Author Name:** ________________________

### ERROR TYPE

#### Critical: could compromise continuity of care, such as medical word misuse or omitted dictation, incorrect patient demographics (electronic misfile)

- **Wrong or omitted:**
  - medical term
  - dosage
  - indices

- **wrong patient demographics**
  - wrong originator
  - missed carbon copy
  - wrong carbon copy

**Total Points for Critical Errors**

#### Major: could compromise the integrity of the document without risk to patient care, such as omitted dictation, some demographic errors, formatting errors, incorrect English word usage

- **Omitted words**
- **unnecessary creative transcription**
- **report type**
- **Wrong English word(s)**

**Total Points for Major Errors**

#### Minor: does not compromise patient care or document integrity but is recommended by standard expectations communicated in Transcription Tips, such as capitalization, punctuation, style and grammar

- **Grammar**
- **punctuation**
- **Typographical / spelling errors**

**Total Points for Minor Errors**

**Total Accuracy (100 – total points) 95% Goal**

**Report reviewed by:** ________________

**Review verified by (optional):** ________________

**Comments:**

R:\Transcription Tips\QUALITY REVIEW FORM.doc 9/8/09