



# Managing Risks with the MT Team

by Ellen Drake, CMT

**R**isk management. When most people hear these words, they probably think about botched operations, patient relations, medical record chart review, attorneys, and maybe malpractice complaints. Rarely does anyone think about medical transcription and those who are responsible for producing it—anyone, that is, except medical transcriptionists.

Medical transcriptionists are acutely aware of the role they play in the limitation of hospital risk by producing timely and accurate reports. Many, however, are unaware that their role in risk management can and should go beyond that. Transcription supervisors, health information managers, the risk management team, and hospital attorneys should consider the valuable contribution medical transcriptionists can make with regard to protecting the hospital, physicians, and staff from liability.

## What Is Risk Management?

Risk management is the reporting, analyzing, and tracking of atypical things that happen in a hospital. In medical transcription, risk management may involve the reporting of inconsistencies within a report, inflammatory or derogatory remarks by the dictator, or the mention of an incident that may not have been reported. Dictations containing potential risk management problems should be routed through the transcription supervisor and department head to the risk management team.

A transcription supervisor should consult with the risk manager on a written policy stating the transcriptionist's role in risk management. If the risk manager agrees, transcriptionists may be required to give to the supervisor copies of reports that contain any of the following:

- Mention of any incident even though dictator states an incident report was completed.
- Derogatory statements referring to another physician, a hospital employee, or the hospital.
- Comments regarding injury to a body structure during the performance of an operative procedure or untoward complications as a result of anesthesia or the procedure.
- Aborted procedures or operations due to inadequate preparation of the patient or difficulties performing the procedure.
- Report of hospital-incurred incidents such as drug overdose, wrong drug administered, or patient injury.
- Inappropriate comments about the patient.
- Comments about patient dissatisfaction with personnel or treatment.
- Tests performed or drugs administered that were not ordered by the physician.
- Positive test results that may not have been on the chart or which the physician failed to note prior to the patient's discharge.

Once policies and procedures have been established, an in-service meeting should be held not only to review the policies and procedures, but also to educate transcriptionists about how to avoid risk in the transcription of reports and what constitutes a reportable incident. *Giving the transcription team a copy of the policies and procedures is not enough.* Thorough discussion of the types of incidents that constitute risk and anecdotal examples are necessary to be certain that transcriptionists understand what to report. The following discussion may help plan an in-service presentation.

## Where to Begin

Risk management begins even before the first line of a report is transcribed. It begins with meticulous attention to the correct spelling of the patient's first and last names, entering the correct patient number in the report, correctly spelling and entering the physician's name in the report, and entering the correct dates of admission, discharge, or procedure. While new technology makes retrieving this information and inserting it into the report easier, it also introduces new ways to make mistakes. Lack of attention while performing what may constitute an "automatic" procedure could mean incorporating a "Jr." when the report is really on "Sr.," or mother's number instead of daughter's when their names are the same, or even the name of someone completely unrelated to the patient.

Transcriptionists should be alert to names that may be either first or last names and should check for both in the master patient index when in doubt. For example, the physician may dictate a name like James Dean, when the patient is actually Dean James. It is not inconceivable that both names could appear in the master patient index because they are two different people. Social security number (if known), birth date (if given), date of admission, age, and admitting physician should be checked whenever there is a question concerning the patient name.

Hyphenated names, nicknames (e.g., Meg or Peg for Margaret; Bill, Billy, Will for William, which may not be nicknames but actual given names), soundalikes (e.g., Ellen, Helen, Elaine, and Allen), and foreign names (e.g., Hasus, Jesus) can all be sources of error carried on indefinitely in the patient's health record. Unusual first names (such as Syphyllis, Ranellen, Butch, Angel, Princess, and Doc) need to be verified as to spelling and authenticity (real first name or nickname?).

Judith Marshall notes the confusion that arose about a particularly unusual name.

One day we heard a no-nonsense doctor recounting the clinic visit of little Hitler so-and-so. What? We had no chart or patient list [with which to verify this information]. Could parents really name a child this name? They could and did . . . (The



family was visiting America from a foreign land.) Never assume a doctor is kidding with a name.

"Card Sharks," *Medicate Me*, p. 65

It is not unusual for a transcriptionist to find multiple entries with different patient numbers but with the same or only slight variations in spelling, and on closer examination, dates of birth, gender, and other demographic data appear to be the same. These should be reported and an effort made to determine whether they are indeed the same patient or different people. As noted above, parents and children with identical names also present opportunities for error in the patient health record.

### Omit Inappropriate Comments

Slang or vulgar terms used disparagingly to refer to patients should be removed from the record. Physicians may utter such comments in anger or frustration, but they really do not intend for offensive or off-color remarks to be entered in the patient's record and preserved permanently. One physician had to be urged to cease his "constant sarcastic references to every obese female as *that porker*" (Marshall, p. 66).

Neither should disparaging remarks referring to nursing or allied health staff members, management, or other physicians be allowed to remain in a record. One internist who performed the history and physical examinations on patients in the eating disorders unit of a hospital would frequently question the judgment of the psychiatrist who was in charge of the unit, and more than once called him a "fat slob." He seemed to feel that it was intolerable that an overweight physician should be responsible for an eating disorders unit!

While most MTs would not think of transcribing "fat slob" or something like that, administrators and risk managers may never know of that physician's attitude—a dangerous attitude if both physicians were named in the same malpractice case—toward another medical staff member unless such dictation is reported. This is not gossip but, properly reported, is looking out for the best interests of the hospital and even the offending physician.

Another physician who frequently dictated the admitting history and physical within earshot of his patients was dictating about one patient's anxiety and altered mental state in the patient's presence, and recommended a psychiatric consult. Within 10 or 15 minutes of completing the report, the physician came on the dictation lines again, dictating a "correction" to the previously dictated report and asked that the references to the patient's mental state be removed. The patient had become quite angry at the physician's implications that the patient was "crazy" and demanded that a new report be dictated. At the second dictation, the transcriptionist could hear the patient complaining angrily in the background. This unhappy patient could easily imagine receiving poor, inadequate, or even incompetent care culminating in a malpractice complaint.

One transcriptionist received considerable criticism because a patient had received a copy of a report in which she was consistently referred to as *he*. The patient took immense offense and felt that the report was implying that her sexual orientation was equivocal. The patient actually threatened a lawsuit. The physician dictator had been foreign, and foreign doctors often confuse feminine and masculine pronouns. The patient's name was one that could have been a male or female, and the transcriptionist either had not noticed that the gender was inconsistent within the report or had not checked the health record to be certain of the gender.

Not only are the latter two examples risk management problems but also patient relations problems. It would be in the best

interests of the hospital to have any ancillary departments that are involved or implicated in some way contacted by the supervisor about such problems.

An older physician at a small rural hospital was reluctant to adapt to new practices and procedures, and his nemesis became the PRO (Peer Review Organization). Almost every surgical procedure and discharge summary contained some kind of defamatory remark about the PRO. If he was not lambasting the PRO, it was the UR (Utilization Review) Committee. He would make remarks like, "I wanted to perform [a certain] procedure, but the PRO would not approve it, so I had to perform [another procedure] which I did not feel was in the patient's best interest," or "This patient really needs to be in the hospital another few days, but the UR committee insists on discharging the patient, even though I have repeatedly stated that the patient is not ready for discharge."

These types of inflammatory comments are inappropriate and could increase the hospital's and physician's risk of a malpractice judgment should the case end up in court for any reason.

### Watching for Inconsistencies

The transcriptionist is expected to remain alert throughout the entire transcription of any given report in order to detect inconsistencies within the report, but access to the patient's chart is needed to verify and correct most inconsistencies. When the transcriptionist can access the patient's pharmacy and laboratory records via the appropriate databases on the mainframe, many inconsistencies can be avoided. If one of these routes is not available, the report should be "flagged" to the attention of the physician to make the necessary corrections.

In some cases, the areas of inconsistency within a report may be widely separated. The original statement at the beginning of the report (saying, for example, that the patient was admitted with pain in the *left* knee) may not be contradicted until the very end of the report (for example, Discharge Diagnosis: Dislocation, *right* knee).

The following are excerpts from actual physician dictation. Each contains an inconsistency.

This patient developed a persistent lesion on the inner aspect of the left upper lip. This lesion was at the junction of the vermilion and mucous membrane. A punch biopsy was obtained of this 1 cm lesion and was read as a probable verrucous squamous cell carcinoma of the lower lip.

He was referred to our office for evaluation recently and was noted to have a normally positioned urethral meatus but a persistent ventral hood with deficient ventral penile foreskin. Testes were bilaterally descended. He is to be admitted on an elective basis at the convenience of his parents' schedule. The plan is for removal of the dorsal hood, artificial erection to rule out chordee, and circumcision.

The patient is approximately one week prior to the onset of her menstrual period. The ultrasound shows a complex cystic ovary on the right side. Left ovary is deep into the cul-de-sac area, but is essentially normal with a small 1.5 cm follicle. Pelvic examination reveals the uterus to be retroverted, mobile. Both adnexal areas reveal no masses or thickening. The right adnexal area is slightly tender. Cannot appreciate the complex cystic ovary on the left side on bimanual examination.

In the first example, the physician dictates *upper lip* in the first sentence and *lower lip* in the last sentence. In the second example,



the patient has a *ventral hood* and later a *dorsal hood*. In the final example, the ultrasound report notes a cystic ovary on the *right* side, but on physical examination, the physician states he cannot appreciate the cystic ovary on the *left* side.

### Note Errors and Incomplete Dictation

Transcriptionists are also expected to detect erroneous or incomplete drug dosages, laboratory values, and other measurements and to correct these (if the correct value can be clearly ascertained) or to flag the report to the attention of the physician for further clarification. Should charts with inaccurate or incomplete information end up in court, the opposing attorneys could have a field day. The following examples of actual physician dictation contain such errors.

The patient's physical examination revealed a 2 x 1 x 1 mass in the right upper pole of the thyroid.

Lasix 20 q. day, Micro-K 10 q. day, Zantac 150 p.o. b.i.d.

In the first example, it cannot be known whether the measurements are in millimeters or centimeters or even inches. The report should be flagged asking the physician to clarify. In the latter example, the measurements are again omitted, but consultation with the *Physicians' Desk Reference* or the *American Drug Index* would provide the usual units used for each of these medications—milligrams (mg) for Lasix and Zantac, and milliequivalents (mEq) for Micro-K.

In some cases, risk management involves recognizing when the dictation is not an error, is not slang, is not inflammatory, and letting the work remain as dictated. Each of the following excerpts contains dictation that a transcriptionist might mistakenly believe was an error in the dictation.

She gives a history of shooting crank. Since that time, the left antecubital space has been infected.

The blistering is typical of strep. I would go ahead and give her 2 million q.6h. of the penicillin and modify therapy according to culture report.

The patient underwent an intravenous pyelogram to rule out obstruction caused by tumor or stone. The urogram was negative.

In the first example, a transcriptionist might think *crank* should be *crack*, but *crank* is a different street drug from *crack*. In the next, 2 million (units) of penicillin may seem excessive to an inexperienced transcriptionist who might think the physician meant milligrams or milliliters, but it is a standard dose for the problem indicated. In the last example, *pyelogram* and *urogram* are used interchangeably.

At times, the physician must indicate that the results of a procedure cannot be found, or that an unusual test result was artificial in nature or the result of an error in the testing process. These remarks should not be edited as they form an important part of the record with legal implications. *These excerpts demonstrate remarks that should never be deleted.* They should, however, be reported to risk management to see if the problems noted can be resolved.

EKG showed sinus bradycardia with no acute ischemic changes. Repeat EKG showed a right bundle branch block with first-

degree AV block. The pattern on this EKG was so different it may not have actually been the same patient.

Chemistry panel showed a BUN of 26 with a creatinine of 1.6, a calcium of 11.7, SGOT of 271, LDH of 690, alkaline phosphatase of 69. Urinalysis on admission cannot be found in the chart.

Remarks regarding the administration of an overdose or an unprescribed drug are important to the health record in that the patient's subsequent treatment may be affected by the incident and the information should never be deleted from the report. Failure to include the report of such incidents in a document could also appear to be an attempt to hide incriminating material from the court should the situation result in litigation. The incident in the second excerpt below might have made the 6 o'clock news. To remove all documentation of the incident from the report would definitely look like a cover-up.

The following examples should be reported to the risk management department and/or health information management director by way of the supervisor.

Gastroscopy Report: Premedication: Demerol 50 mg, Vistaril 25 mg IM. The patient was also given Versed 10 mg IM by mistake, and was quite well sedated at the time of the procedure.

This 6-month-old child presented to the emergency room with a history of being listless. [History, Lab, and Physical examination are then given in the report.] As the child's insurance was through the employee's union, the child could not be admitted. We were told that at that time there was no surgeon available, but if we were able to find a surgeon in the area we might be able to transfer the patient. The child continued to get worse. The child was here from 1410 to 1845, a delay of 4<sup>1</sup>/<sub>2</sub> hours. We tried our best to get permission to have the child admitted and operated on here, but we were refused. As it happened, the child was transferred after about 4<sup>1</sup>/<sub>2</sub> hours of stay here, and after the child was admitted [to another hospital] the child could not be treated there because of absence of a surgeon. The child was subsequently transferred to [another facility] where the child was operated on.

**W**hen it comes to risk management, a hospital cannot be too conscientious. The transcription department should probably hold an in-service education meeting on risk management at least yearly, and newly employed transcriptionists should be instructed on their role in risk management on a one-to-one basis or via videotape or audiotape on the subject.

Ellen Drake, CMT, Director of Education, Health Professions Institute, is co-author of the Medical Transcription Module in the AHIMA Independent Study Program in Medical Record Technology (1993), in which a brief discussion of risk management appears. She is the former owner of a medical transcription service and a former teacher of medical transcription at a community college.

