

✓ *What's it All About?*

The patient! The quality of each document has a direct impact on the patient's experience and safety. When our quality is high, we can enhance the patient's experience and even expedite their treatment. When our quality is poor, injury or even death can result! Even a single critical error can change the course of that patient's treatment. What a weighty assignment we have every day with every report we touch! Our MLS and QC are qualified, trained professionals who play a vital role in patient care each day. These conscientious employees ask themselves, "what if this was my mother's report, my spouse's report or my child's report?" and "how would I feel if an error in their report resulted in delay of care, misdiagnosis or even death?" In today's EHR world it is no longer just a paper document placed in a paper folder. Reports are now electronically shared with multiple providers instantly, carried forward time and time again. We cannot assume how much of the context is read or how far forward it's carried. While a single critical error can decrease the pay of an MLS or QC, how much *more* do our patients stand to lose from that same critical error?

✓ *Impact or Not?*

ERROR: No recent fever, chills, rigors, **on** headache. (*Reader may think the symptoms are 'on top of' the headache.*)

CORRECTION: No recent fever, chills, rigors, **no** headache.

ERROR: Follow in 2 weeks. If not feeling better, will get chest x-ray. (*Reader may think no x-ray at this time.*)

CORRECTION: Follow in 2 weeks if not feeling better. Will get chest x-ray.

ERROR: We are going to increase the Dilaudid 2 mg. (*Reader may think they are increasing existing dose by 2 mg*)

CORRECTION: We are going to increase the Dilaudid **to** 2 mg.

✓ *Common Misconceptions*

- It's "just a typo" so it should only be scored as Grammar/Word Misuse/Typo error. Not every "typo" falls into that category. It may be a typo AND have the potential to impact patient care, so each error is evaluated individually.
- It's "nonsensical" so it should be not be critical. While some nonsensical errors are indeed major (only impacting clarity/integrity) some nonsensical errors alter the care of the patient severely. See customer testimony example below.

✓ *Customer Testimony*

"Our patient had 'non-diabetic gastroparesis' but the MLS typed '9 diabetic gastroparesis.' Because of this, the patient was given the diagnosis of being diabetic which was repeated throughout his record after that. The chart was then billed with the diagnosis of diabetes. The patient had to come to HIM to submit a request to amend his record and then we had to work with physicians to do an addendum to their reports. This has taken a great deal of time to get all of this done. We now have to have coding look at the chart and possibly rebill if necessary. While physicians should carefully read their dictations before signing, we all know that with most physicians this is not a reality."

Quality Quote:

"In the race for quality, there is no finish line" – Doris Kearns