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Dictation System

User Manual for Physicians

Transcription Services

Effective On June 28, 2011

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Welcome to Fraser Health Dictation System

The dictation system is completely integrated across Fraser Health.

Certain identifying information must be entered by the physician at the beginning of each dictation, which in turn ensures the dictation is correctly routed to the Medical Transcriptionist. The site identifier, date of dictation and worktype priority are all critical pieces of information that enable the dictated note to be matched to the correct patient visit.

When the report is complete, and filed against the correct visit, it then becomes available for viewing in the Electronic Medical Record (EMR) of Meditech.

1. To start, **dial the dictation number for your site** (see site list & phone numbers on next page)**.** These phone numbers can be interchanged, as FH voice system is across 12 sites.

2. When prompted, **enter your user ID followed by the # key.** This is usually your MSP number.

3. When prompted, **enter the site number** where your patient was treated and registered. The patient must have a valid registered visit in order to have a dictation transcribed.

4. When prompted, **enter the worktype number followed by the # key** (see list on page 5)**.**

5. When prompted, **enter the Medical Record Number (Unit Number)** of the patient followed by the # key. You will then hear an intermittent tone.

6. **Press 2, wait a few seconds, and then begin your dictation.**

Keypad Navigation

Press
1 To **listen**.
2 To toggle between **record/dictate and pause**.
3 To **rewind**.
4 To **stop**.
5 To **end** your dictation and start another.
6 To make the dictation a **priority** (urgent cases only).
7 To **fast forward**.
8 To **rewind** to the beginning of the dictation.
9 To **disconnect and log out**.

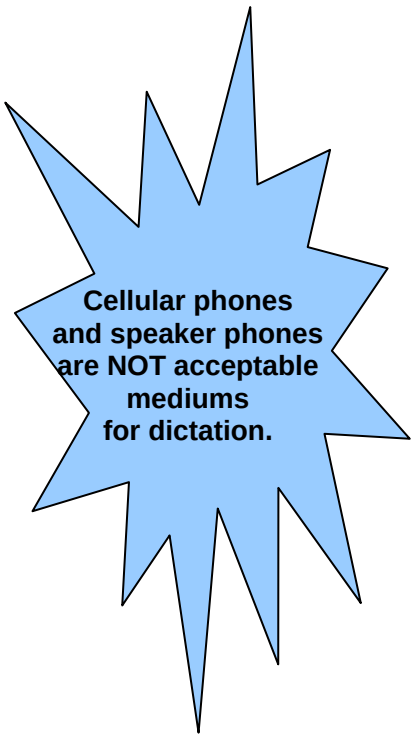
Transcription Contact Information

If you experience any problem with dictation system, please contract the Transcription Services Systems Application Coordinators:

Linda Long (604) 953-5015 Ext 763217 | Sukhwinder Randhawa (604) 953-5015 Ext 763209

Site List and Dictation Phone Numbers

Site Name	Site Number	Dictation Phone Number
BUH ERH RMH RCH Queens Park	1 2 3 4 12	(604) 520-4050
LMH SMH JPOCSC Czorny Fleetwood	11 15 18 41 43	(604) 585-5500
DH PAH	9 10	(604) 535-4515
CGH FCH	6 8	(604) 703-2001
MMH ARHCC MSA ECU	7 16 13	(604) 851-4989



Worktype List

General reports:

10 Consultation
12 Anesthetic consult
15 History & Physical/Progress Notes
16 ER outpatient H&P
23 Subacute Narrative Summary
25 Narrative/Discharge Summary
27 TCU Transfer

Cardiology reports:

32 ETT
33 ECG
34 Echo
35 Cardiology Consultation
36 Holter Monitor

Operative reports:

20 Operative Reports
26 Delivery Note
42 Endoscopy Reports
43 Bronchoscopy

Clinics:

45 Sleep Clinic
46 TIA RAC Clinic
47 SANE Clinic
48 Nutrition Clinic
49 Renal Clinic
63 Neurology Clinic
64 Rapid Access Clinic
65 Ortho/Cast Clinic
66 Asthma Clinic
67 Nerve Block/Pain Clinic
68 Healthy Heart Clinic
69 Psychiatric Clinic
70 Diabetes Clinic
71 Oncology Clinic
72 Gestational Diabetes Clinic
73 Obstetric High Risk Clinic
74 Plastics Clinic
75 MDC Chemotherapy
76 Pacemaker Clinic
77 Outpatient Clinic Note
78 Continuing Care Report
79 Elderhealth
80 GI Clinic

Diagnostic reports:

11 Bone Density
13 MRI
30 Medical Imaging – General
31 CT scan
34 Echo
37 MIBI
38 EEG
39 Nuclear Medicine
40 Pulmonary Function
41 EMG
44 Fluorescein Angiography

Histopathology:

50 Rush/Small Bx GROSS
51 Lab Surgical
52 Rushes/Small Biopsy
53 FNA-Cytology
54 Bone Marrow
55 Gross Autopsy
56 Final Autopsy
57 Supplementary Reports
58 Correspondence
59 Lab Admin
60 Pathologist GROSS
61 Regional GROSS
62 Prosector GROSS
81 Coroner Gross Autopsy
82 Coroner Final Autopsy
83 Pathologist Micro

Administrative reports:

84 NetCare Program
85 Administration memos
86 CTE minutes-mort review
87 Fraser North Admin memos
88 Hospitalist Admin

IMPORTANT INFORMATION Required for EACH Report

- **Your full name/specialty**
  If you are a resident, spell your name and dictate your preceptor name.
- **Type of report**
  Consult, history, OR, NS, Delivery note, etc.
- **Patient's full name**
  First, middle, last *with spelling if a difficult name*.
- **Patient's unit number**
  Found on the top right hand corner of chart pages.
- **Date and Clinic**
  Event date and service patient received. For reoccurring visits please specify which account this report needs to be associated with.
- **Copies**
  Physicians' full names (first, then last *with spelling if a difficult name*), specialty, and the city of practice. ** Please refer to the "Requesting Copies" section at the end of this manual.
- **Accession/Requisition Number**
  For all medical imaging reports associated with PACS.

For specific Report Types:

History and Physical Reports

Please dictate in brief point form the following essential information, with headings as outlined below.

ADMITTING DIAGNOSIS
[*]

HISTORY OF PRESENT ILLNESS
[*]

PAST MEDICAL HISTORY
[*]

PAST SURGICAL HISTORY
[*]

MEDICATIONS
1.

ALLERGIES
[*]

SOCIAL HISTORY
Smoking: [*]
Alcohol: [*]

FAMILY HISTORY
[*]

PHYSICAL EXAMINATION (examples are beside each)
General: On examination, he was undistressed and pain free.
Vitals: BP 1' 0/60. Resting pulse 92/min. Respirations 20 to 24 per min.
Head and neck: Pupils equal and reactive.
Chest: Normal breath sounds.
CVS: Normal heart sounds with no audible murmurs.
Abdomen: Soft. Normal active bowel sounds.
Extremities: Normal.
CNS: Moves all extremities.

INVESTIGATIONS
Lab: [*]
Medical Imaging: [*]

ASSESSMENT AND PLAN:
[*]

For Specific Report Types:

Operative Reports

Please dictate in brief point form the following information, as outlined below.

Surgeon:
Assistant: ***If applicable (spell out names)***
Anesthetist:
Anesthesia:
Proc. Date: ***Must be identified***

Pre-Op Dx:
Post-Op Dx:
Operation:

PROCEDURE
(Dictate details of procedure)

Standard operative report templates can be created and saved for future use.
- Contact Transcription Services to do this.

Discharge Summary Reports

Please dictate in brief point form the following information, as outlined below.

Date of admission:
Date of discharge:

ADMISSION DIAGNOSIS
[*]

DISCHARGE DIAGNOSIS
[*]

COURSE IN HOSPITAL
[*]

INVESTIGATIONS PENDING
[*]

CONDITION ON DISCHARGE
[*]

DISCHARGE MEDICATIONS
1.

RECOMMENDATIONS FOR FOLLOW UP
[*]

FOLLOW UP INSTRUCTIONS TO PATIENT
[*]

For Specific Report Types:

Cast Clinic Dictations

Orthopedic surgeons who see patients in a follow up cast clinic should utilize the multipart forms that are provided for each patient upon registration to the clinic.

Family physicians are sent a copy of the multipart form for their records. The only time that a dictation should be completed is for the reasons outlined below:

- The case may be involved in a legal proceeding.
- WCB cases.
- Complicated cases in which a detailed report is needed.

Salutations

Transcribed reports are part of the patient's Health Record and available for the healthcare team to review; therefore, we ask that you refrain from starting and ending your dictations with salutations.

Also, avoid using the word "you" when referring to a physician within your report. Dictations that are personalized will be edited by Transcription Services for clarity.

Patient Demographic Information

Transcription Services will not include dictated demographic information, such as a patient's address or phone number, within a report.

Prioritizing a Report

Priority dictations can be identified using the 6 key at the time of dictation if a report is required urgently for immediate patient care.

Dictating physicians who are found to be using the priority key for dictations other than for immediate patient care will receive a letter outlining priority definition with a copy to the physician's medical director.

One Report per Dictation - Do Not Dictate in Batches

In order for dictations to be located efficiently for patient care, **each report requires its own dictation**. Just press 5 on the keypad to begin a new dictation and enter in the appropriate worktype and patient information. For example;

- If dictating a consultation and an operative report for the same patient, each worktype requires a separate dictation.
- If dictating on a series of patients, a new dictation is required for each patient.

Batch dictations may be rejected for transcription. Transcription Services accepts no responsibility for arranging an alternate service.

Unclear Dictations

We are committed to providing a quality transcribed document and will not guess if your dictation is unclear.

The standard practice for unclear dictation is to place the document on HOLD (delaying the distribution) and send the document back to the dictating physician with a clarification request.

We ask that you review the document and send back for completion and distribution. If the document is not sent back within 10 days from the request, the document will be signed off as is with a blank and a disclaimer to contact the dictating physician for clarification.

Corrections/Edits to a Report

All reports will be dictated in a signed status as heard in the dictation. Please note that we do not provide a proofreading or rough draft service for transcribed reports; therefore, we edit errors only.

To add information to an existing report, please dictate an Addendum, state the Job number and the patient information.

If your report has a critical error, note the error (please print correction) on the report, initial and date beside it to authenticate your correction, and return it to the site for processing. Reports for RCH, BUH, ERH, DH or PAH can be faxed to **604-520-4724.** Reports for SMH, LMH, ARH, MMH, RMH, CGH, FCH or JPOCSC can be faxed to **1-877-851-4987.**

Residents/Fellows

Physician residents and fellows may utilize the Fraser Health dictation system as directed and under the guidance of the preceptor physician overseeing their residency.

- The Resident will sign on using their unique dictation ID number. The resident must begin each dictation by stating and spelling their first and last names.
- Resident must identify preceptor at the beginning of the dictation.
- Please refer to page 3 for contact information to obtain your Resident ID number.
- Residents will not receive a paper copy of the transcribed report.

Dictations NOT Accepted for Dictation

- Letters, including but not limited to:
    - Lawyers
    - RCMP
    - Outside agencies and sporting associations.
    - Immigration.
    - Medical Administration
    - Family members
- No show dictations for patients who fail to show up for a procedure or visit.
- Patients not seen onsite or registered at the time of dictation, including but not limited to:
    - Telephone consultations
    - Team conferences.
- Review panels and interdisciplinary rounds reports.
- Patient visit to a physician's office prior to arriving at the hospital.
- Dictations pertaining to visits older than 1 year from the date of discharge or outpatient event.

When dictation is discovered on the system for the above, the documents will not be processed. Transcription Services accepts no responsibility for arranging an alternate service.

Requesting Copies - Things to Remember

There are many physicians with the same or similar names. Please ensure that you state the **first name, last name, city and specialty.**

Fraser Health physicians are asked to contact the Service Application Coordinators to be set up for copy receipt. Copies can **only** be received via fax or on-site/hospital mailbox; copies will not be mailed out. If a physician is not set up for receipt of copies by one of the outlined methods, the report will show that a copy has not been sent.

Please note, reports can be viewed and printed as necessary via EMR (electronic medical record) at anytime. EMR is available across Fraser Health, and all appropriate health care individuals have access to view patient's dictated reports from previous and current visits.

Please do not request a copy to non-physicians or specific departments with a site that has this access. The intent is to reduce the number of copies printed within a site for confidentiality control, as well as cost savings.

As outlined in FOIPPA, we are restricted in our ability to send out a copy without proper authorization (patient consent); therefore, we do NOT send copies to the following individuals/ organizations:

- Directly to patients
- Family members of the patient
- Employers
- RCMP
- Correctional institutions
- Insurance companies
- ICBC
- Immigration Office
- Motor Vehicle Branch
- Lawyers
- Sporting associations
- Coroners (Release of Information will release upon receipt of an order to seize)
- Schools, including College of Physicians and Surgeons
- Residents and medical students
- Physicians outside of Canada
- Physicians without an office, including retired physicians who no longer have a practice
- Clinic practitioners without an office
- Chiropractors
- Physiotherapists
- Optometrists
- Nurse practitioners (except for dictating nurses)
- Clinics without an authorized physician as the designated recipient

Suggestions for Reduced Turnaround Times

Dictations are transcribed as quickly as possible by in-house medical transcriptionists and, where backlog requires, an outsourcing company. No dictations are sent out of Canada for transcription. We use poolscripts to prioritize the dictations with diagnostics and inpatient consultations ahead of outpatients. We are working at standardizing the workflow across Fraser Health and are committed to reducing turnaround times.

You can help to reduce turnaround time by the following:

1. Learn how your recording equipment works. We would be happy to show you if you are unsure.

2. Assemble all the necessary documents that you will need *before* starting to dictate.

3. Make sure you are in a **quiet area** so your dictation can be heard clearly by the transcriptionist. A noisy dictating area may result in incomplete reports being returned for verification.

4. Identify yourself at the beginning of your dictation and state what dictation you are doing, i.e., what type of reports and the date you want reflected in the transcription, the date of patient examination and the date of your dictation.

5. Always state and spell full details of the following: addressee's full name, mailing address, patient record number, and the subject matter.

6. Try to use the same phrases in each of your report types. Be consistent in the way you approach similar reports. Make sure you use the same headings whenever possible. This makes it easier to transcribe your work and lessens the chance of error.

7. Please **speak clearly** and at a regular pace. Always pause or dictate punctuation to separate different numerical values.

8. Pause slightly before speaking when starting your recorder and pause briefly before stopping recording. This prevents words from being “clipped.”

9. Please speak with inflection in your voice. Monotonous voices tend to put transcriptionists to “sleep.”

10. Please speak with the microphone at the recommended distance from your mouth for optimum sound quality.

11. **Spell unusual words** that may represent *diseases, drugs, or procedures* not normally found in the mainstream of daily work.

12. **Always include punctuation,** especially when starting new paragraphs.