SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records & Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-Chairs, SESLHD Health Records & Medico-Legal Committee
FUNCTIONAL GROUP(S)	Records Management – Health
KEY TERMS	Health care record, documentation, medical record, clinical record, electronic medical record, transcription, dictation, letters, correspondence
SUMMARY	This procedure aims to provide clear governance for the outsourcing of dictation/transcription services across SESLHD

1. PROCEDURE STATEMENT

This procedure aims to provide clear governance for the outsourcing of dictation/transcription services across SESLHD. This ensures that:

- Only the vetted and approved vendor 3M/M*Modal is utilised for outsourced dictation and/or transcription
- Utilisation of the service is fit for purpose
- A clear and consistent approach to processes and functionality
- Uniform auditing processes

2. BACKGROUND

In 2019, NSW Health undertook a Transcription Tender process which identified four approved vendors for outsourced dictation and transcription. In 2020 a SESLHD/ISLHD tender process was undertaken to choose a single vendor for transcription services. 3M/M*Modal's was successful in obtaining the tender. 3M/M*Modal is the only authorised vendor for outsourced transcription/dictation in SESLHD/ISLHD.

Dictation and transcription that is not outsourced, i.e. provided in-house by NSW Health employees or by dictation to screen software, is not within scope of the tender or this procedure unless aspects of the process are outsourced – such as utilising 3M/M*Modal's dictation system.

2.1 Definitions

Chart: also known as "health record"

Client/patient: any person to whom a health care provider owes a duty of care in respect of provision of health care services

Confidentiality*:* the restriction of access to information, and the control of the use of release of personal information, in order to protect patient privacy

Dictation*:* the action of dictating words to be typed

Duplicate registrations: instance where one patient has been issued with two medical record numbers

Electronic Health Record: Includes all electronic health record systems such as eMR Cerner, eMaternity, eRIC, MOSAIQ, ARIA or any other electronic medical record application/system.

eSign: Functionality within 3M/M*Modal Fluency for Transcription site where dictated letters are held until reviewed and signed by the dictator.

Health Information:

(a) personal information that is information or an opinion about:

(i) the physical or mental health or a disability (at any time) of an individual, or

(ii) an individual's express wishes about the future provision of health services to him or her, or

(iii) a health service provided, or to be provided, to an individual, or

(b) other personal information collected to provide, or in providing, a health service, or

(c) other personal information about an individual collected in connection with the donation, or intended donation, of an individual's body parts, organs or body substances, or

(d) other personal information that is genetic information about an individual arising from a health service provided to the individual in a form that is or could be predictive of the health (at any time) of the individual or of any sibling, relative or descendant of the individual, or

(e) healthcare identifiers, but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of the HRIP Act generally or for the purposes of specified provisions of the HRIP Act

Health Record: a documented account, whether in hard copy or electronic form, of a client/patient's health, illness, and treatment during each visit or stay at a public health organisation
Note: holds the same meaning as "health care record", "medical record", "clinical record", "clinical notes", "patient record", "patient notes", "patient file", etc.

Health Service Staff – Anyone who carries out work for NSW health service, including employees, visiting health practitioners, contractors and sub-contractors, agency staff, volunteers, apprentices, trainees, and students.

HIM: Health Information Manager

Hold queue: Functionality within 3M/M*Modal's Fluency for Transcription website where dictated documents that require a further quality review by SESLHD staff are stored prior to review/signature by the dictator.

HRIP Act (HRIPA): Health Records and Information Privacy Act 2002 (NSW)

misuse of information: a staff member has knowingly and intentionally accessed, used and/ or disclosed information held by the health service for a purpose outside of, and unrelated to, their work duties. Such breaches of privacy may possibly constitute corrupt conduct.

MRM: Medical Record Manager

Lanier: Previous name for 3M/M*Modal system – not in use anymore but may still be referred to as this by some staff

Outsource: Contracting out goods or services from a person, supplier, or vendor outside of NSW Health

Transcription: The process processing recorded speech into typed form

Work types: Back-end of the 3M/M*Modal system setup that assists template allocation

3. RESPONSIBILITIES

3.1 Dictators will:

- Register for access to 3M/M*Modal prior to dictation
- Work with the site to ensure appropriate work types are available if required
- Ensure dictations are performed in a clear and complete manner as per the this document
- Review and correct any identified quality markers/issues prior to sign-off
- Sign-off all dictated letters within the set key performance indicator (KPI) of 14 days
- Alert site transcription system administrators/managers of any changes to personal information or issues with systems
- Use the system for the designated function within the NSW Health Code of Conduct and privacy policy and legislation.

3.2 Site typists will:

- Transcribe dictations from the 3M/M*Modal system in a timely and accurate manner
- Ensure any quality markers or queries are flagged for clinical staff review and correction
- Alert site transcription system administrators/managers or 3M/M*Modal of any issues or changes
- Use the system for the designated function within the NSW Health Code of Conduct and privacy policy and legislation.

3.3 Site transcription administrators/managers will:

- Register new users
- Assist with password resets and other access queries
- Assist in developing new work types
- Raise a request for new eMR note types with the Forms Committee if required
- Ensure documents with quality markers or queries are reviewed within a timely manner
- Raise any issues or improvements 3M/M*Modal and SESLHD HealthICT and assist in testing where required
- Conduct appropriate audits where applicable
- Utilise electronic health record systems and iPM PAS to resolve queries
- Liaise with clinic/department administrative staff to resolve any scheduling issues

- Oversee the dispatch of letters where required
- Use the system for the designated function within the NSW Health Code of Conduct and privacy policy and legislation.

3.4 Clinic/department administrative staff will:

- Assist dictators or site transcription administrators/managers with scheduling queries or data corrections

3.5 Health Information Managers will:

- Assist with service queries or issues
- Oversee the service provision and governance at each site

3.6 District Managers/ Service Managers will:

- Ensure dictators sign-off letters within a timely manner (KPI 14 business days)
- Assist in resolution of any identified dictation/transcription issues if required

3.7 Health ICT will:

- Alert users of any downtimes that may affect system performance/functionality
- Assist in issue resolution when required
- Assist in testing and implementing new functionality where required

4. PROCEDURE

4.1 Work Type and Letter Template Creation/Changes

Each individual unit or department utilizing dictation and transcription services requires an individual work type and subsequent letter template.

Each work type is assigned a “Work Type Number” which must be used by staff when dictating as it governs the eventual processing and template population for services.

All letter templates within a facility must be standardised to keep system maintenance streamlined.

Work types and letter templates can be created by contacting your site Health Information Manager/Transcription Manager.

A list of current work types can be found on the SESLHD Transcription Services intranet site.

4.2 SESLHD account database

All users must be registered within the 3M/M*Modal system. Users will be registered based upon their role by the site/unit managers. There is a central user database shared across SESLHD.

4.3 Account registration

All users must complete and sign an application form and provide an @health email address to ensure any required correspondence is secure. Application forms for sites are available on the SESLHD Transcription Services intranet site.

Dictators
Registered staff are provided with an individual dictation access code that must be used when dictating as the information linked to it is used to populate the signature section of transcribed letters.

Upon registration, the dictator will also be provided with their individual Fluency Flex login details (Username, Password, and Company Code).
Note: This will not necessarily be the same as the staff member's network login

Typists (Editors)
If applicable, an editor account can be created by 3M/M*Modal upon request.

Administrators/Managers
Staff members who undertake quality assurance, dictation/transcription support, and/or account registration must be registered as administrative or manager accounts. These accounts are created by 3M/M*Modal upon request.

4.4 Activating/Deactivating Accounts

When a user ceases employment within SESLHD, their account should be deactivated to ensure the security of the personal health information held within. Prior to deactivation outstanding letters need to be checked and escalated if required (i.e. staff member no longer working in SESLHD)

4.5 Dictating: scope and requirements

3M/M*Modal offers dictation via telephone or mobile phone application.
Please note that the mobile phone application is not approved for use at Prince of Wales Hospital, Royal Hospital for Women, or Sydney/Sydney Eye Hospital due to a pending Health ICT security review.

Dictation instructions for the phone and mobile application can be found on the SESLHD Transcription Services intranet site.

Dictations are outsourced through 3M/M*Modal. 3M/M*Modal transcribers and quality assurance staff have limited access to information held within SESLHD/ISLHD systems and no access to electronic health records. Only attendance information is available.

As such, dictators must ensure they either dictate or link via the mobile application the following information for each patient/client:

- Dictator name
- Dictated for name (if applicable)
- Patient name (given and family)

- Patient MRN (for their local site)
- Date of clinic attendance / outpatient encounter
- Name of addressee
- Full address of addressee
- Name of any CC's
- Full address of any CC's

Dictators may request their letter be marked as "urgent" within their dictation or by contacting the relevant site's transcription manager/administrator. The dictation will then be flagged as a "STAT" by the transcription team or marked as a priority job by the manager/administrator and transcribed within an hour. All other letters aim to be transcribed within 24 hours of dictation.

If dictators want information copied from a previous letter into their current one, the transcribers will not complete this task. Dictators should note while dictating that they will copy information upon review. Section 5 of the Editing Letters in eSign QRG instructs dictators how to copy and paste from their previous letters.

If a patient "did not attend" or is a "no show" then the Cerner Scheduling Letter template should be utilised instead of dictating a letter. All patient/client related dictations must have a corresponding attendance within eMR.

Please note that for patient/client attendances, a letter is not considered an appropriate substitute for normal documentation processes. Therefore, the transcribed letter should supplement the clinical notes within the paper or electronic health record.

4.6 Maintaining the GP database

The GP database may be manually modified to ensure appropriate information is available. If required, the appropriate iPM team should be notified of any changes.

Additionally, the iPM GP Database should be extracted and provided at least twice a year to 3M/M*Modal for updating.

4.7 Quality assurance

A first round of quality assurance is undertaken by 3M/M*Modal staff.

If there are no quality issues/questions, the document will be sent directly to the dictator's eSign queue for review, revision, and sign-off.

If quality issues or questions have been noted, the document will be tagged according to a set quality codes and sent to the SESLHD/ISLHD site/facility administrator/manager hold queue for further review/correction. Once resolved, the letter will be sent to the dictator's eSign queue for final review, revision, and sign-off.

Dictators are expected to verify/sign letters within 14 days of delivery to their eSign queue.

4.8 Document dispatch

Documents will be dispatched based upon their work type. Depending on the work-type settings, documents may be:

- printed to a centralised or department/unit printer for posting
- imported to eMR PowerChart against a patient encounter
- exported to another electronic health record.

Documents exported to PowerChart will be marked with the date of verification and exported to the correct document type (such as OP Letter <Specialty>) and linked with the relevant encounter.
Note: Specialised/individual settings may attract a fee charged to the individual cost centre

4.9 Amendments to verified documents

If a document requires amendment, the local administrator/manager should be consulted. Depending upon the time between the original document and the amendment, they may be able to retrieve the original document prior to dispatch and reallocate the letter to a dictator for revision within the Fluency for Transcription system.

However, if this is not possible, an additional addendum letter will need to be dictated and dispatched separately.

All amendments made to letters within Fluency for Transcription are re-imported to PowerChart.

4.10 Duplicate Registrations

In the instance that one patient has been issued with two MRNs, their related electronic health records will require merging by the site iPM team and/or SESLHD UPI team. The MRN that the patient retains is the “Major MRN” and the “Minor MRN”

Merging of duplicate registrations will not affect any dictation/transcription services except when a document is dictated against a MRN that becomes a merged “minor MRN” prior to sign-off.

When this occurs – the process outlined in the Patient Duplicates and Mix-ups QRG should be followed.

4.11 Downtime

In the event of planned or unplanned downtime within Cerner eMR, 3M/M*Modal Dictation/Transcription Services, or other related systems, please refer to the downtime document located on the SESLHD Transcription Services intranet site.

5. DOCUMENTATION

Information and QRGs for dictators and administrators/managers are available on the SESLHD Transcription Services intranet site.

6. AUDIT

6.1 Unsigned Overdue Letters

Dictators must sign-off their letters within 14 days of delivery to their eSign queue. This audit identifies dictators who have unsigned overdue letters. This report should be run at least fortnightly by the site's Health Information Manager. Instructions for running these reports can be found in the Audit-Unsigned Letters QRG.

Dictators identified as having unsigned overdue letters should be notified and provided with instructions for Editing and Signing a Letter as well as contact details for any questions/issues (i.e. password reset, deactivated account, etc).

If a dictator does not resolve their unsigned overdue letters after notification, the issue should be escalated to their superior as well as the site's Medical Director.

6.2 Inactive User Review

Identifies users who have been inactive for over a set period of time. If a user has been inactive for 6 months their login should be deactivated. Instructions on activation/deactivation can be found within the User Management QRG.

Prior to deactivation, the dictator's account must be checked for outstanding unsigned letters. If outstanding unsigned letters exist, the dictator should be notified. If the letters remain unsigned, this should be escalated to their superior and the site's Medical Director. If the staff member is no longer working within SESLHD, it may be necessary for the letters to be reassigned to another staff member for review/sign-off.

To be run at least once a year by site Health Information Managers.

6.3 Ad Hoc Quality Reviews

Ad hoc quality reviews may need to be conducted in response to issues with transcription or service quality.

To be conducted by Health Information Managers as required.

6.4 Ad Hoc Mailing - "Return to Sender" Reviews

When dispatched documents are returned to the service as "Return to Sender" by post, a review must be conducted. This review should cover whether:

- Addressee details are incorrect
- Addressee details have changed
- Addressee details are up to date in iPM
- Addressee details are up to date in 3M/M*Modal
- An error has been made by the dictator
- An error has been made by the transcriber

Any issues identified should be addressed (such as, incorrect address in system).

To be conducted by site administrators/managers as required.

6.5 eMR Interface Audit

eMR Report that identifies dispatched letters which have been rejected by eMR PowerChart. Letters must be reviewed and corrected to ensure successful importing into PowerChart.

To be conducted by Health Information managers at least once a month.

7. REFERENCES

- Health Records and Information Privacy Act 2002
- NSW Health Privacy Manual for Health Information (2015)
- NSW Health PD2015_049 Code of Conduct
- NSW Health PD2012_069 Health Care Records – Documentation and Management
- SESLHD Branding Style Guide

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
September 2022	0	Author: Margaret Suda (initial draft)
November 2022	1	Approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
December 2022	1	Approved by SESLHD Clinical and Quality Council.