

**STATEMENT 3.2.14.1 – STATEMENT ON DICTATION SYSTEM IN WINDSOR**  
**Undergraduate Medical Education**

Approved by: Clerkship & Electives Committee  
Date of original approval: August, 2013  
Date of last review: June 2018

**I. PURPOSE**

The dictation system in a clinical learning environment (hospital, clinic, long term care facility or any other affiliated clinical care environment) is provided for the clinical documentation of the patient record required for an assessment visit.

**II. DEFINITIONS**

**WRH-MC** Windsor Regional Hospital – Met Campus  
**WRH-OC** Windsor Regional Hospital – Ouellette Campus

**III. STATEMENT**

**General Guidelines: Windsor Regional Hospital – Met Campus**

- All documents must be legible
- Use of unapproved abbreviations is strongly discouraged
- Every entry must be authenticated (includes e-signature) and dated by the author
- Transcribed documents are strongly recommended in accordance with resources available
- Electronic authentication is in place – as per policy all authenticated documentation must be reviewed for accuracy by the physician.

**History and Physical**

- A History and Physical must be completed for all inpatients (includes medical, dental and midwifery examinations).
- All History and Physicals must include:
  - a. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number /account #, gender, date of birth, etc.)
  - b. Chief complaint and present illness
  - c. Past medical history, medications, allergies, family medical history
  - d. Physical examination and assessment
  - e. Diagnosis
  - f. Treatment Plan

### **Operative Report**

- An Operative Report must be dictated for each patient for whom an operative procedure was performed.
- All Operative Reports must be signed /electronically authenticated by the surgeon performing the procedure.
- All Operative Reports must include:
  - a. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, etc.)
  - b. Date of procedure
  - c. Distribution of copies (i.e., referring physician, family physician)
  - d. Pre-operative diagnosis
  - e. Proposed operative procedure (if different from procedure performed)
  - f. Operative procedure performed
  - g. Description of procedure performed
  - h. Condition of patient during and at conclusion of operative procedure
  - i. Post-operative diagnosis

### **Discharge Summary**

- A Discharge Summary/Final Note must be dictated for all inpatients.
- All Discharge Summaries/Final Notes must be authenticated by the attending physician.
- Discharge summary is required on patients who are admitted and then admission is cancelled.
- For psychiatric patients that are admitted to the acute care center first and then admitted to psychiatry, a discharge summary is necessary from both the general practitioner and the psychiatrist. The general practitioner's discharge summary provides summary as to what went on during the acute care stay for the physician.
- All Discharge Summaries must include:
  - a. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, Admission and Discharge Dates)
  - b. Distribution of copies (i.e., referring physician, family physician)
  - c. Brief summary of the management of each of the active medical problems during the admission; including major investigations, treatments and outcomes.
  - d. List of diagnoses, including the identification of most responsible diagnosis and pre-admit and post admit co-morbidities.
  - e. Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment
  - f. Follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports needing follow-up

### **Health records shall be completed within the following timeframes:**

#### **Admission History & Physical Examination Report**

Within 24 hours of admission and/or prior to any surgical procedure.

#### **Progress Notes**

**ICU** – should be completed at least daily.

**Acute Care** – should be completed with sufficient clarity and frequency to clearly document the patients' course of treatment and as condition changes and increase to daily if condition deteriorates or changes significantly.

**Consultation Report** – at the time of consultation

**Operative Note** – immediately following operative procedure

**Discharge Summary** – at the time of discharge as per OHIP schedule of benefits

**Medical Certificate of Death** – Immediately at the time of death or as soon thereafter. If a death certificate does not get copied for the chart then a FORM 1 Certificate of Death needs to be completed by the attending physician.

TELEPHONE DICTATION INSTRUCTIONS	
Outside Line: <u>(519) 257-5155</u> Within Hospital (Met/Western): <u>Ext. 75155</u>	
1. Enter the 4-digit doctor identification number.	
2. Enter the 1-digit facility number ("1" for Western, "2" for Met & "3" for WRCC).	
3. Enter the 2-digit work type number (see below).	
WORK TYPES	
01	History & Physical Exam
02	Consultation Report
03	Progress Note
04	Operative Report
05	Cardiopulmonary
06	Discharge Summary
07	Clinic Note
08	Labour & Delivery Note
4. Enter the 6-digit patient check in number and/or patient encounter number.	
5. Begin dictation.	
<b>NOTE:</b>	<b>STATE PATIENT NAME CLEARLY &amp; THEN SPELL FOR ALL DICTATIONS</b>
Press	1 to LISTEN
	2 to DICTATE
	3 to REVERSE a few words
	4 to PAUSE
	5 to START NEWreport
	6 to GO TO END of dictation
	7 to FAST FORWARD
	8 to REVERSE to beginning
	9 to END connection
	* to CORRECT I.E number
	0 for ASSISTANCE

**PHYSICIAN DOCUMENTATION GUIDELINES – Windsor Regional Hospital – Ouellette Campus**

**General Documentation Guidelines**

- All documents must be legible

- Use of unapproved abbreviations is strongly discouraged
- Every entry must be authenticated (includes e-signature) and dated by the author
- Transcribed documents are strongly recommended in accordance with resources available

Electronic authentication is in place – as per policy all authenticated documentation must be reviewed for accuracy by the physician.

### **History and Physical**

1. A History and Physical must be completed for all inpatients (includes medical, dental and midwifery examinations) or any out-patient surgical patient having a general anaesthetic.
2. All History and Physicals must include:
  - a. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number /account #, gender, date of birth, etc.)
  - b. Chief complaint and present illness
  - c. Past medical history, medications, allergies, family medical history, social history
  - d. iv. Physical examination and assessment
  - e. v. Diagnosis, provisional or otherwise
  - f. vi. Treatment Plan
3. The H & P for Elective surgical patients MUST be dictated 72 hours prior to the date of admission. This is to ensure that the report is transcribed and in the Pre-Admission clinic to be placed in the patients chart. Any surgical patients without an H & P shall not leave the nursing unit for the O.R. Any patient proceeding to the OR without an H & P should be entered into the Safety Reporting System for follow up.
4. The report type is "02" for a H & P
5. Please enter "00000000" (eight zeros) for the account # for Pre-Op H & P
6. The attending physician shall be responsible for seeing that a complete history and physical examination is recorded on the patient's chart within 24 hours of admission. (In case of a readmission, it may be comparatively brief, and for this purpose a readmission is defined as a patient who has been readmitted within 30 days of discharge, the diagnosis remaining unchanged).

### **Operative Report**

1. An Operative Report must be dictated for each patient for whom an operative procedure was performed.
2. All Operative Reports must be signed /electronically authenticated by the surgeon performing the procedure.
3. All Operative Reports must include:
  - a. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, etc.)
  - b. Date of procedure
  - c. Distribution of copies (i.e., referring physician, family physician)
  - d. iv. Pre-operative diagnosis
  - e. v. Proposed operative procedure (if different from procedure performed)
  - f. vi. Operative procedure performed
  - g. vii. Description of procedure performed
  - h. viii. Condition of patient during and at conclusion of operative procedure
  - i. ix. Post-operative diagnosis

### Standardized Reports

At HDGH, we encourage the set-up and use of standardized or “norm” reports. Contact Maureen Robbins, Ext 3083 if you are interested in setting up standardized reports. This would eliminate the need for repetitive dictation and transcription and improves report turnaround time. (i.e., Operative Reports)

### Discharge Summary

1. A Discharge Summary/Final Note must be dictated for all inpatients within 48 hours.
2. All Discharge Summaries/Final Notes must be authenticated by the attending physician.
3. Discharge summary is required on patients who are admitted and then admission is cancelled.
4. For psychiatric patients that are admitted to the acute care center first and then admitted to psychiatry, a discharge summary is necessary from both the general practitioner and the psychiatrist. The general practitioner’s discharge summary provides summary as to what went on during the acute care stay for the physician.
5. All Discharge Summaries must include:
  - a. Identifying information (e.g., Author’s name and status, name of most responsible physician, name of patient, Health Record number, Admission and Discharge Dates)
  - b. Distribution of copies (i.e., referring physician, family physician)
  - c. Brief summary of the management of each of the active medical problems during the admission; including major investigations, procedures performed, treatments and outcomes
  - d. List of diagnoses, including the identification of **most responsible diagnosis** and pre-admit and post admit co-morbidities affecting the hospital stay
  - e. Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment
  - f. Follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports needing follow-up
  - g. Discharge summaries are normally 2-5 minutes in length. The Ontario normal standard is 2.9 minutes.

Note the requirement to complete within 48 hours which is mentioned in the physician fee schedule (Ontario). Refer to page 32 – “Subsequent Visit by MRP – day of discharge (C124)”, as follows:

Definition/Required elements of service: Subsequent visit by the MRP – day of discharge is payable to the physician identified as the MRP for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arrangement for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

To support correct Patient Record Coding and weighting of cases, remember to include the following while dictating:

### History, Physical and Plan of Care

A brief synopsis of the following areas should be included in order to support coding:

Date of Assessment/Consultation	History of Present Illness	Medications
Family History	Physical Examination – incl. head and neck, chest, CVA, abdomen,	Summary/investigation of Patient Condition and Diagnosis

	extremities	
Review of systems/Functional inquiry	Past Medical History (Co-Morbidities)	Allergies
Reason for Assessment/Consultation	Planned investigations (lab work, ultrasounds, CAT scan, etc)	Plan of Care Social/Personal History

**New or Existing Conditions Managed During Hospitalization**

**REMEMBER TO INCLUDE:**

- Co-morbidities as part of History, Physical, Consult and/or Discharge Summary Dictation
- “Due to”, “Related to”, or “Secondary to” to link the cause and effect diagnoses
- For a malignancy CLEARLY identify: 1) Primary and secondary sites, 2) Local effects of tumor (i.e. edema, dysphasia, dyspnea), 3) functional activity of tumor.

Identify significant diagnosis/problems that impact the complexity of the case and/or ELOS:

Anemia - cause	DVT/Pulmonary Embolus/Phlebitis/Thrombophlebitis	Hypoglycemia/Hyperglycemia
Cardiac Arrhythmia – specify	Edema	Hypertension/Hypotension
CHF – Specify acute/chronic	Electrolyte imbalance – specify	Ileus
Chronic Skin Ulcer(s) – specify location & type & degree	Fever/Pyrexia	Incontinence
Confusion/Delirium/Paranoia	Respiratory Failure (acute or chronic) -specify	Infection – site(s) & organism(s)
Dehydration – specify reason	Shock – specify type	Pneumonia – organism/aspiration
Depression	Urinary Retention	Pulmonary Edema
Diabetes – Type 1 or 2 must be stated and also insulin/non-insulin dependence	Urinary Tract Infection	Renal Failure
Diarrhea – specify reason	Stroke – Indicate Hemorrhagic or infarct – infarct indicate type – thrombus or embolic	

**Procedures**

Documentation for any procedure should include:

Date & Time of Procedure	Type of Anesthesia Used (including Local)	Physician name
Problems Experienced	Insertion Site	Specifics of any device inserted into the patient (i.e. type of CVL, Pacemaker, stent)

**CLEARLY DOCUMENT ANY POST PROCEDURAL PROBLEMS:** Below is a list of flagged interventions (money generators) and any issues we have found as to the availability of the information:

Defibrillation/Cardioversion	Paracentesis	Dialysis
Heart Resuscitation	Vascular Access Device (PICC)	Arterial Line
Feeding Tube – percutaneous (PEG)	Radiotherapy	Tracheostomy

Parental Nutrition – infusion or injection only	Mechanical Ventilation (Invasive)	Mechanical Ventilation (Non-invasive)
Thrombolytics	Bone Marrow	Lumbar Puncture
Endoscopy	Bronchoscopy	Cardiac Catheterization
CPR	Thoracentesis	Cell Save - intraoperative
Chemotherapy		

**Identification of Advanced Directives and End-Of-Life Care**

By completing accurate documentation on the patient record of Advanced Directives and End-Of-Life Care, coding can occur more efficiently. Methods for improvement are:

- Indicating primary diagnosis of palliative care due to condition when dictating history, physical, and discharge summary
- Through completion of DNR form in a timely fashion especially indicating DNR III

The following documentation is sufficient evidence of palliative/end-of-life comfort care:

- A complete DNR III form signed by the physician, with supporting notation that the patient has a palliative diagnosis
- Any documentation of palliative, end-of-life, or comfort care in the physician progress notes, but preferably in the Discharge Summary

**Summary of Health records completion timeframes:**

**Admission History & Physical Examination Report**

Within 24 hours of admission and/or prior to any surgical procedure.

**Progress notes:**

- **ICU** - should be completed at least daily.
- **Acute Care** - should be completed with sufficient clarity and frequency to clearly document the patients' course of treatment and as condition changes and increase to daily if condition deteriorates or changes significantly.

**Consultation Report** - at the time of consultation. The consultant must state reason for consult, their assessment and their findings. They do not need to do a recap of the history that is already on the chart. If the consult is acting as a history then of course the patient's medical history needs to be included.

**Operative Note** - immediately following operative procedure

**Discharge Summary** – at the time of discharge (or within 48 hours) as per OHIP schedule of benefits

**Medical Certificate of Death** - Immediately at the time of death or as soon thereafter. If a death certificate does not get copied for the chart then a FORM 1 Certificate of Death needs to be completed by the attending physician.



**Internal Ext: 6888**  
**External Dictation #: 1-866-548-8153**  
**User ID: \_\_\_\_\_**

**Work Types**  
 01 – Discharge Summary

02 – History & Physical  
03 – Progress Note  
04 – Inpatient Consult Note  
05 – Operative Report  
06 – Minutes (meetings)  
07 – Clinic/Outpatient Consult  
08 – Trauma Team Leader Report  
09 – EEG  
12 – TIA Clinic  
40 – Internal Medicine Clinic

**Keypad Operating Features**

1 – Listen/Playback  
2 – Record/Dictate  
3 – Rewind  
4 – Pause  
5 – Complete job  
6 – Go to end  
7 – Fast forward  
8 – Go to beginning  
\*clear field

**Dictation System Instructions**

\* Enter dictation ID  
\* Enter work type  
\* Enter patient account number  
\* Begin dictating  
\* Pause press 4 / Continue press 2  
\* To dictate more than one report, press 5 at the end of the first report; repeat from step 2  
\* End/disconnect dictation, press 9

**For Complete/Accurate Reports**

- Speak slowly and clearly
- Identify yourself
- Enter correct dictation extension, dictation ID, work type, patient ID
- State visit and surgery dates
- Spell patient's name and new/difficult drugs

MedQuist Support: 1-800-DICTATE