

A decorative graphic on the left side of the slide consisting of a blue arrow pointing right, with several thin, curved blue lines extending upwards and outwards from its base.

A Study on **Medical Scribing Errors** at IKS Health, Mumbai

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Introduction

- A Medical Scribe is essentially a personal assistant to the physician; performing documentation in the EHR, gathering information for the patient's visit, and partnering with the physician to deliver the pinnacle of efficient patient care.
- Prescribing faults and prescription errors are major problems among medication errors. They occur both in general practice and in hospital, and although they are rarely fatal they can affect patient's safety and quality of healthcare.

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- Medication errors are among the most common medical errors in the hospitals. Scribing error is a specific type of medication errors and is due to data entry error that is commonly made by the human operators.
 - Prescription errors encompass those related to the act of writing a prescription, whereas prescribing faults encompass irrational prescribing, inappropriate prescribing, under prescribing , overprescribing, and ineffective prescribing, arising from erroneous medical judgment or decisions concerning treatment or treatment monitoring.



OBJECTIVES



- ▶ To measure the percentage of medical scribing error.
- ▶ To identify the causes leading to medical scribing errors.

Methodology

- Study design: Descriptive, Cross- Sectional Study.
- Setting: IKS Health, Mumbai.
- Duration of Study: 5th Feb 2018 - 5 May 2018.
- Sample Size: 450 medical chart notes.(150 medical chart notes per month)
30 Medical Scribe.
- Sampling Technique: Randomized sampling.
- Data Collection: A US group of Hospital and IKS Health (Mumbai).

Results



Classification of Errors:

Critical - Client SLA

Critical - Incorrect data -
Patient Safety

Critical - Missed data - Patient
Safety

Critical - Patient ID error

Major- Failure to Flag

Major - Incorrect Word

Major - Incorrect Doctor Name

Major - Incorrect Gender

Major - Incorrect Data
Capture

Major - Missed Data

Major - Plan - Use of layman
terminology

Minor - Formatting Error

Minor - Grammar Error

Minor - Spelling - Medical

Minor - Spelling - Non
Medical

Minor - Omitted Word/s

Minor - Incorrect Word/s

Minor - Historian captured
incorrectly

Minor - Patient words not
captured (HPI)

Minor - Punctuations

Feedback - Others

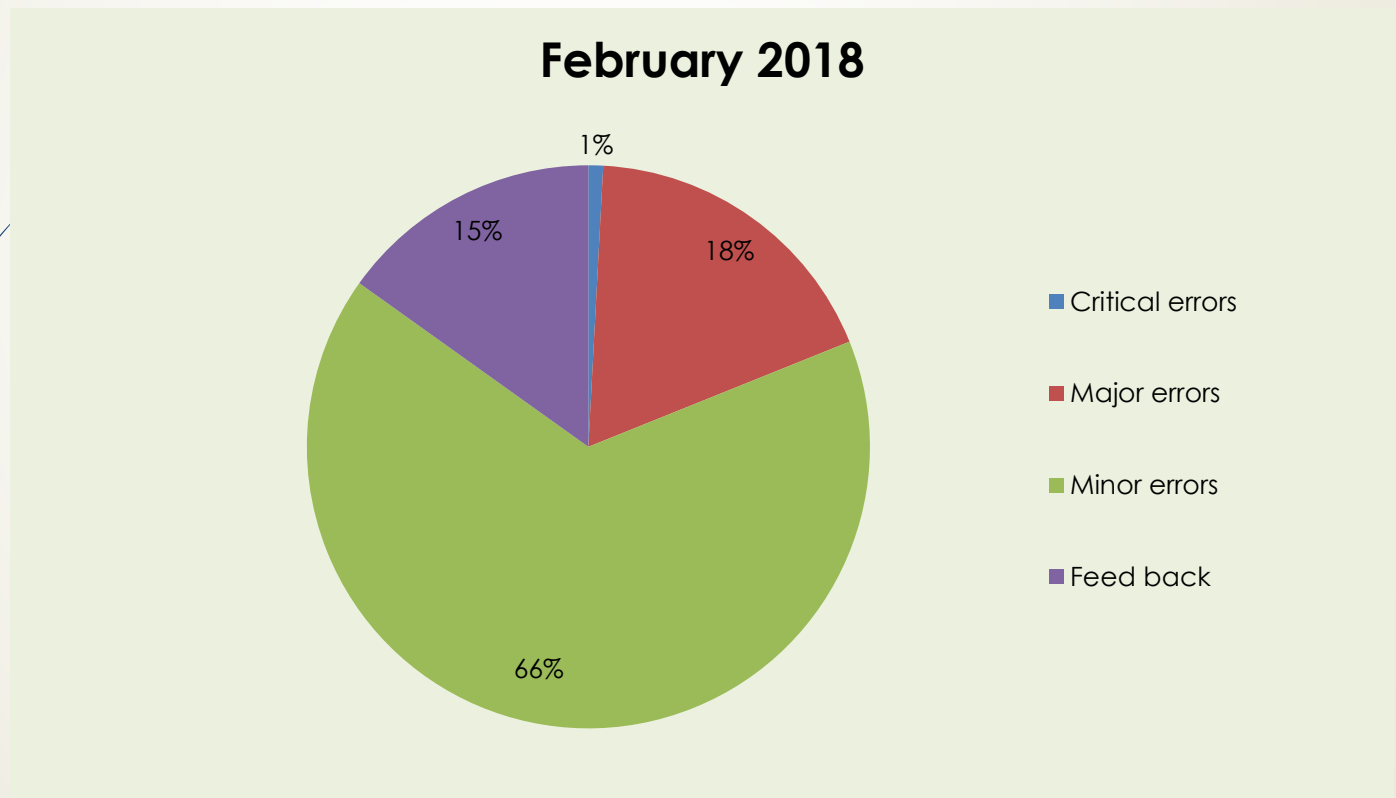
Feedback - Storyline

Feedback - Crispness

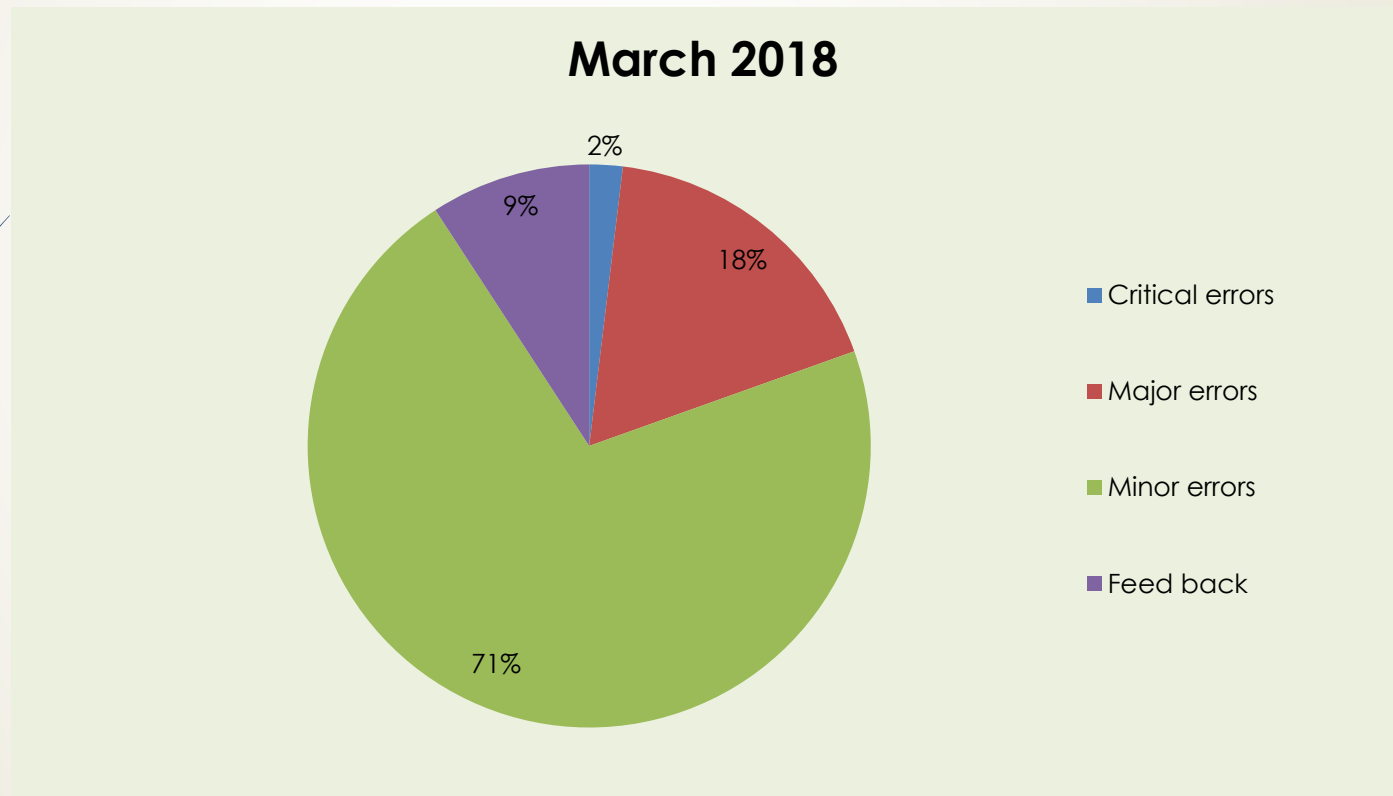


Month-wise
distribution of errors:

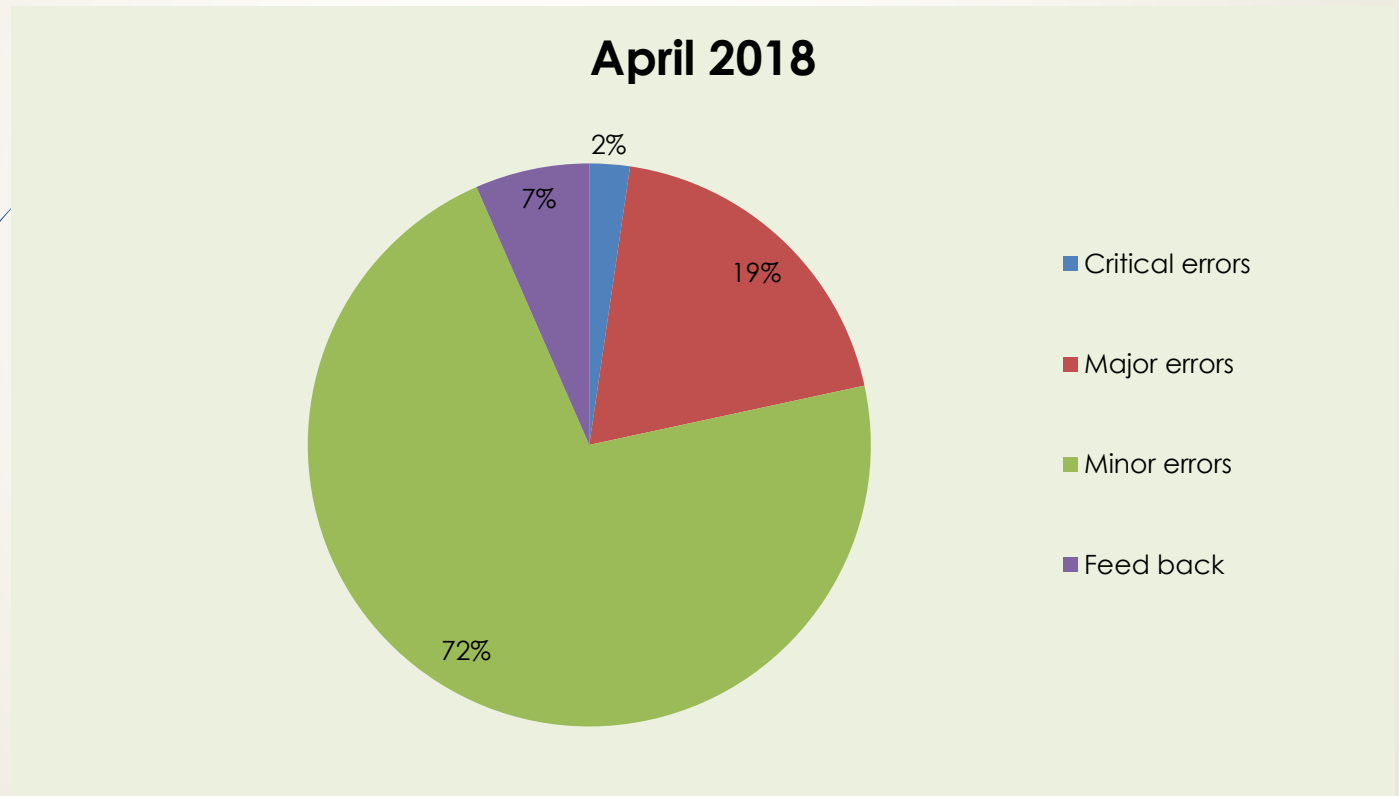
Distribution of errors in February 2018



Distribution of errors in March 2018



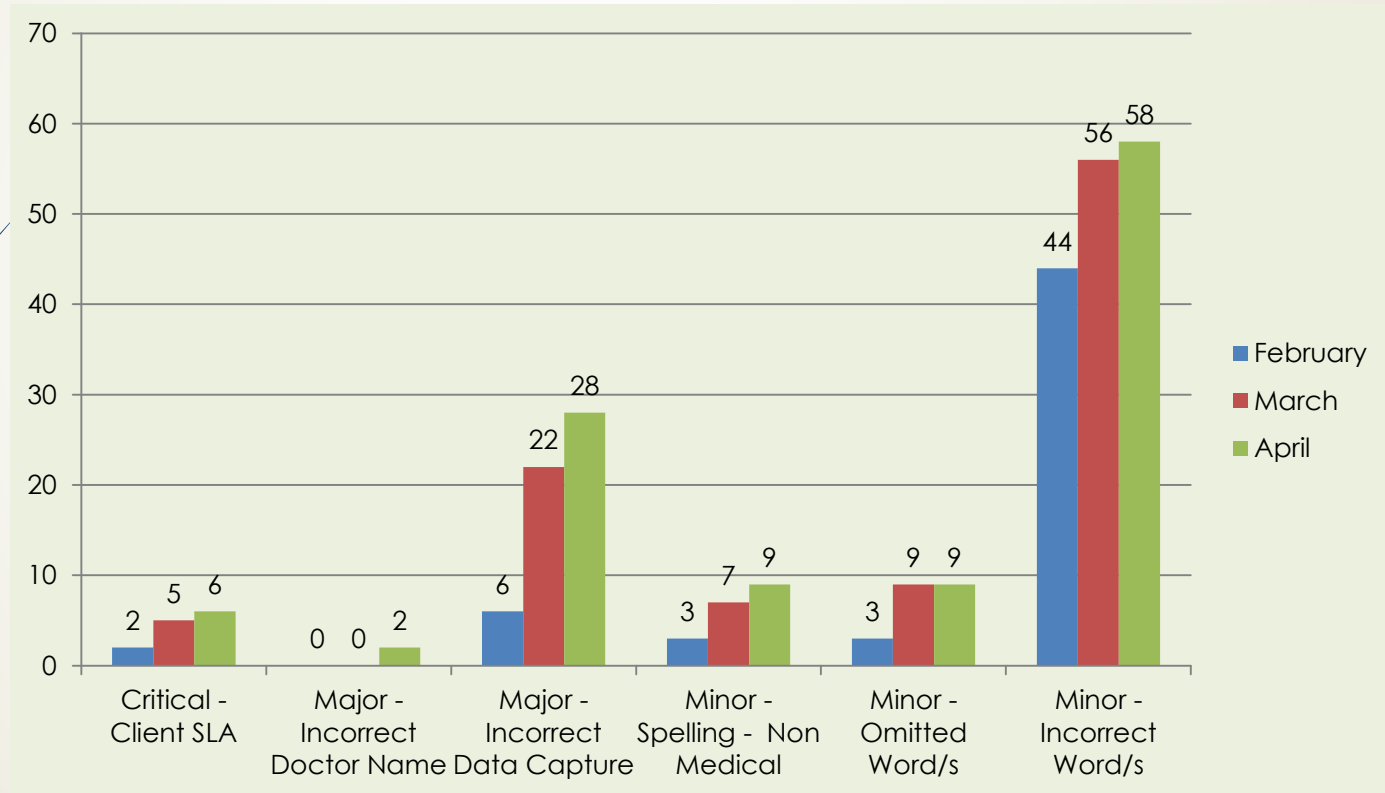
Distribution of errors in April 2018



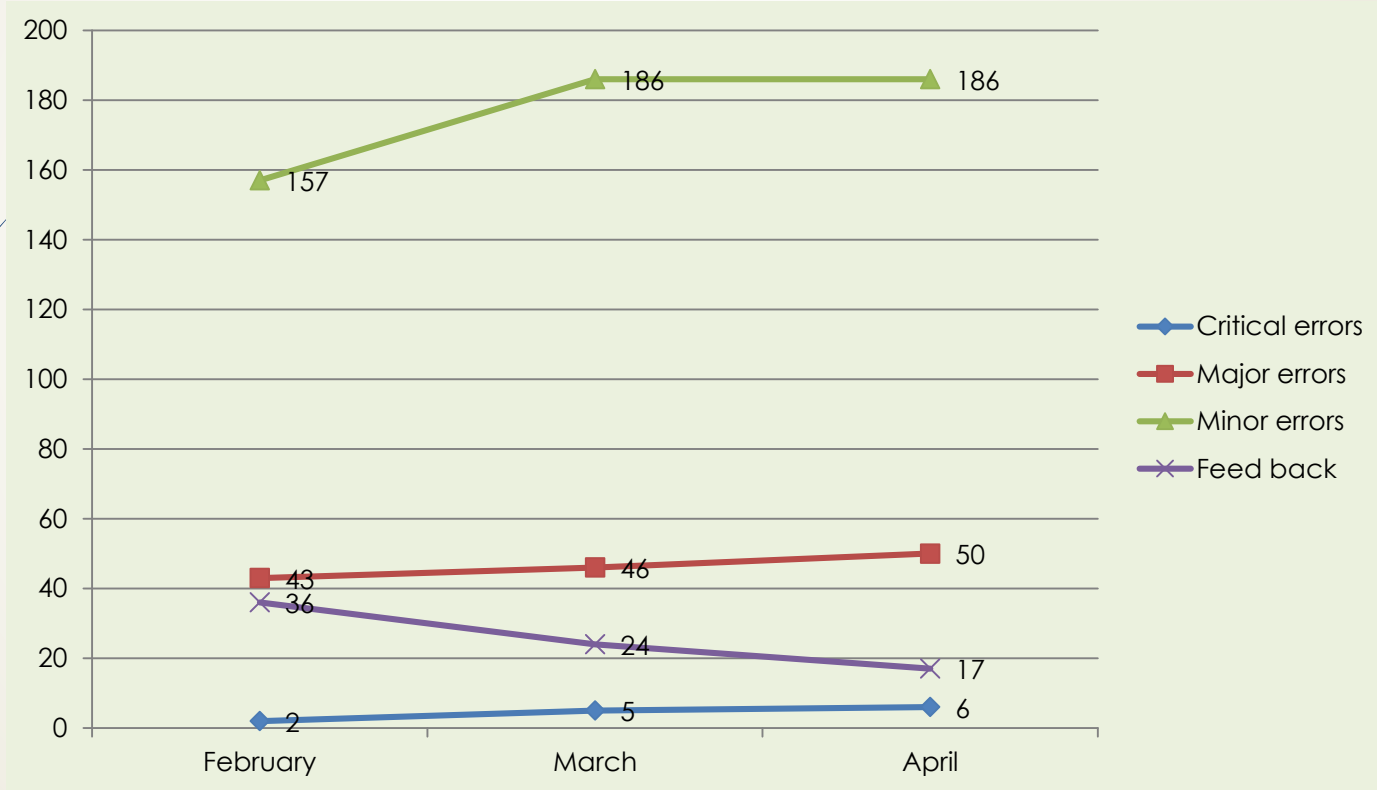
Comparison of distribution of errors in February, March and April (2018).



Types of Errors increased in the period; February to April (2018).



Total number of errors occurred of different category per month



Reasons for errors

- High attrition rate.
- Lack of one to one feedback system between quality analyst and scribe.
- Relatively less time for proof reading of the medical chart note due to over productivity.
- Variation in training methodology.
- Technical issue.

Suggestions:

- Create an employee friendly working environment to reduce the high attrition rate.
- Establish a process of one to one feedback between quality analyst and scribe.
- Reduce little work load on the scribe, which increases the time for proof reading of the medical chart note.
- Standardized training process, which reduces the variation in the training methodology.

Conclusion:

- There is remarkably increase in the scribing errors seen in the given time duration (February 2018 to April 2018). A slight change in company policy in creating an employee friendly working environment along with standardized training process may well reduce many of the errors.
- Interventions that are based on a sound theoretical understanding of the causes of errors are potentially more likely to be successful. Certainly, from what we currently know, such interventions must also address human factors, in addition to offering technological solutions.

References

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- ▶ Reddy L.K.V.A.G. Modi, B. Chaudhary, V.Modi, M.Patel Medication errors –A case study, 2010, page 112, Vol:7, Journal 2.
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- ▶ Thakur H, Tharwani V, Raina RS, Kothiyal G, Chakarabarty M. Noncompliance pattern due to medication errors at a teaching Hospital in Srikot, India. Indian J Pharmacol. 2013 May-June;45(3)

Thank you

