

Policy: Copy and Paste within the Electronic Health Record

ORGANIZATIONAL: Affects two or more departments.							
Folder	Organizational Choices: Health Information Mgmt			Sub-Folder (If Applicable)	n/a		
Original Effective Date	4/1/2017	Scope	What departments does this policy apply to? State "All" as is may apply to the entire organization. All				
Approved (Approver/Date)	MDRC: 2/20/2020						
Last Reviewed/ Revised Date	2/20/2020	OSHA Category (If Applicable)	Not Applicable	Standard (If Applicable)	RC 01.01.01	Number of pages	3

PURPOSE:

To establish standards for the appropriate use of copy/paste functionality and to avoid cloning risks within the electronic health record (EHR).

GUIDELINES:

- Quality documentation supports patient care, continuity of care, record integrity, and accurate coding for professional fee and facility billing consistent with the complexity of a patient's clinical condition.
- Providers documenting in the EHR must avoid indiscriminately copying and pasting another provider's medical record documentation, electronic mail communication, or redundant information provided in other parts of the health record.
- Per the Joint Commission (February 2015), risks of copy/paste functionality include, but are not limited to:
 - Copying and pasting inaccurate or outdated information
 - Redundant information in the EHR, which makes it difficult to identify current information
 - Inability to identify the author or intent of the documentation
 - Inability to identify when the documentation was first created
 - Propagation of false information
 - Internally inconsistent progress notes
 - Unnecessarily lengthy progress notes

PROCEDURE:

Definitions:

Clone: Documentation that is identical or unreasonably similar to previous entries for a patient (or from another patient's medical record). Includes copying material from a prior note and placing it into a current record without review and updating. The term cloning carries a negative connotation, suggesting the writer did not elicit the information being recorded and may suggest to later reviewers of the document that the note written does not describe accurately the care that was provided on that date. This may have negative implications for coding and billing.

Copy: For the purpose of this policy, the terms copy or copying are synonymous with copy/paste, copy forward, imported documentation, roll-in, pull-forward, auto-populate, or any other intent to move previously created documentation from one part of the medical record to another section of the medical record (or to another patient's record).

Cut: Removing or deleting text from a document (prohibited for completed or authenticated documentation).

Paste: Placing information copied or cut from a document or section of the medical record into another document or section of the medical record.

Templates: A format for recording information and/or pre-formed text which may be placed into the patient record and then modified with patient-specific information as needed. Templates allow consistency in recording useful information and serve as a reminder to the writer of important elements that should be present in medical record documentation.

Process:

1. Providers are required to document in compliance with all federal and state laws and Medical Staff Bylaws and Rules and Regulations.
2. The creator of each document is responsible for all the content of that document and must ensure that any material included in the document accurately reflects the care provided during that episode of care, including any material that may have been copied or pulled forward into the document from another field or other documentation.
3. All copied information from other sources shall be credited to that author.
4. It is appropriate to copy and include information needed to support clinical decision making and the care rendered during a specific episode of care.
5. The copying of information from one patient's record to a different patient's record is prohibited except in the circumstance when documentation was entered in error.
6. Cloning of documentation is prohibited. If documentation is pulled forward or copied, it must be reviewed and updated or edited for accuracy prior to author authentication.
7. Information copied from the note of another provider should be referenced to include the date, time, and author of the original entry. Information copied from a previous note by the same author should include only that information that is unchanged. For

notes that reflect HPI, interval history, and assessment and plan, these should be documented to reflect the current visit. If they are copied from a previous note, the HPI should be newly created to reflect the information specific to the current visit being documented. Interval history, subjective HPI, PE, and assessment and plan should not be copied/pasted without updating each section of the note with current information and assessment.

8. Use of templates is permitted.
9. Providers are encouraged to cite and summarize applicable lab data, pathology and radiology results, and other pertinent results, rather than copy such reports in their entirety into progress notes and other documentation. The entry should be referenced with the date of the original data that were summarized or cited. Clinical documentation that was created more than 60 days prior should not be copied or carried forward.
10. Providers are responsible for correcting any error identified within their documentation prior to authenticating a medical record entry. Documentation must be reviewed prior to authenticating/signing. If an error is identified from a previously authenticated note, the provider should specify the correction in the new note AND amend/addend the original note.
11. Once a note has been entered into a patient's record and has been authenticated (signed), it is considered final and becomes a part of the patient's legal health record. Any additional information or changes to content must be entered as an addendum.
12. Providers who identify errors in source documents of other authors should notify HIM. All notes from the original source that contain errors must be corrected.
13. Providers are responsible for clearly identifying who performed each service documented within the note. When entering patient data into the EHR that the provider did not personally take or test, the provider must attribute the information to the person who did.
14. If the provider references a prior section within the record (e.g., review of systems), he or she must reference the note with sufficient detail to uniquely identify the source. Example: "For review of systems, see note dated MM/DD/YY."
15. Failure to comply with this procedure subjects the provider to corrective disciplinary action per Medical Staff Rules and Regulations, Bylaws, and hospital policy.

REFERENCES:

- AHIMA. (2009, January). Auditing copy and paste. *Journal of AHIMA*, 80(1).
- AHIMA. (2016). *Copy functionality toolkit. A practical guide: Information management and governance for copy functions in electronic health record systems.*
- Joint Commission. (2015, February). Preventing copy-and-paste errors in EHRs. *Joint Commission: Quick Safety*, Issue 10.
- UCONN Health. (2013, June 13). *Copy and paste functionality in electronic record documentation.*
- UC San Diego Health Sciences Compliance Program. (2015, July 30). *Copy/paste guidelines: Guidance for appropriate use of electronic health record functions.*

Attachments: (Label as Appendix A, B, C, etc.)