



Current Status: Active

PolicyStat ID: 4356141



# Saint Thomas Health

Origination:	12/2017
Effective:	12/2017
Last Reviewed:	12/2017
Last Revised:	12/2017
Next Review:	12/2019
Owner:	Cynthia Figaro: V.P. Corporate Compliance
Section/Dept:	Corporate Responsibility
References:	
Applicability:	Saint Thomas Health

## Use of Copy and Paste Functionality for Documentation within the Electronic Health Record (EHR), 65

### PURPOSE:

This policy provides guidance on the use of the "copy-paste" functionality (CPF) in a manner that allows practitioners to benefit from the efficiency potential of the CPF without jeopardizing the integrity of the content of clinical documentation.

### SCOPE:

This policy applies to all individuals who have access to, and documentation privileges within, individual patient medical records generated and/or stored within any EHR used in Saint Thomas Health.

### DEFINITIONS:

**Advance copy-forward/Autopopulate:** refers to the placement, by either staff or the EHR software, of clinical information into the current clinical record before the practitioner takes control of the documentation process during the current clinical visit.

**Cloning:** the production of medical records that are the same, or nearly the same, **or appear to be the same**, as previous records. This term is not synonymous with "copy-paste", and it should be used only in reference to medical record documentation that has been produced by CPF used so excessively and inappropriately that the credibility of the medical record is compromised.

**Copy-paste:** refers to the process by which selected text or object(s) contained in one digital document is imported unchanged into another document. Other terms commonly used to describe this process are "copy-forward", "pull-forward", and "carry-forward".

**Dynamic Information:** information that can be expected to change frequently from visit to visit. e.g. Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS), Examination (EX), Impression/Diagnosis, Plan.

**Exploding Macros:** refers to a functionality whereby the simple act of "clicking" on a single word (such as "normal") or symbol results in the automatic documentation of a pre-set series of data elements. Use of this functionality without sufficient professional and system constraints creates significant risk of "cloning".

**Imported Documentation:** refers to documentation that has been inserted into a medical record as a result of utilization of the CPF or some other system interface.

**MEC/Affiliate Leadership:** refers to the Medical Executive Committee and the affiliate Leadership positions of the Medical Staff.

**Professional Constraints:** refers to the professional discipline required of the practitioner to use the CPF only in a manner that preserves the integrity of the medical record.

**Responsible Party:** The term "responsible party" is used generically as a place-holder to preserve for each Saint Thomas Health facility the opportunity to designate within its organizational structure the most appropriate position/role to be responsible for the various provisions of the policy. The "responsible party" may be the same position/role for all of the provisions of the Policy or different positions/roles for different provisions.

**Source Document:** refers to the document which is the source of the "imported documentation".

**Stable Information:** information not expected to change very often from visit to visit. e.g. Past, Family and Social History (PFSH).

**System Constraints:** refers to software design capabilities within the EHR that allow those charged with control and oversight responsibility over the EHR to adjust CPF access and applicability regarding individual practitioners and particular elements of the medical documentation. System constraints allow for the maintenance of medical record integrity in the absence of adequate professional constraints.

## **POLICY:**

Recognizing that within Saint Thomas Health there may exist numerous EHRs with different CPFs and different levels of available system constraints over the use of these CPF's, this policy is written with the intent that Saint Thomas Health will make full use of the available system constraints to carry out the intent of this policy. It is also the intent of this policy that, if the available system constraints on any EHR are insufficient to carry out the intent of this policy, the responsible party(ies) within Saint Thomas Health will work with the relevant EHR vendor(s) to develop sufficient system constraints within the EHR. Beyond the system constraints, and of greater importance, are the professional constraints that are the responsibility of all creators of documentation within an EHR. The specific provisions of this policy address those professional constraints.

1. All individuals documenting in an EHR are responsible for the accuracy and integrity of their documentation whether the content is original or imported from another source.
2. Effective with the date of this policy, all new members of the Medical Staff to be granted EHR documentation privileges shall, on a timely basis, successfully complete a training program on the proper use of the CPF of the EHR and the professional constraints on the use of the CPF. As a requirement for successful completion of training, the individual shall agree in writing to comply with this policy and to exercise the professional constraints identified in the training. As of the effective date of this policy, current members of the Medical Staff shall receive education via a distributed newsletter that outlines key guidance from this policy.
3. All imported documentation should be edited by the practitioner to assure that only accurate and medically necessary imported documentation remains in the documentation of the patient encounter.
4. Any error(s) in the imported documentation should be corrected by the practitioner.
5. Any recognized errors in the source documentation should be reported to Health Information Department

to facilitate correction of the source-document error(s).

6. The use of the CPF to import documentation from one patient's medical record into the medical record of a different patient is strictly prohibited. The exception to this is the maternal/infant delivery records where it is common practice to share data between the mother and infant's chart.
7. Imported documentation serving as documentation of work/care not performed by the author(s) of the current note should be accompanied by documentation of its source. Imported documentation serving as documentation of work/care or treatment performed by the author(s) of the current note, but not during the current patient encounter, should be accompanied by documentation of its source. Imported documentation serving only as documentation of work/care actually performed during the current patient encounter by the author(s) of the current note does not require source documentation.
8. It shall be the responsibility of the MEC/Affiliate Leadership and Nursing Leadership to incorporate medical review to identify **potential** medical documentation "cloning" into the Saint Thomas Health regular medical record reviews.
9. It shall be the responsibility of the MEC/Affiliate Leadership to establish a process for determining whether identified **potential** medical documentation "cloning" represents **actual** medical documentation "cloning".
10. It shall be the responsibility of the MEC/Affiliate Leadership to develop and Implement Saint Thomas Health corrective action policy(s) to effectively deal with occurrences of medical documentation "cloning".
11. It shall be the responsibility of the MEC/Affiliate Leadership to develop specific Saint Thomas Health guidelines on the use of the CPF on both "stable" and "dynamic" information.
12. It shall be the responsibility of the MEC/Affiliate Leadership to develop specific Saint Thomas Health guidelines regarding "advance copy-forward"/"auto-populate" functions in the EHR.
13. It shall be the responsibility of the MEC/Affiliate Leadership to develop specific Saint Thomas Health guidelines regarding the use of "exploding macros" in the EHR.
14. It shall be the responsibility of the MEC/Affiliate Leadership to develop specific Saint Thomas Health guidelines regarding the use of CPFs in software other than the EHR (e.g. Microsoft Office) to import documentation into the documentation of a patient encounter.

## REFERENCES AND RESOURCES:

All revision dates:

12/2017

### Attachments:

[Copy and Paste Functionality Policy Guidelines](#)

### Approval Signatures

Step Description	Approver	Date
	Cynthia Figaro: V.P. Corporate Compliance	12/2017
	Amanda Campbell: Executive Assistant	12/2017

**Saint Thomas Health**  
**Copy and Paste Functionality in Electronic Documentation (Policy 65)**  
**Attachment (Guidelines) 10-10-17**

1. Incorporating information that is not original to the author into a note also has the potential to jeopardize patient care and to expose practitioner(s) and/or STH to liability on several fronts. Risks include the following:
  - A. Populating a note with outdated, conflicting, incomplete or inaccurate information. This can result from many of the copy functions available in an EHR. For example, the ability to default or auto populate checkboxes (primarily in review of systems and physical exams) to “no” or “negative” upon starting a new note or closing a note may inadvertently include conflicting information in a single note; for example, a negative finding in the review of systems, but a positive chief complaint.
  - B. Inability to identify the original author in the EHR;
  - C. The original date of note creation may not be evident or may be difficult to locate;
  - D. Notes that are repetitive, inconsistent or identical
    - Such notes do not further the care of the patient and, over time, are likely to be ignored by care givers due to stagnant information;
    - Repetitive documentation may call into question the medical necessity of the care, thus triggering insurance payment denials, audits and/or investigations;
  - E. Notes that are too long and contain irrelevant information
    - When a note is excessively long and cluttered with “canned” text, the important parts are likely lost to the reader. This increases the risk that pertinent, new and critical information is overlooked, or may not be read by other practitioner s.
  - F. Misleading or false attribution of work performed by others into the current note.
2. Documentation from an outside software platform is allowed to be imported into an STH electronic health record.
  - A. All imported/pasted documentation should be edited by the practitioner to assure that only accurate and medically necessary documentation remains in the patient encounter.
  - B. The note entered into the EHR must accurately reflect the clinical work performed on each separate date of service, with clear attribution of the work of others as applicable.
  - C. Practitioners should refrain from copying and pasting entire notes from a prior encounter, since this practice leads to the appearance of prohibited “cloned” documentation, and also increases the potential for errors.
  - D. Imported documentation from another care practitioner serving as a clinical note of care not performed by the author(s) of the current note should include the proper notation including date, and its original author(s).
3. Imported documentation serving as clinical note of care or treatment performed by the author(s) of the current note, but not during the current patient encounter, should include the proper notation including the date, and its original author(s). It is the responsibility of each practitioner to ensure that “stable – information not expected to change very often” is reviewed and appropriately updated. For example, inquire if there is updated information regarding past family and social history.
4. It is the responsibility of each practitioner to ensure that “dynamic information – information that changes often” is updated at each encounter. For example, update at each encounter such

**Saint Thomas Health**  
**Copy and Paste Functionality in Electronic Documentation (Policy 65)**  
**Attachment (Guidelines) 10-10-17**

components as chief complaint, history of present illness, review of systems, diagnoses, assessment, and plan.

5. A practitioner may set up a template via “auto-text share” or auto populate. The practitioner must ensure that documentation is edited and accurately reflect the current patient’s condition or treatment regime. Advance copy-forward feature is not operational in Saint Thomas Health’s EMR.
6. The practitioner may pull forward all or select diagnoses. The practitioner should only list diagnoses that are currently being treated at the visit or encounter.
7. A practitioner may create an initial evaluation note but the note must be updated as to current treatment, patient progress, and change in plan, and patient response to treatment regime at each encounter/visit.
8. A practitioner may “tag” a note or interpretation so that the documentation appears in the progress note or hospital course. The system will record the source of the note or interpretation with a footnote.
9. When copying and pasting a note from another practitioner, the original source or author of the documentation must be cited.
10. The MEC/Affiliate Leadership may delegate the duty to incorporate medical documentation review into the compliance review function to identify potential medical documentation “cloning”. Appropriate education shall be provided to the practitioner. If the practice is not resolved in a timely manner, the results of the review process shall be reported to the respective physician leader.