Copying and Pasting of Medical Record Documentation Policy

PURPOSE: To establish policy, procedures, and responsibilities for providing guidance on the use of copying and pasting in the RPMS-EHR.

POLICY: Providers documenting in the RPMS-EHR must avoid indiscriminately copying and pasting another provider's progress note, discharge summary, encrypted PHI electronic mail communication and duplicate/redundant information provided in other parts of the EHR.

RESPONSIBILITIES:

1. The HIM Director has the responsibility for overall compliance and enforcement with this policy.
2. The Clinical Director is responsible for educating providers on the content of this policy and taking corrective action when providers abuse the copying and pasting function.
3. Health Information Management and Quality Improvement are responsible for referring repeated cases of inappropriate copying and pasting to the Clinical Director for corrective action and to the Compliance Officer for review and facility-wide trending.
4. The Medical Record Committee, through the medical record review function, monitors providers and the quality of their documentation. This review function will include the use of copying and pasting. Findings will be reported to the appropriate Clinical Director and/or the Service Unit Governing Body for action.
5. Failure to comply with this policy may be deemed a violation of the Privacy Act requirement (5 U.S.C. Section 552a(e)(5) – agency records are accurate, relevant, timely and complete) as well as the Medical Staff Bylaws.
6. Disciplinary action may be taken if violations of this policy are validated per IHS disciplinary action guidelines, rules, and regulations for:

    1) Failure to safeguard confidential information
    2) Deliberate failure or unreasonable delay in carrying out instructions
    3) Falsifying official agency records

PROCEDURE:

1. Information that is copied, pasted, imported must be attributed to the original source.
2. The purpose of a progress note is to provide an accurate depiction of treatment on a specific date of service. It is unnecessary to duplicate by copying and pasting information that does not specifically impact a specific date of service.

3. Occasionally a lab result may be helpful in clarifying treatment and it is appropriate, on a selective basis, to include those results in the note by referring/repeating them without copying and pasting verbatim into the note. It is inappropriate to fill the progress note with redundant information (information already available in a section of RPMS), such as lab results, radiology reports, or other ancillary information that is pulled in by a template or copied and pasted. Such redundant information makes it difficult to read the progress note and quickly elicit pertinent facts about a specific date of service. A liability issue may occur when abnormal lab results, x-rays, etc., are contained within the body of a note but not addressed in that note.
4. Only those diagnoses that were addressed or directly impact a specific date of service are included in the note. It is inappropriate to copy and paste or pull in as an object, the entire problem list on each note. The problem list is a reflection of all of the patient's problems, either past or present, and may not be relevant to a specific date of service.
5. Templates with standard wording can save time however each progress note should be a succinct recapitulation of a unique episode of care. If templates are used, the wording is changed from visit to visit to reflect the care given for that episode of care, not a mirror image of the care given in all previous encounters. Validity of an exam may be questioned if each exam contains exactly the same wording in exactly the same sequence.
6. Information presented in treatment groups, e.g., Mental Health and Behavioral Science (MH&BS), Day Treatment, Addictive Disorders, Smoking Cessation, Diabetic Group Education, etc., that is pertinent to each patient in the group, may be copied and pasted for each patient's note. Providers must be certain that no identifying information about other patients is copied and pasted nor a signature block. Providers must also include specific information for each individual patient along with the general group information to individualize the note for each patient.