UCONN HEALTH

POLICY NUMBER: 2013-02

June 11, 2013

POLICY: COPY AND PASTE FUNCTIONALITY IN ELECTRONIC RECORD DOCUMENTATION

It is the policy of UConn Health to maintain the integrity of the documentation within the electronic medical record for purposes of accurate clinical communication, to enhance patient safety, support medical necessity and serve the business and legal needs of UConn Health. It is the policy of UConn Health to maintain health records that will not be compromised and will support the requirements as listed above. Clinical providers are permitted to use the "copy and paste" functionality when documenting within electronic medical record systems for the purpose of patient care.

Clinical providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, or reused. When information is reused from a prior note, the clinical provider is responsible for its content.

PURPOSE:

To provide guidance on the use of copy functionality when documenting in the electronic medical record and to ensure that copying occurs through a thoughtful, evaluative process that assists with the accurate documentation of the specific services provided and produces a note that enhances patient care.

INTENT:

For the purposes of this policy, "copy" shall be understood to include cut/paste, copy/forward, cloning and any other intent to move documentation from one part of the patient's electronic record to another part of the same patient's record.

SCOPE:

This policy applies to all individuals document within the electronic medical record systems of UConn Health.

DEFINITIONS:

1) Cutting - Removing or deleting text from a document (this is prohibited for completed or authenticated documentation).

2) Copying-Duplicating text found in an original document and placing that copied text into a new document, while leaving the original text intact.

3) Pasting - Placing information copied or cut from one document into another document.

4) Copy/Forward – Copying a significant section or an entire prior note which is then edited and updated.

5) Cloning - 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 that 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 implications for billing. In essence, cloning is mindless copying.

6) 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 reminder to the writer about important elements that should be in a given document.

PROCEDURE:

1) Providers are required to document in compliance with all federal and state laws and Medical Staff Rules and Regulations.

2) The writer of each document is responsible for all of the content of that document, and must ensure that any material copied into that record accurately reflects the care provided during that episode of care.

3) All copied information from other electronic sources shall be credited to the 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 record to a different patient's records is prohibited except in the circumstance when documentation was entered in error.

6) Cloning of documentation is not allowed.

7) Information copied from the note of another provider should be referenced to include 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, 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, assessment and plan should not be copied/pasted without updating each section of the note with current information and assessment.

8) Template use is acceptable.

9) Copy/paste or copy/forward of student notes is prohibited, except as allowable by federal regulations.

10) Providers are encouraged to cite and summarize applicable lab data, pathology, 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.

11) Providers are responsible for correcting any errors identified within their documentation. If an error is identified from a previous note, the provider should specify the correction in his/her new note or via addendum.

12) Once a note has been entered into a patient's record that has been signed or is closed, it is considered final; any additional information required must be entered as an addendum.

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New Policy: 6/11/13