POLICY TITLE: Copy and Paste Functionality in Electronic Documentation	
ENTITY: ☒ T.J. Regional Health **☒ T.J. Samson ☒ T.J. Health Pavilion ☒ T.J. Health Columbia**	
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APPROVED BY: Jodie Holgate (EVP Patient Care Services), Megan Calkins (EVP CNO), Mei Deng (EVP CFO), Neil Thornbury (Chief Executive Officer)	**EFFECTIVE DATE: 05/17/2019**

PURPOSE:

To establish a policy which provides guidance to T.J. Regional Health affiliated providers and individuals with documentation privileges on the compliance related limitations applicable to "copy and paste" functionality (CPF) and documentation within an electronic health record (EHR). T.J. Regional Health promotes the creation of an accurate and concise medical record that facilitates patient safety, quality care, and appropriate billing for healthcare services in all patient care documentation, including all forms of electronic documentation, as well as transcription and hand-written documentation. The purpose of accurate concise documentation in the EHR is to ensure that all users documentation of clinical activities support and promote,

- High-quality clinical care;
- Patient safety and quality improvement;
- Timely and accurate documentation to support billing for the care provided;
- Timely and accurate documentation for care planning and continuity of care;
- Compliance with regulatory requirements such as the Medicare Conditions of Participation, The Joint Commission standards, and state and federal law.

SCOPE:

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

DEFINITIONS:

Affiliated Providers – Independent physicians or practitioners who are members of a TJRH facility's Medical Staff, and provide care to patients in a clinically integrated setting at a TJRH facility or otherwise require access to information for patients they have in common with TJRH for treatment, payment, or health care operations relating to such patients.

Auto populated elements – refers to the placement, by either staff or the EHR software, of clinical information (i.e., vital signs, allergies, medications, lab values) into the current clinical record before the provider takes control of the documentation process during the current clinical visit.

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Cloning – the production of medical records that are the same, or nearly 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”.

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.

Macros – means a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text.

POLICY:

Individuals documenting in the T.J. Regional Health EHR must avoid copying and pasting another users progress note, discharge summary, encrypted protected health information (PHI), electronic mail communication and duplicate/redundant information provided in other parts of the EHR. The user providing a patient service must accurately and concisely document the services provided and information gathered during each patient encounter, whether the documentation is in a form of electronic documentation, is transcribed, or hand-written. Electronic health record users must review and edit previously documented information that is carried forward, imported, or supplied by use of a template to remove all information that does not accurately reflect the services provided during the encounter being documented and to add any missing information pertinent to the current encounter.

1. All users documenting in an EHR are responsible for the accuracy and integrity of their documentation whether the content is original or imported from another source.

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PROCEDURES:

A. General Requirements

Each user must meet the following general requirements with regard to any entry in a patient's EHR:

1. The signer of each entry is responsible for all of the content of his or her documentation, whether the content of the documentation is original, created using Carry Forward, or includes Auto-Populated Elements or Macros.
2. Each user is responsible for confirming the accuracy of documentation and making any necessary corrections, whether the documentation is created personally or by an authorized scribe.
3. Each user must review information created using Carry Forward or Auto Populated Elements for accuracy and completeness and must edit the information, as appropriate, with specific attention to removal of elements that are no longer pertinent, inaccurate or are not relevant to the current patient encounter.
4. When using Carry Forward and especially Copy and Paste functionality, limit such information to only currently pertinent and clinically relevant information.
5. All documentation, including any documentation created using Carry Forward, Auto-Populated Elements, and Macros, must adequately document the reason for the encounter; assessment, clinical intervention or diagnosis; medical plan of care; patient progress; and date and identity of the user in sufficient manner to comply with good medical practice; billing rules; state, federal, and regulatory requirements and all applicable T.J. Regional Health policies.

B. Responsible Parties

1. All T.J. Regional Health department directors that oversee users with any EHR privileges will be responsible for educating users of the requirements of this policy.
2. Unless otherwise set forth in this policy, the T.J. Regional Health executive team will be responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at T.J. Regional

Health, and that instances of noncompliance with this policy are reported to the Compliance Officer.

C. Auditing and Monitoring

1. Any recognized error(s) in the source documentation should be reported to the Transcription department for monitoring and reporting purposes.
2. It shall be the responsibility of the Transcription department to establish an auditing process that incorporates medical record reviews to identify potential medical documentation "cloning" and/or other critical errors.
3. The transcription staff will report any findings to the Compliance Officer.

D. Enforcement

All employees and users with documentation privileges whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures including the Medical Staff Bylaws, Rules and Regulations.

Users found to be abusing documentation tools (i.e., inappropriate use of Carry Forward and Copy/Paste functionalities, inadequate editing of Auto Populated Elements or insufficient customization of Macros) will be subject to performance management including:

a. Monitoring;
b. Remedial Education;
c. Revocation of the ability to use certain documentation tools;
d. Corrective Action pursuant to Medical Staff Bylaws.

REFERENCES:

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