GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL POLICY & PROCEDURES

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
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TITLE: **COPY AND PASTE FUNCTIONALITY AND USE OF TEMPLATES IN THE ELECTRONIC HEALTH RECORD (EHR)**				
LAST REVIEWED/REVISED: 12/2016				
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PURPOSE:

The purpose of this Policy is to establish the standards and criteria for the appropriate use of "copy and paste," (a.k.a. Cloning, Importing, Copy Forward, "Recent" button) and Note templates within the Electronic Health Record (EHR). This document will support and promote:

- Patient safety and quality improvement
- Timely and accurate documentation for care planning, continuity of care, and for supporting billing for the care provided
- Compliance with regulatory requirements such as the Centers for Medicare and Medicaid (CMS) Conditions of Participation and the Joint Commission Standards, Federal and Territory rules regarding appropriate provider documentation and the accepted standards of care.

POLICY:

It is the policy of the Guam Memorial Hospital Authority (GMHA) to maintain the integrity of the documentation within the electronic health record for purposes of accurate clinical communication, to enhance patient safety, support medical necessity and serve the business and legal needs of the GMHA.

Clinical providers at GMHA are permitted to use the "copy and paste" functionality when documenting within electronic health record systems for the purpose of patient care. The electronically stored and/or printed patient information is subject to the same medical and legal requirements as handwritten information in the health record.

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 author is responsible for its content.

DEFINITIONS:

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 of 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.

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

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

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

Pasting: Placing information copied or cut from one document to another document.

Clinical Provider: Attending physicians, Certified Registered Nurse Anesthesiologists, Certified Nurse Midwifes, Licensed Nurses, Pharm-MD, Dietitians or any other type of therapist or technician who may create clinical notes.

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 about important elements that should be in a given document.

CLINICAL PROVIDERS RESPONSIBILITY AND EXPECTATIONS:

Clinical Providers who elect to copy information permitted as under this policy are responsible for the following:

1. Documentation should provide an accurate depiction of treatment surrounding a specific date of service.

2. The Attending Physician is ultimately responsible for the accuracy of the health record for each patient under the physician's care.

3. Clinical Providers are required to document in compliance with all Federal, Territory laws; hospital policies and procedures, Medical Staff Bylaws, Rules and Regulations, Centers of Medicare and Medicaid's Conditions of Participation, and The Joint Commission's Standards.

4. Clinical Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, re-used or from a template.

5. Clinical Providers will avoid indiscriminately copying or use of the "recent" icon providing redundant information from other parts of the EHR (e.g. other clinical provider's progress notes, or discharge summaries.)

6. Templates with standard wording such as "Within Normal Limits" (WNL) can be used in certain cases, however each progress notes should be a succinct recapitulation of a unique episode of care. Clinical Providers will avoid the indiscriminate use of the Within Normal Limits (WNL) icon potentially documenting information that was not performed. If the WNL icon is used it is

expected the clinical provider will de-select items not performed and ensure that abnormal findings are documented correctly.

7. Clinical Providers are responsible for correcting any errors identified within documentation and clearly noting that this is a correction of previously inaccurate information.

8. Clinical Providers must notify the Medical Health Records Department immediately regarding any erroneous entries that cannot be corrected by the provider (e.g. wrong patient, wrong record).

9. Plagiarized data in the patient record is prohibited. Clinical Providers are responsible for citing the outside or third party source when external data is documented in a note.

10. Clinical Providers are responsible for clearly identifying the individual who performed each service documented within the note and when entering patient data into the medical record that the provider did not personally take or test, the Clinical Provider must attribute the source and their credentials.

10. Clinical Providers must participate in and successfully complete all applicable required EHR training prior to utilizing the EHR System for documentation purposes.

ACCEPTABLE USE OF COPY AND PASTE PROCEDURES:

I. COPYING FROM THE AUTHOR'S OWN NOTE

A. Clinical Providers may copy relevant portions of the patient's previous notes or use the "recent" icon, to the extent it represents the level of work performed by the Clinical Provider during the current visit and is revised to reflect any changes in the information. The Clinical Provider's signature shall serve as their attestation that the information is accurate and that all information is current and represents the Clinical Provider's services for that date of service.

B. Clinical Providers are allowed to import sections of lab data, pathology, and radiology reports if a specific test or report section AND a date is included.

C. Clinical Providers are responsible to check for contradictory information in the medical health record documentation. (Ex. Post Op Dates, Admission Dates).

D. Clinical Providers are responsible for ensuring significant abnormalities that are copied into the chart are also documented in the Assessment and Plan section of the note (e.g. an elevated potassium level copied into a note should have a plan to address the abnormality).

E. Clinical Providers are responsible for reviewing, updating and marking as "reviewed" the Problem List. Clinical Providers are to ensure only current

problems/diagnosis assessed during their current office encounter are documented in the Assessment/Plan.

F. The Clinical Provider may copy the following from his/her own note, but must edit the following sections to make them current:

1. History of Present Illness
2. Review of Systems: he/she must reference the documentation with sufficient detail to uniquely identify the source document. Example: "For review of systems see clinic note documentation dated 1/1/20XX."
3. Exam (e.g. vital signs)
4. Assessment and plan: If the Assessment/Plan is copied and unchanged from the previous note, Clinical Providers are responsible to attest that there has been no change.
5. Medications and doses: Medications lists must be verified that each medication is still in use, add current medications to the list and remove any inactive medications from the medication list. Clinical Providers can import the current list into the active document and update it. They must verify that it is accurate prior to signing the note.

G. Once a note has been signed as final, additional information may only be added as a separate addendum that is clearly marked with dates and times.

II. COPYING MATERIALS FROM A NOTE AUTHORED BY ANOTHER AUTHOR

A. Copied information must be attributed to the author by name or position, by date and note type, must be set off by quotation marks, and should be identified by the use of a different font or italics.

B, Copied information must be identifiable to include the author of the copied information and the date of the previous note. Failure to properly attribute authorship has potential risks of becoming a false claim and jeopardizing the integrity of the legal medical record.

C. Clinical Provider must ensure that the information copied is relevant to the patient's current episode of care and is reviewed and revised to reflect any changes in the information prior to authentication.

D. Copying limited documentation from the note of another author is acceptable. Types of documentation that can be copied from one report in the EHR to another report of the same patient include:

1. Problem list
2. Past medical history
3. Social history
4. Family history
5. Pathology and cytology report sections (such as diagnosis),

6. Radiology reports (such as impression or preliminary diagnosis.

E. Documentation must indicate that the section was copied and from where.

III. DOCUMENTATION WHICH SHOULD NOT BE COPIED FROM THE NOTE OF ANOTHER

A. Copying information from one patient's medical record to a different patient's medical record is strictly prohibited.

B. Do not copy information from nursing notes or from other ancillary staff or students.

IV. PRE-CONSTRUCTED PHYSICAL EXAMINATION TEMPLATES

A. Templates with standard wording can be a time saver, however, each progress note should be a succinct recapitulation of a unique episodes of care. If templates are used, the wording should be 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.

B. The physical examination templates which do not afford the involved provider with an opportunity to include case-specific information and/or results for the current visit or encounter, and which do not accurately reflect the actual physical examination performed during the current encounter, are strictly prohibited. If a department would like to develop their own template, they should consult with the compliance office to evaluate if the template meets federal/state regulations.

RISKS ASSOCIATED WITH THE INAPPROPRIATE USE OF COPIED DOCUMENTATION IN THE EHR:

I. PATIENT SAFETY

The inappropriate use of copied documentation may result in several risks to patient care. These risks include critical patient or treatment information being overlooked as a result of unnecessarily lengthy Clinical Provider documentation, misinterpretation of the chronology of a patient's illness and the services rendered to address that illness, and inconsistencies among current symptoms, examination findings, and treatment plans. Additionally, the inability to accurately identify each medical record author may bring into question the credibility of medical entries, and has the potential to have a negative effect on patient care.

II. PROFESSIONAL BILLING:

All Clinical Provider documentation must comply with all Federal and Territory laws and GMHA policies and guidelines. Clinical Provider documentation must support medical necessity and the appropriateness of services provided. Copied

documentation that is not appropriately edited and updated to reflect patient and visit-specific information does not, in most instances, meet the medical necessity requirements established by third-party payers for coverage or payment of services. All entries in the medical record must be patient- and visit-specific and only reference the actual data collected or services performed at that encounter or visit by the documenting provider. Clinical Providers must take every effort to avoid over-documenting by inserting irrelevant or unnecessary documentation into the medical health record, or by not appropriately editing and updating system-generated templates and information. Clinical Providers may reference other provider's entries in the patient's record when that information is pertinent to the reason for the current visit and done in accordance with applicable federal and state rules and the guidelines included in this policy.

III. PATIENT PRIVACY

Each note must be unique to the individual patient. Copying documentation from one patient's record into another patient's record puts the patient's privacy and the hospital at risk for potential violations of the Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

COMPLIANCE:

I. MONITORING

Compliance will be monitored by chart review or by routine audits. Any discrepancies noted will be addressed to the Medical Health Records Administrator for correction. It will also be monitored and reported through the current incident reporting system.

II. AUDITS AND INVESTIGATION

A. Clinical Providers documenting in the EHR must avoid indiscriminately copying and pasting other Clinical Provider's progress note, discharge summary, and redundant information provided in other parts of the health record.

B. Documentation that is repetitive, inconsistent or identical may call into question the medical necessity of care resulting in denials, audits and/or investigations by the Departmental Chair, the Chief of Staff, the Compliance Officer, or by the Assistant Associate Medical Director.

ACCOUNTABILITY AND DISCIPLINE:

I. ACCOUNTABILITY

A. The authors are liable for the content of copied items within the notes they authenticate. As part of the health record review function, use of copy and paste functionality will be monitored and where violations occur, findings will be reported to the Medical Executive Committee for disciplinary or other adverse action.

NOTE: Criminal charges may be filed when in violation of Federal law.

B. Failure to comply with these standards may be deemed a violation of the:

1. Privacy Act requirement (5 U.S.C. Section 552a(e)(5); or
2. Standards of Conduct for Elected Officers, Appointed Officers, and Public Employees of the Government of Guam (4 GCA, Chapter 15)

II. DISCIPLINARY ACTION

A. If a Clinical Provider is found to have inappropriately used copied documentation in the medical health record, appropriate disciplinary actions may be taken, up to and including suspension of hospital privileges or termination of employment.

B. The corrective/disciplinary action will be taken per GMHA Medical Staff By-laws Article VIII and/or Human Resources Rules and Regulations.

C. The corrective action may be reported to National Practitioner Data Bank according to the Health Care Quality Improvement Act.

REFERENCES

GMHA By-laws 2015 Article VIII
GMHA Medical Records Rules and Regulation
Healthcare Quality Improvement Act of 1986, Title IV of Public Law 99-660
Joint Commission: Quick Safety Issue 10; Feb 2015, retrieved from https://www.jointcommission.org/assets /1/23/Quick_Safety_Issue_10.pdf
Privacy Act of 1974 5 U.S.C Section §552a http://www.justice.gov/opcl/privstat.ht
Standards of Conduct for Elected Officers, Appointed Officers, and Public Employees of the Government of Guam (4 GCA, Chapter 15) retrieved from http://www.guamcourts.org /compileroflaws/GCA/04gca/4gc015.PDF

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

Submitted by: Human Resources Department

Policy No.: A-RC300

Policy Title: Copy and Paste Functionality and Use of Templates in the Electronic Health Record (EHR)

	Date	Signature
Reviewed/Endorsed:	12/07/16	
Name: Title:		Michael Klemme Chairman, HIM Committee
	Date	**Signature**
Reviewed/Endorsed:	12/14/16	
Name: Title:		PeterJohn D. Camacho, M.P.H. Chairman, Executive Management Council

*Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.