East Jefferson General Hospital | Medical Staff Policy & Procedure
Metairie, Louisiana

Policy No.: MSO – 8

Effective Date: 11/12/2013

Title: **COPY AND PASTE POLICY**

Approval by:

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Chief of Staff

Reviewed: 3/8/16
Revised: 3/8/16

I. POLICY

To provide a policy on appropriate copy and paste function within the EJGH Electronic Medical Record. The Electronic Medical Record is intended to produce an accurate and timely record of the status of the patient, medical decision making, and the outcomes of treatment in both the inpatient and outpatient settings at EJGH. As documentation may be used by multiple individuals for clinical, educational, compliance, financial and legal purposes, information must be accurate and attributable to a single author.

II. DEPARTMENTS AFFECTED: Medical Staff, All Departments

III. POSITION STATEMENT

The copy and paste function within the medical record improves documentation of historical data which does not change. However, this function can also propagate inaccurate data rapidly when the information is not critically evaluated by the author/ copier. When used appropriately, it reduces errors of omission or in transcription and minimizes inclusion of incorrect or inaccurate information. The copy and paste function should NOT be used to document information that is expected to change and could only be presumed to be correct at the time the health care team member obtained them. It should always be clear that copied documentation represents work done at the current encounter and does not simply repeat documentation of work done previously, nor does it add unnecessary documentation for the purpose of supporting billing.

IV. PROCEDURE

A. General Rules

1. The author of a note is responsible for the entire content.

a. The note must be read before signature.

b. The author should confirm that copied information remains accurate and complete and was thoroughly reviewed. Changes and additions should be noted as appropriate.

c. Avoid copying and pasting typographical errors.

d. Avoid copying addendums and headers regarding note status when copying a previous note

2. Copying from the author's own note

a. Any copied material must be attributed: origin/location and author of original documentation.

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3. Copying material from a note authored by another
a. Should be attributed to the author
1. By name or position
2. By date and note type and/or from what location.
b. Should have clear identification of where copied material starts and stops.
c. Use of a different font or italics may be helpful to identify copied information.

B. Documentation is acceptable to copy from the note of another author once checked for accuracy by the utilizing author.

1. Types of documentation which may be copied:
a. Allergies
b. Historical Procedures and Surgeries
c. Previous Medical History
d. Previous Developmental History
e. Immunizations
f. Family History
g. Previous Social History
h. Pathology or Cytology Reports – should indicate report was copied
i. Radiology Reports – should indicate report was copied
j. Procedure reports – should indicate report was copied
k. Dates of Scheduled Appointments and/or Procedures
l. ROS if current and appropriate to immediate visit

2. Medication Lists
a. Use of each medication should be verified by one or more of the following:
i. Directly with the patient
ii. By a family member
iii. By direct inspection of medication containers
iv. By review of orders, ePrescibe data (Sarne, 2006) or pharmacy records
v. With a pharmacist
vi. With a physician, nurse or other appropriate health care team member
b. Current medications not on the list should be added
c. If the accuracy of the list cannot be verified.
i. The source of the list should be identified

ii. A statement should be added that the list is not verified.

C. Documentation which should usually <u>NOT</u> be copied from the note of another author:

1. Types of documentation which usually should NOT be copied:

a. Chief Complaint and the History of Present Illness must always be current and documented by today's provider.
b. Physical Examination
c. Assessment
d. Plan

2. Special circumstances may necessitate copying information listed above in Section C.1.

a. If the patient is not (no longer) able to provide the information for HPI, document the reason and what information can be assessed from other annotated sources