Cut, Copy, Paste: EHR Guidelines

Save to myBoK

by Margret Amatayakul, MBA, RHIA, CHPS, FHIMSS, Mary Brandt, MBA, RHIA, CHE, CHP, and Michelle Dougherty, RHIA

A nurse sits down at the computer to document in the patient's electronic health record (EHR). To complete her SOAP note, she copies the text of another nurse's entry to capture the patient's subjective complaints and symptoms. She then goes to the lab system and intake-output records to copy and paste the objective data from these sources into her documentation. Next she enters her assessment of the patient during her shift, and finally copies and pastes a plan from the patient's electronic care plan.

Three quarters of her entry was copied and pasted from other documentation—is this an acceptable practice?

This is not an uncommon scenario in healthcare today as organizations move toward EHR systems. This article will look at the guidelines facilities should establish for cutting, copying, and pasting entries in the EHR.

Be Aware of Risks

To speed up the documentation process clinicians may:

- Cut and paste all or part of their own note from an earlier encounter to the present encounter
- Cut and paste all or part of another clinician's note into their present encounter
- Cut and paste staff e-mail messages into the present encounter
- Cut and paste comments from a patient's e-mail message
- Cut and paste test results and values from various systems

Cutting and pasting is a time saver; however, it poses several risks, including:

- cutting and pasting the note to the wrong encounter or the wrong patient
- lack of identification of the original author and date
- the acceptability of cutting and pasting the original author's note without his or her knowledge or permission.

To address these concerns, providers must establish guidelines for cutting and pasting documentation in their facility's EHR system. The "cut and paste" functionality available in most word processing systems eliminates duplication of effort and saves time, but it must be used carefully to ensure accurate documentation.

Completeness, Accuracy Key

Regulatory and accreditation requirements do not delve into where or how information is obtained to create the content of an entry. In general, entries must be complete, accurate, timely, and authenticated. The Federal Rules of Evidence state that the entry must be made by a person within the organization who has knowledge of the acts, events, conditions, opinions, or diagnoses appearing in the record. An individual using information from other sources to develop his or her entry in the EHR should meet this standard.

Just as with paper-based records, clinicians using electronic documentation are responsible for the completeness and accuracy of their entries. Cutting and pasting entries they have made in the patient's record during a previous encounter is an acceptable practice, as long as care is taken to make the entry in the correct encounter record for the correct patient and to ensure that applicable changes are made to variable data.

Down to Basics

Organizations can follow these basic guidelines for common cutting and pasting scenarios:

Copying from another clinician's entry: If all or part of an entry made by another clinician is used, the clinician making the entry takes responsibility for the accuracy of the entry incorporated into one's own documentation. Otherwise, the entry should be quoted directly from the original entry and should be attributed to the original author.

For example, a clinician quoting another clinician's entry may make the following entry: On August 16, 2002, Dr. Smith saw the patient in the GI Clinic for chronic epigastric pain. The impression he documented at that time was "chronic epigastric pain of varying intensity over a three year period; etiology unknown."

If another clinician's note is quoted directly and properly attributed to that clinician and the appropriate encounter, there is probably no need to get the original author's permission to quote the entry.

Copying test results/data: If test results are cut and pasted into an encounter note, the date of the original test results should be noted, along with the electronic system in which they reside. This will allow another clinician reading the note to reference the original test results, if needed.

Copying from another source (e-mail): If information is taken from another source, such as an e-mail message the patient sent the clinician describing his or her symptoms or response to medication, the information should be quoted directly and attributed to the patient and the date and source of the original information annotated.

Copying for reuse of data: If cutting and pasting is for reuse of data, such as to record information about a series of visits for a chronically ill patient, care must be taken to reuse only the information that actually applies to the current visit and to record any new information. Such re-use of information is becoming popular in EHR systems. It saves time, but will be frowned upon by any auditor if it is not clear that each use is unique.

Organizations should develop policy and procedures related to cutting, copying, and pasting documentation in their EHR system. By following these guidelines and training clinical staff, providers can allow cutting and pasting within certain boundaries.

References

Dougherty, Michelle. "Practice Brief: Maintaining a Legally Sound Health Record." *Journal of AHIMA* 73, no. 8 (2002): 64A-G.

Centers for Medicare & Medicaid Services. "2002 Federal Regulations for Hospitals: State Operations Manual, Appendix A. Interpretive Guidelines—Hospitals." Available at www.cms.hhs.gov/manuals/pub_07.asp.

Joint Commission on Accreditation of Healthcare Organizations. "Management of Information." *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, Update 1. Oakbrook Terrace, IL: Joint Commission, 2003.

Margret Amatayakul *(margretcpr@aol.com) is president of Margret\A Consulting, LLC, an independent consulting firm based in Schaumburg, IL;* ***Mary Brandt*** *(mbrandt@brandt-associates.com) is president of Brandt and Associates, Inc.;* ***Michelle Dougherty*** *(michelle.dougherty@ahima.org) is an HIM practice manager at AHIMA.*

Article citation:
Amatayakul, Margret, Mary Brandt, and Michelle Dougherty. "Cut, Copy, Paste: EHR Guidelines." *Journal of AHIMA* 74, no.9 (October 2003): 72,74.