Health Record Data Replication Policy

Approved by WUSM Faculty Practice Plan: October 13, 2009
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PURPOSE: The purpose of this policy is to establish guidelines on the utilization of the copy/paste and copy/forward function within the Electronic Health Record (EHR) and to institute a Washington University Medical Center (WUMC)-wide policy for all providers. The policy applies to members and employees of the Faculty Practice Plan (FPP) at Washington University School of Medicine, Barnes-Jewish Hospital (BJH), Barnes-Jewish West County Hospital (BJWCH) and St. Louis Children’s Hospital (SLCH). The Health Record Data Replication Policy encompasses the use of templates, macros, imported or reused information.

POLICY: Medical records are created for every patient who receives treatment, care or services at WUMC and are maintained for the primary purpose of providing patient care. The record shall contain sufficient information to identify the patient, support the diagnosis(es), justify treatment, document the course and results and facilitate the continuity of patient care. Documentation must be accurate and concise, and must reflect the services rendered at the time of each encounter. Providers documenting in the EHR must avoid indiscriminately copying and pasting notes and duplicate/redundant information provided in other parts of the EHR. Any data that is copied from one portion of the EHR to another must be updated and verified prior to affixing an electronic signature. As a general principle, when used, the provider should, Copy, Paste, and Update data. Replication of data generated by a medical student is limited to the Review of Systems, Past Medical History, Family History and Social History.

PROCEDURE: Providers have complete responsibility for each individual entry and the total content of their medical records entries, whether the content is original, copied/pasted or copied/forwarded. If information is copied and pasted or copied and forwarded from a previous note to a new note, the provider is responsible for confirming the accuracy, updating information as appropriate and reconciling the new information so that the note is entirely accurate and reflects the current evaluation. Citing any historical information from a patient medical record always requires review and, when appropriate, attribution of the original source by the provider. The provider’s signature shall serve as his/her attestation that the information (whether the content is original or copied) is accurate, and that any copied information is current and represent the provider’s services for that date of service.

DEFINITIONS:
- Attribution – Specific citation to the original source of the data, including the original provider and the original date
- Auto-populated/Pre-populated - Automatically generated information in electronic format that does not require positive action or selection by author (provider)
- Copy/Paste and Copy/Forward – Selecting data from an original source to reproduce in another location in the record
- Data Replication – Utilization of the copy/paste, copy/forward or template functionality in medical records
- Macro – Expanded text that is triggered by abbreviated words or keystrokes

Acceptable Copy/Paste and Copy/Forward Guidelines *Not Requiring* Attribution of the Source

Data replication can be utilized after careful review, updating and verification of the accuracy of the information, under the following circumstances and consistent with the following parameters. Information to be copied and pasted should not be older than six (6) months from the date of the original note. Types of documentation which may be copied, pasted, auto-populated and updated:

- Past medical/surgical history notes from the same patient
- Social History and Family History from the same patient
- On campus laboratory data from patient medical record

Acceptable Copy/Paste and Copy/Forward Guidelines *Requiring* Attribution of the Source

In most cases, providers are responsible for citing and summarizing applicable lab data, pathology and radiology reports rather than copying such reports in their entirety to the notes. However, there may be instances when the provider determines it necessary to incorporate such reports, in part or in whole, into their documentation. The source of the original information must be identified (i.e., prior note’s author and date). Types of documentation which may be copied and pasted with an attribution of the source and date of the data:

- Text from a pathology report
- Text from an off campus laboratory report
- Text from a radiology report
- Text from a procedure note

Acceptable Copy/Paste and Copy/Forward Guidelines *Requiring* Attribution of Source and Declaration of Updating

In all cases, providers are responsible for documenting the History of the Present Illness (HPI) for each encounter. In some limited cases, involving complex, ongoing care, portions of the HPI may be copied and pasted:

- When the current patient visit note HPI/Interval History has been significantly updated and
previous versions of the HPI/Interval History are utilized within the current note specifically for continuity of care

- Medical Decision Making (MDM) and Plan of Care can be copied and pasted only when used as historical information and only when done specifically for continuity of care. MDM for the current visit may not be copy and pasted for the current problem.

**Copy/Paste and Copy/Forward Not Acceptable:**

- Patient notes from a different patient
- Teaching Physician Attestation
- Physical Examination
- Medical Decision Making and Planning (see exception in prior section)

**Templates with Standard Wording, Macros and Exploding Notes**

- Templates, macros, exploding notes or structured notes are acceptable when initiated by the provider, by positive action or selection and should be customized to each specialty or provider. The final note in the record must sufficiently describe the specific services furnished to the specific patient on the specific date.