QuickSafety
An advisory on safety & quality issues

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Preventing copy-and-paste errors in EHRs

Issue:

The use of the copy-and-paste function (CPF) in health care provider's clinical documentation is increasing as the adoption of Electronic Health Records (EHR) has accelerated in response to national incentive programs. The widespread use of the CPF by providers in the inpatient setting has already been documented in medical literature.[1] While the practice of duplicating information within the same patient record or moving it across multiple records can foster prompt communication, improve efficiencies and, most importantly, increase time spent with patients, these benefits must be weighed against the potential risks to the integrity of the medical record. The risks include:[2, 3]

- Copying and pasting inaccurate or outdated information
- Redundant information in the EHR, which makes it difficult to identify the current information
- Inability to identify the author or intent of the documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes

The integrity of the patient record and notes in the EHR are of paramount importance as the EHR is becoming the dominant tool for communication between providers, supplanting aspects of verbal communication that assist in medical decision making, clinical follow-up, transitions of care, and medication ordering and dosing. The Joint Commission has received reports to the Sentinel Event database noting documentation errors and other problems with the data integrity of the clinical record. Several sentinel events leading to patient harm reported the CPF as the specific root cause. Although it is difficult to determine how often the CPF leads to patient harm due to the challenge of accurately identifying and tracking this information, as the adoption of EHRs continues to increase, the potential for patient harm due to the CPF also increases. Examples of harm include outdated weight information used for dose calculation of chemotherapeutic agents, and lengthy progress notes that prevent timely and efficient communication.

Safety Actions to Consider:

All organizations that use EHRs should be aware of the risks of the CPF and collaborate with their health care providers to ensure this tool does not lead to unintended consequences that may result in patient harm. There are a number of actions that health care organizations can take to help prevent copy-and-paste errors in EHRs, including the following recommendations from the American Health Information Management Association:

- Develop policies and procedures addressing the proper use of the CPF to assure compliance with governmental, regulatory and industry standards.
- Address the use of features such as copy-and-paste in the organization's information governance processes.
- Provide comprehensive training and education on proper use of copy-and-paste to all EHR system users.
- Monitor compliance and enforce policies and procedures regarding use of copy-and-paste, and institute corrective action as needed.

In addition, the following recommendations from The Joint Commission can further support the safe use of the CPF in EHRs:

(Cont.)

- Work collaboratively with health care providers, medical societies, and others in the organization to carefully balance the benefits of the CPF with the potential risks, and to develop training and education related to the CPF.
- Have a process where the accuracy of the clinical record is monitored. This process should include a feedback loop to inform health care providers when their documentation is not accurate or is overly redundant.
- Begin a focused and ongoing professional performance evaluation (OPPE) with specific triggers and measures related to the accuracy of the clinical record.
- Maintain robust quality review process(es) in which all cases of potential misuse or error due to CPF are evaluated consistently and comprehensively to identify opportunities for improvement in patient safety.

Resources:

1. O'Donnell HC, et al: "Physicians' Attitudes Towards Copy and Pasting in Electronic Note Writing," *Journal of General Internal Medicine*. 24(2008):63-68
2. Kuhn T, et al: "Clinical Documentation in the 21st Century: Executive Summary of a Policy Position Paper From the American College of Physicians." *Annuals of Internal Medicine*, 17 February 2015, Vol 162, No. 4
3. Bowman S: "Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications." *Perspectives in Health Information Management.* Fall 2013:1-19
4. American Health Information Management Association: "Appropriate Use of the Copy and Paste Functionality in Electronic Health Records." AHIMA Position Statement (accessed February 10, 2015)
5. Hammond KW, et al: "Are Electronic Medical Records Trustworthy? Observations on Copying, Pasting, and Duplication." American Medical Informatics Association Symposium Proceedings. (2003):269–273
6. Thornton JD, et al: "Prevalence of Copied Information by Attendings and Residents in Critical Care Progress Notes." *Critical Care Medicine*, 41(2013):382-8
7. Wrenn JO, et al: "Quantifying Clinical Narrative Redundancy in an Electronic Health Record." *Journal of the American Medical Informatics Association*, Volume 17, Number 1 (2010):49-53 (accessed February 10, 2015)

Note: This is not an all-inclusive list.

The Joint Commission.