**The Use of Copy And Paste Functions for Electronic Medical Records**

The primary purpose of clinical documentation should be to support patent care and improve outcomes through enhanced communication. Since the electronic medical record (EMR) is now the primary tool for documenting patient encounters and communication between clinicians, the integrity of the data they contain is of great significance.

EMRs have greatly improved medical record legibility and accessibility, but not necessarily their readability or accuracy. Of particular concern is the use of the copy and paste function (CPF). Although CPF has the potential to improve efficiency, it also poses potential risks to the integrity and accuracy of the medical record.

Clinicians can use CPF to copy a note from a previous patient encounter, paste it into a new patient encounter and edit it, rather than writing an entirely new note at each visit. Problems arise when the clinician performs CPF and performs little or no editing at all, resulting in notes that:

- contain outdated or irrelevant information
- propagate false information
- misrepresent what actually occurred during a patient encounter
- make it difficult to identify the duration of a problem
- confuse medication dose changes or other instructions to the patient.

Unedited CPF can also lead to notes that do not have a clear narrative style and are unnecessarily lengthy. Carrying forward large amounts of possibly irrelevant information can also cause information overload, which can cause clinician's to miss important pieces of information and result in medical errors.

In addition, regular use of duplicate entries, especially in the history of present illness and assessment and plan, may be grounds for denial of payments by insurance carriers, and may facilitate or appear to facilitate attempts to inflate, duplicate or create fraudulent healthcare claims.

Similarly, pre-populating data fields in an EMR before a patient visit raises ethical and legal concerns where it documents exams that were not performed and/or documents the review of systems/physical exam as normal when, in fact, they were abnormal, changed, or not performed at that visit.

Clinician's using CPF or pre-populating data should do so carefully and judiciously to create efficient and complete clinical notes that will enhance communication, while avoiding duplication of notes and the propagation of outdated information that does not reflect the current condition of the patient. Clinicians should ensure that information contained in EMR for each patient encounter is based on the actual information that was obtained or reviewed and the assessments that occurred at that visit.

References:

https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_10.pdf

http://www.cmsdocs.org/news/emr-cloning-a-bad-habit

http://bok.ahima.org/PdfView?oid=300306

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