# SESLHD PROCEDURE COVER SHEET

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| **NAME OF DOCUMENT** | eMR - Copy and Pasting within Electronic Documentation |
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| **EXECUTIVE SPONSOR** | Director, Clinical Governance and Medical Services |
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| **FUNCTIONAL GROUP(S)** | Records Management - Health |
| **KEY TERMS** | eMR, Documentation, Copy and Paste |
| **SUMMARY** | This procedure is to advise clinical information system users (including the electronic medical record) of best practices when using *Copy and Paste* functionality. |

# eMR - Copy and Pasting within Electronic Documentation

SESLHDPR/605

## 1. POLICY STATEMENT

As per NSW Ministry of Health Policy - PD2012_069 Health Care Records - Documentation and Management health care records must provide an accurate description of each patient / client's episodes of care or contact with health care personnel.

Although NSW Health Policy is not yet updated to reflect emerging technologies with information systems and clinical data entry, accuracy in the health record is a primary objective.

## 2. BACKGROUND

The significant uptake of clinical information systems brings many benefits in the entry and viewing of electronic documentation.

Copying and pasting is a broadly utilised tool within information systems and brings advantages including the reduction of data entry and associated efficiencies. In health settings, there is a high incidence of copy and paste utilisation.

However, the process and human factors involved with copy and paste functionality is known to cause significant errors. These errors in context of an electronic medical record patient file may lead to adverse patient outcomes, erroneous medical record content, incorrect information provided in the transfer of care (e.g. discharge summaries), medico-legal implications, and sometimes death as noted in recent coroner's findings. As such it is strongly advised not to use copy and paste functionality.

A large international partnership studying the safe use of copy and paste in health care settings recognised the prevalence of copy and paste utilisation and the risks that can occur with this use (ECRI, 2016). There are four key recommendation areas produced from this partnership:

(1) Provide a mechanism to make copy and paste material easily identifiable
(2) Ensure that provenance of copy and paste material is readily available
(3) Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste
(4) Ensure that copy and paste practices are regularly monitored, measured and assessed.

These recommendations are valid for any health care setting utilising information systems. Whilst there are currently technical limitations around recommendation 1 and 2 (future information system upgrades will bring new functionality to address these recommendations), recommendations 3 and 4 can be addressed locally.

It is however noted that Cerner/Oracle does not have the capability at this time. With NSW moving to a Single Digital Patient Record (SDPR) we are unsure what functionality will be available within EPIC for copy and paste.

## 3. RESPONSIBILITIES

### 3.1 Clinicians are responsible for:

- As a general principle, avoiding or not copying and pasting information within clinical information systems, including ensuring the correct patient and encounter
- As the author of a clinical document, the clinician is the person responsible for ensuring all information is accurate and appropriate
- When a clinician feels it is necessary to copy and paste clinical information, they should do so with caution understanding potential risks, how to identify them if they occur and how to correct them.

### 3.2 Clinician managers are responsible for:

- Ensuring clinicians are provided with knowledge and education materials in relation to documentation.

### 3.3 Health Information Units and EMR training and Support teams are responsible for:

- Ensuring there is procedural knowledge and education materials available for all staff who may be documenting within clinical information systems
- Ensuring that clinical staff are advised that the practice should be avoided due to the risks attached.

### 3.4 Digital Health is responsible for:

- Continuing to investigate technical solutions that will allow for appropriate automatic referencing (quotation of source) when copy / paste or equivalent functionality is utilised
- Co-ordinate development / updating of Quick Reference Guides (QRGs) as required
- Communicating enhancements on documentation copy / paste or equivalent functionality to relevant stakeholders.

### 3.5 SESLHD Health Records & Medico-Legal Committee are responsible for:

- Ongoing ownership of this procedure.

## 4. DEFINITIONS

- **Copy and Paste** – to copy information from a document and put it somewhere else (e.g. into another document)

- **Clinician** – Referring to any medical, nursing or allied health professional who may be documenting within the patient record

- **eMR** - Electronic Medical Record. The Cerner/Oracle eMR is the primary system in use across SESLHD; however, this procedure is relevant to any clinical information system where copy / paste functionality may be utilised.

## 5. PROCEDURE

### 5.1 Avoid use of Copy and Paste functionality where possible

- Copy and pasting can produce unintended consequences and risks. Clinicians and non-clinical staff using copy and paste in clinical information systems should be aware of such risks. These include:
  - Information from one patient being copied and pasted into another patient record
  - Inaccurate, or non-current, information being pasted
  - Information pasted is not relevant to the current visit
  - Sensitive information is pasted into new documents inappropriately
  - Information copied is not identified as copied text and original author may not be referenced
  - Inappropriate information is sent on external correspondence
  - Medico-legal issues associated with above.

### 5.2 When copying, clinicians should:

- Ensure you are copying information from the correct patient record
- Ensure you are copying relevant / applicable and accurate information
- Where possible, include the original author and date / time stamp of information
- Try to avoid copying tables, images and signature as it may corrupt the new document when created.
- Where copying an external document into eMR to avoid corruption it is recommended that the external document is saved in a rich text format (RTF) format or to copy into notepad.

### 5.3 When pasting, clinicians should:

- Ensure you are pasting information onto the correct patient record
- Ensure you are pasting information onto the correct document type and encounter (patient visit)
- Once pasted, ensure that the information is accurate
- Include the source author with date and time where applicable.
- Where pasting into eMR to avoid any corruption of documentation it needs to be pasted from a rich text format (RTF) saved document or from notepad.

### 5.4 Signing documentation:

- All documents should be signed by the author in the information system.
- The author is responsible medico-legally for all the content included within their documentation, including any copied and pasted information.
- Saved documents should never be left unsigned in the eMR patient record at discharge.
- Unsigned documents are rendered as ‘not verified’ in the system.

## 6. DOCUMENTATION

- eMR Quick Reference and Training Guides.

## 7. AUDIT

- Auditing of copy and paste should be included within clinical documentation audits performed by respective Health Information Units when such functionality is available
- Auditing of this may prove difficult if there is no source quoted and would be on a best-effort basis
- Auditing may capture the identification of copy / paste, accuracy and source inclusion.

## 8. REFERENCES


- NSW Ministry of Health Policy Directive - PD2012_069 Health Care Records - Documentation and Management
- ECRI, 2016. Partnership for Health IT Patient Safety, Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste.


## 9. VERSION AND APPROVAL HISTORY

| Date | Version | Version and approval notes |
|---|---|---|
| 9 June 2017 | DRAFT | Lee Speir – initial draft |
| July - September 2017 | 0.1 | Reviewed: SESLHD Health Records and Medicolegal Working Party |
| 25 October 2017 | 0.2 | Approved: SESLHD Health Records and Medicolegal Working Party |
| 23 May 2018 | 0.3 | Review following Draft for Comment in April 2018<br>Reviewed and Approved: SESLHD Health Records and Medicolegal Working Group |
| July 2018 | 1 | Processed by Executive Services prior to submission to SESLHD Clinical and Quality Council |
| August 2018 | 1 | Endorsed by SESLHD Clinical and Quality Council |
| April 2020 | 1 | Executive Sponsor updated to Director Corporate and Legal Services. |
| August 2020 | 2 | Minor review made by the SESLHD Health Records and Medico Legal Committee. National Standards updated to version 2. Executive Sponsor, Author and Position Responsible for the document updated. Section 5.4 updated. |
| September 2020 | 2 | Approved by Executive Sponsor. Published by Executive Services. |
| August 2022 | 3 | Minor review made by the SESLHD Health Records and Medico Legal Committee |
| July 2023 | 4 | Final review and edits made with additional point added to 5.2 and 5.3 prior to submission |
| 13 June 2025 | 4.1 | Minor review by the SESLHD Health Records and Medicolegal Committee: added information to background from a coroners recommendation, update to Cerner to new vendor Oracle, and reference link update. Approved by Executive Sponsor. |