

PROFESSION

EHRs: "Sloppy and paste" endures despite patient safety risk

Copying and pasting information is common within EHRs, but the practice sometimes can lead to confusion and endanger patient care.

By KEVIN B. O'REILLY, amednews staff. Posted Feb. 4, 2013.

During the winter holidays, a patient at Yale-New Haven Hospital in Connecticut had a large pressure ulcer with an abscess. A surgical intern made a note in the patient's electronic health record that said, "Patient needs drainage, may need OR."

The problem? The same note appeared for several consecutive days, even after a surgical team successfully drained the abscess. The intern had copied and pasted the previous day's note, but failed to appropriately update it to reflect the fact that the drainage was done. The note confused the consulting infectious disease team and nearly led to an unneeded change in the patient's antibiotic regimen.

General internist Leora Horwitz, MD, was serving as attending physician and clarified the electronic record.

"I knew [the note] was rubbish," she said.

The practice of carelessly copying and pasting previous information, often dubbed "sloppy and paste," is on the decline at Yale-New Haven Hospital but is widespread across medicine and can lead to mix-ups that sometimes harm patients, research shows.

"It's especially problematic when you have multiple teams taking care of the patient and we're communicating through the chart, which happens very often nowadays because physicians don't see each other as often as we used to," said Dr. Horwitz, assistant professor of medicine at Yale University School of Medicine. "We do rely on the chart in many cases, and it can lead to genuine confusion."

Taking a shortcut

A study in February's *Critical Care Medicine* found that copying and pasting is the rule in EHRs rather than the exception.

Using a software program that can detect identical matching word sequences, researchers examined the assessment-and-plan portions of more than 2,000 progress notes for 135 patients created by 62 residents and 11 attending physicians working in a Cleveland medical intensive care unit. For the residents, 82% of the notes contained 20% or more copied text, while 74% of attending doctors' notes also exceeded that rate of copying and pasting.

A similar study in the January-February 2010 issue of *Journal of the American Medical Informatics Assn.* found a copy-and-paste rate of 78% in sign-out notes generated by internal medicine residents. The rate of copied text in progress notes was 54%, the study said.

Such findings are representative, said Robert Hirschtick, MD, who has written widely about sloppy and paste. He is associate professor of medicine at Northwestern University Feinberg School of Medicine in Chicago.

"It's an epidemic," he said. "And it's among people who should know better. The common characteristic is that it's a tremendous time-saver to take this shortcut for people too busy to do it the right way. The right way is to make sure everything in that note you're about to sign reflects what's going on today."

At times, careless copying and pasting has made Dr. Hirschtick's job more difficult. On one occasion, he was called to consult on the case of a patient in a coma, experiencing postoperative complications. He visited the family and began by noting that the patient was only on his third day in recovery from surgery.

"They looked at me like I was from Mars," he said. The patient's surgery had taken place more than a month before the meeting with the family.

"For the previous 5½ weeks, the note said 'post-op day No. 2,' and was copied and carried forward day after day," Dr. Hirschtick said. "I said, 'Oh, I'm sorry. I misread the note,' but I never did fully recover from that. Why would this family believe what I had to say after that?"

Other times, patients are harmed. In a July/August 2007 case study in *AHRQ WebM&M*, an online patient safety journal, William Hersh, MD, described the case of a 77-year-old woman hospitalized for diarrhea and dehydration after chemotherapy.

An intern noted that the patient would receive heparin to prevent venous thromboembolism. The note was copied and pasted for four days in a row and signed by a resident and an attending physician, who appeared to believe the heparin had been ordered and administered. Ultimately, the patient was discharged without ever receiving the preventive medicine and two days later was rehospitalized and diagnosed with a pulmonary embolism. Only then did physicians realize the patient never got the correct prophylaxis.

"The problem is getting worse now with the rise of EHRs," said Dr. Hersh, professor and chair of the Dept. of Medical Informatics and Clinical Epidemiology at Oregon Health & Science University in Portland.

OIG plans to scrutinize note "cloning"

The Dept. of Health and Human Services' Office of Inspector General says it is concerned about misuse of copy-and-paste in electronic systems. In October 2012, the OIG announced that it plans to review multiple EHR notes for the same patient by the same physician to see whether doctors are copying and pasting the identical note from visit to visit. The practice is sometimes called cloning and could be implicated in fraudulent coding and billing practices.

Although disabling the copy-and-paste function in EHRs would eliminate the problem, it also would make documentation much more time-consuming. There seems to be consensus among physicians, patient safety and health IT experts that such a move would be overkill. Others suggest that EHR systems automatically flag copied-and-pasted text by highlighting or underlining it, though some experts worry that would make long progress notes even more difficult to quickly scan and comprehend.

In 2011, the Dept. of Medicine at Weill Cornell Medical College in New York created EHR documentation guidelines to emphasize that copy and paste "should be used with extreme care," and that text carried forward should be properly updated.

John Halamka, MD, calls for a more radical fix.

"The way we document in medicine has grown up over decades for medical reasons, for billing, for medical-legal justification," said Dr. Halamka, chief information officer at Beth Israel Deaconess Medical Center in Boston. "You wind up with 17 pages of replicated and duplicated and challenging-to-read documentation. I propose we blow up the way we do documentation altogether and replace it with a Wikipedia-like structure."

Such an approach would allow physicians to edit the progress note collaboratively, just as the popular open-source encyclopedia is updated. Dr. Halamka hopes to pilot-test the idea within the next year.

"With that concept, you wouldn't ever really need to copy and paste," he said.

ADDITIONAL INFORMATION:

5 ways to avoid copy and paste errors

Tools commonly available in electronic health records that allow physicians to copy and paste or "copy-forward" patient information should be used with "extreme care," say guidelines on EHR documentation adopted in 2011 and revised in 2012 by Weill Cornell Medical College's Dept. of Medicine in New York. The guidelines, distributed to every incoming intern and fellow, advise physicians to:

- Avoid copying and pasting of text from another person's note without attribution, as that is plagiarism and may constitute billing fraud.
- Avoid repetitive copying and pasting of laboratory results and radiology reports.
- Note important results with proper context, and document any resulting actions. Avoid wholesale inclusion of information readily available elsewhere in the EHR because that creates clutter and may adversely affect note readability.
- Review and update as appropriate any shared information found elsewhere in the electronic record (e.g., problems, allergies, medications) that is included in a note.
- Include previous history critical to longitudinal care in the outpatient setting, as long as it is always reviewed and updated. Copying and pasting other elements of the history, physical examination or formulations is risky, as errors in editing may jeopardize the credibility of the entire note.

Source: "Electronic Health Record Documentation Guidelines V 1.2, 2012-2013," Dept. of Medicine, Weill Cornell Medical College, New York-Presbyterian Hospital

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"Copy and Paste," *WebM&M*, Agency for Healthcare Research and Quality, July/August 2007 (webmm.ahrq.gov/case.aspx?caseID=157)

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