

Clinical Documentation for Pharmacists

May 24, 2008

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Clinical Scenario #1

You are a pharmacist working in a local community pharmacy. Mrs. Jennie Roberts is a 32-year-old nurse who often works night shifts. She comes to ask you a question about an alternative antihistamine for her allergic rhinitis symptoms. She reports a history of allergic rhinitis, usually occurring during the spring months, starting about one month ago and usually lasting 2 or more months. She reports having bothersome nasal congestion, runny nose, sneezing, as well as red itchy eyes which seem to be worse this year compared to previous years. She has been taking loratadine (Claritin®) 10 mg once daily in the morning for the last 3 weeks with little benefit. She has not tried any other medications. She does not complain of cough or fever. The only other medical condition she has is asthma for which she currently takes Advair 250 diskus, 1 puff BID. She has a drug plan through her employer. You would like to suggest a nasal corticosteroid.

Exercise # 1: Prepare a brief documentation note that reflects the care provided

Jennie Roberts 101 Main Street	Pharmacist Consultation Note	Date:

Exercise # 2: Choose one of the structured formats and main components from Table 1 below and re-write your note

Jennie Roberts 101 Main Street	Pharmacist Consultation Note	Date:
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Clinical Scenario #2

You are a hospital pharmacist on a surgical ward. Mr. Jerry Tomkins is a 60 year old retired teacher who was admitted 3 days ago for cardiac observation following an episode of symptomatic atrial fibrillation. He has been receiving warfarin prior to and during his hospital admission. Routine screening on admission identified colonization with MRSA. He has tested positive previously despite following decolonization protocols. The infectious disease team started him on the following decolonization protocol yesterday: doxycycline, rifampin and fucidic acid for 5 days. The pharmacy department in your hospital has an anticoagulation service. Mr. Tomkin's INR is 2.8 today on 3 mg of warfarin and he is to be discharged tomorrow afternoon. You suggest a warfarin dosage change and make plans to discharge warfarin monitoring to his family physician.

Exercise # 1: Prepare a brief documentation note that reflects the care provided

Jerry Tompkins 102 Main Street	Pharmacist Consultation Note	Date:

Exercise # 2: Choose one of the structured formats and main components from Table 1 below and re-write your note

Jerry Tompkins 102 Main Street	Pharmacist Consultation Note	Date:

Table 1. Sample of Main Components for a Comprehensive Medication Assessment

General Categories	Key Components
Introduction	<ul style="list-style-type: none"> \ Date, time \ Identification of pharmacy note \ Patient name \ Referring health care provider \ Brief description of reason for referral (e.g. who initiated consult and patient contact)
Heading or Summary of Problems and Solutions	<p>If multiple drug-related problems or issues have been identified a short summary of the main drug-related problems or issues identified and a brief statement of pharmacist recommendations can be included at the beginning of the note.</p>
Data or Findings: Compilation of subjective and objective data and medication history	<ul style="list-style-type: none"> \ Chief complaint or patient concern \ Pertinent demographic information about the patient. \ Subjective (S): include patient complaints or concerns that are reported by the patient or by other health care providers and are based on subjective observations and experiences. \ Objective (O): data based on measurements or documented facts \ Medical History \ Medication History (e.g. current and past medications) \ Compliance Assessment (if applicable) \ Drug Allergies/Intolerances \ Relevant family or social history
Assessment	<ul style="list-style-type: none"> \ A description of the actual or potential drug-related problem. \ Supporting rationale for drug-related problem. \ Identification of goals or desired outcomes of therapy \ Brief discussion of therapeutic alternatives including relevant considerations (e.g. efficacy, precautions, drug interactions, side effects, cost and convenience) if appropriate.
Recommendation(s)	<ul style="list-style-type: none"> \ Brief summary of solution focused recommendation and/or therapeutic plan to resolve the patient's drug-related problem.
Plan	<ul style="list-style-type: none"> \ What action you have taken (e.g. patient education, discussion with physician) or needs to be taken by the physician or by the patient \ Plan for monitoring (e.g. efficacy, side effects) \ Follow up that will be performed by yourself or another health care provider (e.g. what, when and who will be responsible)
Closing	<ul style="list-style-type: none"> \ Closing statement (if appropriate) \ Signature, designation and contact information
References	<ul style="list-style-type: none"> \ Citation and attachment of evidence selected (if appropriate)

From: Kennie N, Farrell B, Dolovich L. Demonstrating value, documenting care — lessons learned about writing comprehensive patient medication assessments in the IMPACT project, Part I. Can Pharm J 2008;141(2):114-9.