

## Clinical Documentation for Pharmacists

Natalie Kennie, BSc(Pharm), PharmD  
Clinical Pharmacist  
Summerville Family Health Team  
Mississauga, ON

## Learning Objectives

- Describe the key reasons for and benefits of documentation
- Describe professional obligations related to standards of practice, legal considerations and confidentiality
- List the essential components that should be included in a documentation note
- Identify formats for structured and unstructured notes
- Draft a documentation note for a sample case scenario

## Recent Articles

- 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.
- Farrell B, Kennie N, Dolovich L. Demonstrating value, documenting care — lessons learned about writing comprehensive patient medication assessments in the IMPACT project, Part II. Can Pharm J 2008;141(3): 182-8.

## Documentation is...

- A record of data collected;
- A description critical thinking and judgment used in identifying and addressing any drug-related problems;
- A description of events or discussions that have occurred with patients and/or their caregivers.

## Why should I document?

- When taking responsibility for a patient's drug-related needs, pharmacists are professionally obliged to maintain a record of care for their patients.

## Keys Reasons for Documentation

- To establish the pharmacist's accountability and responsibility for the medication-related aspects of patient care.
- To communicate with other health care professionals and help them safely manage medication-related care.
- To meet professional standards and legal requirements for the documentation of patient care.

## Benefits of Documentation

- Record of care for follow up and continuity of care.
- Demonstrate pharmacists' value to physicians and other health care providers.
- Justification for reimbursement for pharmacist services.
- Estimation of workload measurement and staff allocation.

## Professional Standards

- Documentation standards have been suggested from a variety of professional organizations...
- Web-based resources:
  - [www.napra.org](http://www.napra.org) The website contains samples of various documentation forms such as the therapeutic thought process, pharmacy care plan and PMDRP.
  - [www.cshp.ca](http://www.cshp.ca) An information paper on documentation of pharmaceutical care in the health care record. CSHP Official Publications. Bayliff, C., & Bajcar, J. (1997). Direct patient care curriculum: Pharmaceutical Care Education Modules, Module #5. Canadian Society of Hospital Pharmacists.
  - [www.ocpinfo.com](http://www.ocpinfo.com) Documentation guidelines for pharmacists 2004. Pharmacy Connection 2004 (Jan -Feb): 8-12.
  - [www.ashp.org](http://www.ashp.org) ASHP Guidelines on documenting pharmaceutical care in patient medical records.

## Pharmacist Prescribing

- CPhA Position Statement on Pharmacists Prescribing (2007): "Actions related to medication management need to be communicated verbally, in writing or through electronic media, when appropriate, to other health care providers in the circle of care and all actions should be supported by documentation." [www.pharmacists.ca](http://www.pharmacists.ca)
- ACCP Position Statement: Collaborative Drug Therapy Management by Pharmacists (1997): "When pharmacists participate in any aspect of collaborative drug therapy management, they must document their activities in the patient's medical records. This information should be available to other health care providers within the health system." [www.accp.com](http://www.accp.com)

## Legal Considerations and Liability

- The patient's health record is created every time documentation occurs.
- Documentation is essential for tracking the consultation or history of the pharmacist-patient interaction that would be required in the case of litigation.
- Without documentary records, a court would have no concrete evidence of the care provided and defense of malpractice litigation would be difficult.
- Incomplete documentation or complete documentation that reveals substandard professional practice increases liability and complete documentation that is consistent with an agreed upon standard of care decreases liability.

## Confidentiality

- Implied patient consent is acceptable within the 'circle of care' including health care providers who deliver care and services for the primary therapeutic benefit of the patient.
- However, providing patients information about the collection, use and disclosure of their personal information is required as part of the consent process. This includes:
  - What information is being collected and how the information will be used
  - Who the information will be shared with
  - Their right to seek access to their own personal information and to have amendments made to that information
  - Their right to submit complaints about the pharmacy's/pharmacist's personal information practices
- Hard copies or electronic records must be stored, used, disclosed and discarded in such a way to ensure patient confidentiality.
- All transfer of consultation notes and sharing of patient health information with other health care providers must be done in a confidential manner.

Canadian Pharmacists Association. Complying with the pharmacist's privacy code and PIPEDA: guidelines and tools for pharmacists. [www.pharmacists.ca](http://www.pharmacists.ca)

## Effective documentation should...

- Be clear, logical and precise
- Be diplomatic and use an appropriate tone
- Be legible, non-erasable (in ink)
- Use abbreviations that are clear and common to health care providers
- Contain all information deemed necessary to support the drug-related problem, clinical decisions and recommendations and pharmacist's actions
- Occur immediately after the activity
- Not delete, remove or rewrite any notes from any part of the health care record

## Challenges with documentation

- Finding time
- Being concise enough for the clinician to read and understand the note but complete enough to reflect all information gathered and decisions made
- Storage and retrieval when needed

## Case Exercise # 1

- Choose one of the case scenarios in the handout and prepare a brief documentation note that reflects the patient care provided.

## Identified Essential Components

- Date of note
- Identification of person(s) involved
- Why the patient was seen/reason for consult
- Patient complaint or concern
- Background patient information/data collected
- Drug-related problem or issued identified
- Pharmacist's assessment, interventions and recommendations
- Care plan developed
- Collaboration with other health care providers
- Follow up
- Identification, signature

## New Brunswick Proposed Requirements for the Record of Prescribing

- 20 (1) A pharmacist who issues a prescription must make and retain a record of:
- (a) the client's name and address;
  - (b) the circumstances under which the drug was prescribed;
  - (c) the rationale for prescribing;
  - (d) a summary of the pharmacist's assessment of the client;
  - (e) the date of the prescription;
  - (f) the name of the drug prescribed, the strength (where applicable) and quantity of the prescribed drug, or duration of treatment;
  - (g) the directions for use;
  - (h) the number of refills available to the client;
  - (i) the name, address, and telephone number of the pharmacist issuing the prescription;

## New Brunswick Proposed Requirements for the Record of Prescribing

- 20 (1)  
(j) any additional information that is necessary for colleagues to provide continuity of care;  
(k) a follow-up plan that is sufficiently detailed to monitor the patient's progress and ensure continuity of care by the pharmacist, or other regulated health professionals or caregivers, if applicable; and  
(l) the date and method of notification of other pertinent care givers of the client.
- Method of keeping prescribing records  
20(2) The information required by section 20(1) may be recorded and retained in a readily retrievable manner electronically, or in written form.
  - Notification to other health professionals  
20(3) The pharmacist, when prescribing a drug, treatment or device, will notify the client's primary care giver.

## Structured Formats

- SOAP (Subjective, Objective, Assessment, Plan)
- FARM (Findings, Assessment, Recommendations, Monitoring)
- DRP (Drug-Related Problem, Rationale, Plan)
- DAP (Data, Assessment, Plan)
- DDAP (Drug-Related Problem, Data, Assessment, Plan)

## Unstructured Notes

- Free-form records of patient encounters.
- At a minimum these notes must be signed and dated.
- May be appropriate when general impressions or patient contact descriptions are noted but no specific action on the part of the pharmacist or physician is required at the time.

## Things to think about...

- Purpose of the note (e.g. pharmacy records, recommendations to physician)
- Who will be reading the note (e.g. physician, covering pharmacist)
- Whether it is a first assessment or follow up
- The pharmacist's activity (e.g. medication review, OTC counseling, prescribing, drug dosing)
- How much information is known by other health care providers involved in the care of the patient
- Who is involved in the patient's care

## Case Exercise # 2

- Choose one of the structured formats discussed and re-write your first documentation note for the case scenario.

## Practical Suggestions...

- Provide the context for the assessment
- Be specific about data sources, history and timing
- Include the patient perspective
- Include necessary information (like lab values and targets) while still being concise
- Focus on solutions not problems

## Practical Suggestions...

- Organize notes with multiple drug-related issues and accompanying recommendations
- Make recommendations that are easily implemented
- If suggesting monitoring be specific about what should be monitored, how often and who will take responsibility
- Make reference to evidence-based resources
- Be diplomatic and choose the right words

## IMPACT Reflections

- Physicians who reviewed the pharmacists' documentation notes began to have clearer expectations of the pharmacists role
- Receiving consult notes seemed to demonstrate the value of the pharmacists assessment and often generated more referrals
- Peer support and feedback was important for improving confidence in documentation

## Getting Started...

1. Identify a patient (e.g. medication review, OTC counseling, medication recommendation, etc)
2. Make a draft outline of the note
3. Choose one of the common formats and try it out
4. Get another pharmacist or physician to review the note for organization, clarity and appropriate amount of detail
5. Create a method for storing documentation notes in confidential manner