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We were interested in pursuing this research because we realized that clinical documentation was a developing skill for many pharmacists and they may benefit from a step-by-step approach. *Nous étions intéressés à mener cette recherche, car nous avons constaté que la documentation clinique est un domaine de compétences que cherchent à développer bon nombre de pharmaciens et que ceux-ci pourraient profiter d'une démarche étape par étape.*

Demonstrating value, documenting care: Lessons learned about writing comprehensive patient medication assessments in the IMPACT project

PART I: Getting started with documenting medication assessments

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This is the first article in a 2-part series describing the documentation approach used in and lessons learned from the comprehensive patient medication assessments written by pharmacists who integrated into family practice sites as part of the Ontario Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics (IMPACT) project. The main objectives of these articles are to discuss issues related to pharmacist documentation of comprehensive medication assessments and to provide strategies, tools, and tips to support the development of pharmacist documentation skills for the primary care setting.

The IMPACT experience

The IMPACT project was a large-scale demonstration project funded by the Ontario Primary Health Care Transition Fund Project, in which 7 nondispensing pharmacists were integrated into 7 different family physician group practices between June 2004 and July 2006. The pharmacists varied in their level of education (6 bachelor level, 1 doctor of pharmacy level) and in their previous and concurrent work settings (hospital, long-term care, and community pharmacies).¹ They participated in a training workshop² and received mentorship from pharmacists with advanced clinical training and experience in

ambulatory or primary care. The IMPACT pharmacists then worked approximately 2.5 days per week over the 2-year period, conducting comprehensive medication assessments for patients, providing drug information and education for health care providers, and implementing approaches to optimize drug prescribing and use within the practice.

Comprehensive medication assessments were carried out for patients who were referred by family physicians and involved the following:

- A review of the medical chart
- A patient interview to gather information on current and past medication history, adherence, and patient-reported medication issues
- Identification of drug-related problems and therapeutic dilemmas
- Provision to the physician of solution-focused recommendations for optimizing drug therapy through discussion and written documentation
- Working with the physician and other team members to develop and implement medication changes, education, or monitoring related to medication use

Before the pharmacists joined the 7 practices, we (the authors) used our collective experience in writing patient consults, as well as in teaching and evaluating pharmacist documentation skills, to

identify the challenges we thought they might face and develop strategies to help them document successfully. Some of these challenges and strategies are outlined below.

Challenges

Some of the common issues pharmacists tend to discuss when the subject of documenting patient care arises include the following:

- Why should I document?
- What do I need to know about professional standards, legal considerations, and liability?
- I didn't learn this in school; how do I get started?

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.³ Such a record involves documenting information collected by the practitioner, decisions made, and actions taken.⁴ Over 15 years' worth of literature, key opinions, professional guidelines, and other texts have discussed and listed the many reasons why pharmacists should document the results of their medication assessments as part of a permanent patient care record that is available to all health care providers in the practice.⁵⁻⁹ The reader is referred to "Documentation Requirements for Seamless Care" in *Seamless Care: A Pharmacist's Guide to Continuous Care Programs* for an excellent summary of the topic.¹⁰ Some of the key reasons for documentation include:

- 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 (including continuity of care within a closed practice environment and between practice sites)
- To meet professional standards and legal requirements for the documentation of patient care (similar to other health care providers in the practice)

Indeed, by documenting patient care activities, pharmacists can demonstrate the value of in-depth medication assessments to physicians, who commonly do not know what to expect from such a service. Documentation also provides a tangible product that can serve a variety of management functions, including workload management, staff allocation justification, and reimbursement justification.¹¹

What do I need to know about professional standards, legal considerations, and liability?

Canadian and American pharmacists' licensing and professional organizations have developed guidelines for patient care documentation that serve as professional standards.^{5,12,13} These guidelines describe documentation as a record of data collected; critical thinking and judgment used in identifying and addressing any drug-related problems; and descriptions of events or discussions that have occurred with patients and/or their caregivers.⁵

Documentation is a mandatory step in the clinical process for all health care providers, and the resulting information becomes a legal document. A portion of a patient's health care record is created every time documentation occurs; health care providers have ethical and legal obligations regarding the manner in which this record is obtained, retained, used, and released,^{14,15} and patients have a legal right to access their medical record and any documentation involving their health care, including pharmacists' notes. If copies are retained, whether hard copies or electronic records, they must be stored, used, disclosed, and discarded in such a way as to ensure patient confidentiality. Similarly, all transfer of consultation notes and sharing of patient health information with other health care providers must be done in a confidential manner.¹⁶

Documentation, ironically, has the potential to both increase and decrease liability for the pharmacist. Liability attaches when the standard of care falls below what a reasonable pharmacist would have done in the same set of circumstances, and documentation may show whether or not the standard of care was met. Incomplete documentation or complete documentation that reveals substandard professional practice increases liability; complete documentation that is consistent with an agreed-upon standard of care decreases liability. Courts rely on such documentation, along with legislation and precedent or previously decided court cases, to make decisions. Without documentary records, a court would have no concrete evidence of the care provided, and pharmacists would have difficulty

Key points

- By documenting patient care activities, pharmacists can demonstrate the value of in-depth medication assessments to physicians, who commonly do not know what to expect from such a service.
- This article describes the importance of documenting patient care, legal considerations, examples of common formats used by pharmacists, and strategies (including web-based resources) employed by the IMPACT team that readers can use to begin enhancing their own documentation skills.
- Pharmacists who are beginning to perform medication assessments and document their recommendations for physicians will find this of interest, as will pharmacy educators involved in designing curricula and teaching documentation skills.

defending themselves in malpractice litigation. In practical terms, health care professionals who normally see large numbers of patients cannot begin to remember the details of a consult that occurred months or years previously. Documentation is essential for tracking the consultation or the history of the pharmacist-patient interaction. However, documentation also indicates what has been done or is planned and can put the pharmacist at potential risk if recommendations are not based on valid information and professional judgment or are not followed up appropriately.¹² Readers are referred to an article by Lahey et al. for an interesting discussion of the importance of competent and thorough documentation for interprofessional practice.¹⁷

To ensure that the record accurately reflects the care provided to the patient, the following points should be considered^{5,12,16}:

- Writing should be clear, logical, and precise.
- Communication should be diplomatic and use an appropriate tone.
- All abbreviations used should be clear and common to all health care providers.
- All documentation must be legible and non-erasable.
- Significant information should not be omitted purposefully. All information deemed necessary to support the drug-related problem and recommendations should be included.
- Documentation should occur immediately after the activity. Information should not be added out of sequence at a later date. If documentation of an intervention is unavoidably delayed, an indication that the note is a "late entry" should be made.
- Notes should not be deleted, removed, or rewritten from any part of the record.
- Other health care providers' notes should not be altered.
- Errors should be crossed out with a single line and initialed.

I didn't learn this in school — how do I get started?

The routine clinical documentation of medication assessments is a new skill for many pharmacists integrating into a family practice setting. Most of the IMPACT pharmacist applicants indicated in their interviews that, while they had some experience writing notes to physicians, they felt this was an area in which their skills could be improved. A similar learning need was identified in previous work conducted by IMPACT researchers.¹⁸ As a result, we explored a variety of strategies to help the IMPACT pharmacists "hit the ground running" when they began working in

BOX 1 Essential components of patient care documentation^{5-9,19-21}

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

the family practices, some of which are discussed in the next section.

Strategies for getting started with documenting care

Prior to integration

Before pharmacists joined the practices, they were provided with clinical documentation guidelines and sample consult notes. These are available at www.impactteam.info (see the Resource Downloads section), and components such as a standard template and format are briefly described below. In addition, pharmacists attended a transitional training program² that included a simulator experience in which pharmacists were required to document the results of a patient interview and their recommendations to a physician.

Soon after integration

In the first few weeks after the pharmacists joined the practices, pharmacist mentors (those with more clinical experience working in primary or ambulatory care) worked closely with the IMPACT pharmacists, reviewing their initial medication assessment consultations and providing feedback using their own experience and clinical judgment, before the assessments were provided to physicians. As well, the integrating pharmacists met with physicians to review the first few patient assessments and documentation notes to get physician input on note format, the amount of detail required, and overall clarity. Pharmacists were encouraged to alter the format of their clinical documentation based on the needs of the specific project sites.

TABLE 1 Sample 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	<ul style="list-style-type: none"> • If multiple drug-related problems or issues have been identified, a short summary of the main drug-related problems or issues and a brief statement of pharmacist recommendations can be included at the beginning of the note
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: 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: 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 the 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"> • Action(s) you, the physician, or the patient need to take (e.g., patient education, discussion with physician) • Plan for monitoring (e.g., efficacy, side effects) • Follow-up that will be performed by you 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)

Later stages

As time went on, pharmacists met regularly via teleconference, MSN chat, and e-mail to share experiences and work on improving the success of their documentation approaches.

Writing about drug-related problems and creating solution-focused recommendations

There are a number of components considered essential by international experts to complete a

pharmacist consult note^{5-9,19-21} (Box 1). Readers are encouraged to review the Canadian Society of Hospital Pharmacists' *Direct Patient Care Curriculum Module 5* for a description of the rationale for each component.²⁰ We also recommended that the IMPACT pharmacists include a brief summary of their solution-focused recommendations on the first page of the consult note so that other busy health care providers could read it quickly. By organizing components into a standard format or template, pharmacists could

Points clés

- En documentant les activités axées sur les soins aux patients, les pharmaciens peuvent démontrer aux médecins la valeur d'une évaluation approfondie de la pharmacothérapie, car les médecins ne savent souvent pas quoi attendre d'un tel service.
- Le présent article décrit l'importance de documenter les soins aux patients, examine les considérations juridiques qui y sont liées et propose des modèles de formats couramment utilisés par les pharmaciens ainsi que des stratégies (y compris les ressources Web) utilisées par l'équipe de l'initiative IMPACT, pour aider les lecteurs à améliorer leurs aptitudes en matière de documentation.
- Cet article saura intéresser les pharmaciens qui commencent à faire des évaluations de la pharmacothérapie et à documenter leurs recommandations destinées aux médecins ainsi que les enseignants en pharmacie qui participent à la conception des programmes d'études et à l'enseignement des aptitudes en matière de documentation.

ensure that their consult note became quickly recognizable by members of the practice.

When it comes to documenting individual drug-related problems and solution-focused recommendations in a consult note, there are a variety of structured approaches that can be used. Each approach includes the same type of information, simply ordered in a different way. These formats are commonly referred to as the following:

- 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)

The use of a standard format such as the ones above encourages completeness of data, ensures consistency, and improves organization of thoughts.⁵ Most physicians are familiar with and use the SOAP approach, but regardless of the format chosen, it is helpful to use the same style, manner, and order

for each patient assessment. Table 1 provides a sample of the main components that should be included in a comprehensive medication assessment.

Unstructured notes are free-form records of patient encounters and care and may also be used for documenting patient care activities. At a mini-

mum, these notes must be signed and dated, with a legible name and contact information.⁵ This type of note may be appropriate when general impressions or patient contact descriptions are noted but no specific action on the part of the pharmacist or the physician is required at the time.

Overall, the format and approach used for documentation depends on practice site preferences, personal communication style, and the minimum requirements for pharmacist standards of practice. Some additional general documentation habits to consider include consistency in terminology and numbers, consistency in the use of drug names (usually generic [brand]), and re-reading documentation after it has been written to ensure that it is complete and accurate. The Web Resources Box contains a number of web-based resources that provide examples of different formats and approaches that can be used.

Reflection

Physicians may not always recognize how pharmacists can contribute to medication-related patient care until they see it in writing. As the first weeks passed in the IMPACT project, it became clear that the physicians involved began to have clearer expectations about the pharmacist role once they had reviewed a few consult notes. Receiving consult notes seemed to demonstrate the value of the pharmacist's patient assessment and often generated more referrals. As more and more pharmacists began consulting with family physicians and providing comprehensive medication assessments, standard documentation approaches were useful for ensuring consistent quality of care and justifying reimbursement for cognitive services.

Next steps

The next article will describe more IMPACT documentation experience, how documentation changed over the course of the project, and practical suggestions for writing documentation notes that will make an impact.

In the meantime, it may be helpful to remember that developing good documentation skills takes time and effort. These suggestions may help you get started:

1. Identify a patient who needs a comprehensive medication assessment and documentation.
2. Make a draft outline of the note (with the essential documentation components) right after the medication assessment to improve the organization of the note and avoid omitting information.
3. Refer to the IMPACT website (www.impact-team.info, Resources Download section) for

Web resources

- IMPACT program, www.impactteam.info, Resource Downloads section: Documentation guidelines and sample notes for comprehensive medication assessments to support integrating pharmacists in developing their documentation skills.
- National Association of Pharmacy Regulatory Authorities, www.napra.org: Samples of various documentation forms, such as the therapeutic thought process, pharmacy care plan, and Pharmacists' Management of Drug-Related Problems.
- Canadian Society of Hospital Pharmacists, www.cshp.ca: An information paper on documentation of pharmaceutical care in the health care record.²⁰
- Ontario College of Pharmacists, www.ocpinfo.com: Documentation guidelines for pharmacists.⁵
- American Society of Hospital Pharmacists, www.ashp.org: Guidelines on documenting pharmaceutical care in patient medical records.¹³

examples of documentation notes and styles.

1. Choose one of the common formats (e.g., SOAP, DRP) for documentation and try it out.
5. Get another pharmacist or physician to review the note for organization, clarity, and appropriate amount of detail.
6. Create a method for storing documentation notes in a confidential manner. ■

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Acknowledgement: The authors would like to acknowledge the input of Marie Berry, BSc(Pharm), BA, LLB, to this publication.

This paper is published on behalf of the IMPACT team members. IMPACT was a large-scale demonstration project funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC) through the Primary Health Care Transition Fund. The views expressed in the report/paper are the views of the authors and do not necessarily reflect those of the MOHLTC.

References

1. Babcock K, Farrell B, Dolovich L, et al. Hiring a pharmacist to work in primary care: application for ambulatory and hospital pharmacy. *Can Pharm J* 2006;139:46-8.
2. Austin Z, Dolovich L, Lau E, et al. Teaching and assessing primary care skills: the family practice simulator model. *Am J Pharm Educ* 2005;69:500-7.
3. Cipolle RJ, Strand LM, Morley PC, eds. *Pharmaceutical care practice*. New York: McGraw-Hill; 1998.
4. Cipolle RJ, Strand LM, Morley PC, eds. *Pharmaceutical care practice*. 2nd ed. New York: McGraw-Hill; 2004.
5. Ontario College of Pharmacists. Documentation guidelines for pharmacists 2004. *Pharm Connection* 2004;Jan-Feb:8-12.
6. Schumock GT, Guenette AJ, Clark T, et al. Hospital main-frame computer documentation of pharmacist interventions. *Top Hosp Pharm Manage* 1993;13:16-24.
7. Sawyer WT. Do we have to document pharmacotherapeutic outcomes? *Top Hosp Pharm Manage* 1992;11:1-9.
8. Guerrero RM, Tyler LS, Nickman NA. Documenting the provision of pharmaceutical care. *Top Hosp Pharm Manage* 1992;11:16-29.
9. Rovers JP, Currie JD, Hagel HP, et al. *A practical guide to pharmaceutical care*. 2nd ed. Washington, DC: American Pharmaceutical Association; 2003.
10. Zwicker LA, MacKinnon NJ. Documentation requirements for seamless care. In: MacKinnon NJ, ed. *Seamless care: a pharmacist's guide to continuous care programs*. Ottawa: Canadian Pharmacists Association; 2003.
11. Bradberry JC, Srnka Q. Pharmacist compensation for ambulatory patient care services. *Am J Manag Care* 1998;4:1727-35.
12. Canadian Society of Hospital Pharmacists. An information paper on documentation of pharmaceutical care in the health care record. CSHP website. Available: www.cshp.ca/productsServices/officialPublications/index_e.asp (accessed January 16, 2008).
13. American Society of Health System Pharmacists. ASHP guidelines on documenting pharmaceutical care in patients' medical records. *Am J Health-Syst Pharm* 2003;60:705-7.
14. Canadian Pharmacists Association. Pharmacist's personal information privacy code. CPhA website. Available: www.pharmacists.ca/content/hcp/resource_centre/practice_resources/pdf/Pharmacist_PIPCode.pdf (accessed January 16, 2008).
15. National Association of Pharmacy Regulatory Authorities. Model standards of practice for Canadian pharmacists. Ottawa, ON: NAPRA; 2003. Available: www.napra.org/pdfs/practice/model_std_practice/MSPCP-Nov2005.pdf (accessed January 16, 2008).
16. Canadian Pharmacists Association. Complying with the pharmacist's privacy code and PIPEDA: guidelines and tools for pharmacists. CPhA website. Available: www.pharmacists.ca/content/hcp/resource_centre/practice_resources/pdf/PrivacyGuidelines_v1.pdf (accessed January 16, 2008).
17. Lahey W, Currie R. Regulatory and medico-legal barriers to interprofessional practice. *J Interprof Care* 2005;19(suppl 1):197-223.
18. Howard M, Trim K, Woodward C, et al. Collaboration between community pharmacists and family physicians: lessons learned from the Seniors Medication Assessment Research Trial. *J Am Pharm Assoc (Wash)* 2003;43:566-72.
19. Currie JD, Doucette WR, Kuhle J, et al. Identification of essential elements in the documentation of pharmacist-provided care. *J Am Pharm Assoc (Wash)* 2003;43:41-7.
20. Canadian Society of Hospital Pharmacists. In: Module 5, Documentation. Direct patient care learning modules: a curriculum for learning. Ottawa, ON: CSHP; 1997. Available at: www.cshp.ca/productsServices/otherPublications/directPatientCare_e.asp (accessed January 16, 2008).
21. Canaday BR, Yarborough PC. Documenting pharmaceutical care: creating a standard. *Ann Pharmacother* 1994;28:1292-6.