

Documentation of Medication Assessments

FHT Pharmacist Networking Meeting
June 23rd, 2008

Session Objectives

- Identify common issues related to clinical documentation of medication assessments for FHT pharmacists
- Describe professional obligations related to standards of practice, legal considerations and confidentiality
- List the essential components of a documentation note
- Identify formats for structured and unstructured notes
- Discuss lessons learned in documenting comprehensive medication assessments from the IMPACT project

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.

FHT Pharmacist Documentation

- What are common issues encountered in documenting pharmacist activities (facilitators, barriers, challenges)?

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.

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.

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 The website contains samples of various documentation forms such as the therapeutic thought process, pharmacy care plan and PMDRP.
 - 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 Documentation guidelines for pharmacists 2004. Pharmacy Connection 2004 (Jan -Feb); 8-12.
 - www.ashp.org ASHP Guidelines on documenting pharmaceutical care in patient medical records.

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

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 pharmacists actions
- Occur immediately after the activity
- Not delete, remove or rewrite any notes from any part of the health care record

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 issue identified
- Pharmacist's assessment, interventions and recommendations
- Care plan developed
- Collaboration with other health care providers
- Follow up
- Identification, signature

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, nurse)
- 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

Documenting in the EMR

- Use of standard templates or formats?
- How to "label" medication assessments?
- What aspects of the medical record should be altered and updated related to medications?
- How to use the EMR to aid in communicating pharmacist's recommendations?

Key lessons learned from the IMPACT project

Useful strategies to help improve documentation by the IMPACT project

- Clinical documentation guidelines (download section on www.impactteam.info)
- Transitional training program
- Review of pharmacist notes by mentors and feedback
- Meeting with physicians and asking feedback about notes
- Pharmacist peer meetings

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
- Use a summary box

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