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

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.nancy.org The website contains samples of various documentation forms such as the therapeutic thought process, pharmacy care plan and PMIDR.
  - www.nacpra.com Documentation guidelines for pharmacists 2004. Pharmacy Connection 2004 (Jan-Feb); 8-12.

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/physician’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.

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