The Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics (IMPACT) Clinical Documentation Guidelines

Rationale

Appropriate documentation of pharmaceutical care activities results in several beneficial effects for the patient, the pharmacist and the health care system: 1) efficient communication of recommendations for improving individual’s patient care, 2) demonstration of the role of the pharmacist in the patient’s care, and 3) promotion of continuity of care by other health care providers.¹

As an integral member of the health care team in primary care, like other health care providers, the pharmacist must document the health care provided. Clinical documentation also establishes accountability and responsibility for professional activities. The primary purpose of documentation is to convey information for use in patient care and serves as a tool for communication among health care providers.

Documentation should serve as your record of the data collected, critical thinking and judgement you used in identifying and addressing drug-related problems identified and to describe events or discussion that you have had with patients and/or their care givers.²

The following document outlines resources and guidelines from various pharmacy organizations (e.g. OCP, CSHP, NAPRA) and project co-investigators to serve as a guide to documenting pharmacist’s activities in primary care and the IMPACT project.

i. Types of Pharmacist Documentation

ii. Types of Pharmacists Activities that should be Documented

iii. Sample Formats for Clinical Documentation

iv. Practical Suggestions

v. A Family Physician Perspective

vi. Considerations for Initiating Pharmacist Documentation at IMPACT sites

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i. Types of Pharmacist Documentation

Documentation of pharmacist’s activities can take place as part of individual pharmacy records or directly in patient medical charts. These records can be paper-based, in a stand alone computer program or as part of an integrated electronic health care record. The principles of documentation are similar among these various medias.

1) Pharmacy Records

Pharmacy records are a means to collect and document relevant patient information for the pharmacist’s reference. Records may serve as a means to collect a complete patient
medication and medical history or part of the assessment process (e.g. therapeutic thought process or the Pharmacist's Management of Drug-Related Problems [PMDRP] form).

Pharmacy records may also include evidence of the pharmacist work up and problem identification, evidence used in the assessment and the detailed care plan (e.g. drug-related problems, interventions, desired outcomes, monitoring plan and follow up), flow sheets for disease or drug data collection and assessment, and an outline of disease or medication education points provided.

Potential information to gather and document in pharmacists record could include the following:

- Demographic data
- Medical diagnoses and conditions, patient signs and symptoms
- Current and past medications (e.g. indication, desired outcomes and response)
- Nonprescription drugs and alternative therapies
- Community pharmacy
- Adherence (e.g. physical and cognitive assessment)
- Allergies (including a description of reaction and the date)
- Drug intolerances (including a description of the reaction and the date)
- Laboratory and diagnostic tests
- Physicians, specialists and health care providers involved in care
- Family and social history
- Immunizations

All pharmacist records (if outside of medical documentation) must be kept confidential and protected from unauthorized access and securely stored in accordance to the Personal Information Protection and Electronic Documents Act.³

**Recommended resource for pharmacist documentation forms:**

[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.

2) Medical Chart/Health Records

Since the health record is the vehicle used by all health care providers to document plan and assessments, it is the best place for the pharmacist to communicate aspects of their assessment and care provided. Pharmacists must be able to demonstrate, through a permanent record, the recommendations and follow up provided for individual patients to whom they provided pharmaceutical care. Written documentation can be used to supplement verbal recommendations and to provide continuity of care among health care professionals. All documentation should be completed promptly after providing care.

Documentation of pharmacist's activities in the patient medical chart can be done in a variety of formats. The format for the documentation should be consistent with policies, procedures and style of documentation in the individual practice site. The pharmacist's documentation, in various practice settings, can be located in the physician's progress section, in an interdisciplinary section, as a consult note or can be located in a separate section for pharmacist's notes. IMPACT pharmacists should negotiate the specific locations and formats of the documentation with the site with the help of the project team (Susan and Apama) and the physicians in the practice.

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ii. Types of Pharmacists Activities that should be Documented

The pharmacist should document pharmacist specific assessments and activities in the medical chart pertaining to drug therapy in the individual patient. This will include the following information:

- Actual or potential drug-related problems.
- Patient, drug or disease data that confirm the validity of the drug-related problem.
- Recommendation(s) for changes in drug therapy, dosage, duration of therapy and route of administration.
- Recommendations for monitoring of response to drug therapy (including clinical or laboratory data).
- Interpretation of clinical findings or laboratory data.
- Description of activities and follow up to be conducted by the pharmacist.
- Patient education or contact activity with the patient.
- Patient specific solicited opinions from other health care providers (e.g. consults).
- Clarification of medication history, regimens or drug allergies/intolerances.

In primary care and during the IMPACT study, the most common reasons for documentation in the medical chart may be:

- **Consult Note**: This is often a more detailed note for a comprehensive pharmacist assessment to detail the drug-related problems identified, assessment and recommendations.
- **Progress Note or Follow Up Note**: To document the progress relating to the original drug-related problem, assessment, recommendations and follow up. A brief note may be made in the progress notes to document the results of a brief pharmacist assessment for one specific and focused issue.
- **Medication Record/History**: Complete list of current and past medications, nonprescription drugs and alternative therapies.
- **Patient Medication Education**: Outline of main education points discussed (e.g. inhaler teaching).
- **Medication Knowledge and Adherence Assessment**: Including a description of the patient’s compliance with their medication regimen, the patient’s understanding of their disease(s) and therapy.

iii. Sample Formats for Clinical Documentation

Documentation notes can be structured and unstructured. Various documentation styles have been used: “SOAP” (Subjective, Objective, Assessment and Plan); “FARM” (Findings, Assessment, Recommendations, Monitoring); “DRP” (Drug-Related Problem, Rationale Plan), “DAP” (Data Assessment Plan); DDAP (Drug-Related Problem, Data, Assessment Plan). These styles offer the advantage of encouraging completeness of data, consistency and improves organization of thoughts. Essential components of patient care documentation have been proposed (See Figure 1). Table 1 provides an example of key components for documentation for the two most common formats that could be used for documenting pharmacist’s activities in primary care.

Unstructured notes are free form records of patient encounters and care. At a minimum, these notes must be signed and dated. These notes may be appropriate where general impressions
or patient contact descriptions are noted, but no specific action on the part of the pharmacist is required at the time.

**Figure 1: Essential Components of Patient Care Documentation**

- Date of note
- Identification of person(s) involved
- Discipline Focus (e.g. Pharmacy Note)
- Why the patient was seen or reason for consult (e.g. consult for a medication assessment, for a 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 HCP
- Follow-up
- Identification: Signature

**Recommended resource for working on documentation skills:**

[www.cshp.ca](http://www.cshp.ca)

Table 1. Sample Components of Documentation Formats

<table>
<thead>
<tr>
<th>General Categories</th>
<th>Key Components</th>
<th>Sample Formats*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Date, time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identification of pharmacy note</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referring health care provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brief description of reason for referral (e.g. who initiated consult and patient contact)</td>
<td></td>
</tr>
<tr>
<td>Heading or Summary of Problems and Solutions</td>
<td>Drug-related Problem/ Issue statement</td>
<td>D: Drug-related problem</td>
</tr>
<tr>
<td></td>
<td>List of main drug-related problems/issues identified and statement of pharmacist recommendations</td>
<td></td>
</tr>
<tr>
<td>Findings:</td>
<td>Chief compliant or patient concern</td>
<td>S: subjective /O: objective</td>
</tr>
<tr>
<td>Compilation of subjective and objective data and medication history</td>
<td>Pertinent demographic information about the patient.</td>
<td>D: Data</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective (O): data based on measurements or documented facts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical History</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication History (e.g. current and past medications)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compliance Assessment (if applicable)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug Allergies/Intolerances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevant family or social history</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>A description of the actual or potential drug-related problem.</td>
<td>A: Assessment</td>
</tr>
<tr>
<td></td>
<td>Supporting rationale for drug-related problem.</td>
<td>R: Rationale</td>
</tr>
<tr>
<td></td>
<td>Brief discussion of therapeutic alternatives including relevant considerations (e.g. efficacy, precautions, drug interactions, side effects, cost and convenience) if appropriate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identification of goals or desired outcomes of therapy</td>
<td></td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>Brief summary of recommendation and therapeutic plan to resolve the patient’s drug-related problem.</td>
<td>R: Recommendation(s)</td>
</tr>
<tr>
<td>Plan</td>
<td>Patient desired outcomes that the plan is aimed at achieving</td>
<td>P: Plan</td>
</tr>
<tr>
<td></td>
<td>What action you have taken (e.g. patient education, discussion with physician) or needs to be taken by the physician or by the patient</td>
<td>M: Management</td>
</tr>
<tr>
<td></td>
<td>Plan for monitoring (e.g. efficacy, side effects)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow up that will be performed by yourself or another health care provider (e.g. what, when and who will be responsible)</td>
<td></td>
</tr>
<tr>
<td>Closing</td>
<td>Closing statement (if appropriate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signature, designation and contact information</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>Citation and attachment of evidence selected (if appropriate)</td>
<td></td>
</tr>
</tbody>
</table>

* SOAP: Subjective, Objective, Assessment and Plan; FARM: Findings, Assessment, Recommendations, Monitoring; DRP: Drug-Related Problem, Rationale Plan; DAP: Data Assessment Plan; DDAP: Drug-Related Problem, Data, Assessment Plan.
iv. Practical Suggestions

General:
- If more than one drug-related problem is identified, list them in order of importance (consider that the physician may not have time to read beyond the first page)
- For information obtained directly from the patient, write “patient states”

How to use a diplomatic style (ie. how to avoid having the identification of drug-related problems come across like criticism):

Use terms like:
- May benefit from
- May improve with
- Suggest
- Consider
- May no longer require
- Patient unlikely to comply with
- Patient would prefer

Avoid wording like:
- Wrong
- Unnecessary
- Must
- Patient does not want
- Inappropriate / not appropriate

How to include necessary information but still be concise:
- Include information the physician needs to make a decision about following your recommendation (ie. the physician should not need to do extra work by flipping through the chart or looking up information – like drug doses - to decide how to proceed). This may involve including the pros and cons of options and the patient’s wishes. Ask your mentor to review your first few documentation samples with this thought in mind.
- Don’t include information that is extraneous to the drug-related issue identified, especially information that the physician already knows (eg. writing a long, detailed introduction about the patient including information like their marital status, medical conditions, socioeconomic status etc. is not necessary and creates extra work for the physician to read). Ask your mentor to highlight extraneous, unnecessary information.
- Consider using plain language to make it easy to read your notes quickly (ie. one or two syllable words instead of three or four syllable words, a few examples below):

<table>
<thead>
<tr>
<th>Rather than this:</th>
<th>Try this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>accomplished</td>
<td>finished</td>
</tr>
<tr>
<td>anticipate</td>
<td>expect</td>
</tr>
<tr>
<td>ascertain</td>
<td>find out</td>
</tr>
<tr>
<td>circumvent</td>
<td>avoid</td>
</tr>
<tr>
<td>commence</td>
<td>start</td>
</tr>
<tr>
<td>endeavour</td>
<td>try</td>
</tr>
<tr>
<td>initiate</td>
<td>begin</td>
</tr>
<tr>
<td>notwithstanding</td>
<td>in spite of</td>
</tr>
<tr>
<td>terminate</td>
<td>stop</td>
</tr>
</tbody>
</table>
Avoid:
- Unnecessary words
- Unauthorized abbreviations
- Deadwood expressions (ie. expressions that can be replaced by fewer words or, if you removed the expression altogether, it wouldn’t change the meaning: eg. “please be advised”, “please find enclosed”, “along this line”, “do not hesitate”, “in reference to your request”, “as a matter of fact”, “it goes without saying”, “pursuant to your request”, “take the liberty to”, “trusting you will”, “I wish to advise”, “thanking you in advance”, “referring to your letter”, etc.).
- Wordiness (a few examples listed below)

<table>
<thead>
<tr>
<th>Rather than this:</th>
<th>Try this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• am of the opinion that</td>
<td>• think, believe</td>
</tr>
<tr>
<td>• as a general rule</td>
<td>• generally</td>
</tr>
<tr>
<td>• at the present time</td>
<td>• now, at present</td>
</tr>
<tr>
<td>• attention is called to</td>
<td>• here is</td>
</tr>
<tr>
<td>• consider favorably</td>
<td>• approve</td>
</tr>
<tr>
<td>• despite the fact that</td>
<td>• though</td>
</tr>
<tr>
<td>• feel free to</td>
<td>• please</td>
</tr>
<tr>
<td>• for the purpose of</td>
<td>• for</td>
</tr>
<tr>
<td>• in all probability</td>
<td>• probably</td>
</tr>
<tr>
<td>• It is recommended that consideration be given to</td>
<td>• I recommend that</td>
</tr>
</tbody>
</table>

Tips to improve the quality of pharmacist recommendations

1. Include information as to why obvious drug-related causes have been ruled out
2. Include complete information in recommendation regarding what drug is being recommended, the dose and the schedule
3. Include pertinent lab values in the rationale for the recommendation
4. Include a brief paragraph at the beginning of the consult to state the nature of the discussion, with whom it occurred, the most important issue(s) identified and the general outline of the recommendations
5. If suggesting monitoring, be specific about what should be monitored, how often and who will take responsibility
6. Include targets when available
7. Include the actual cardiovascular risk score
8. Write concisely, stating the recommendation, then bulleting the rationale
9. Avoid using statements like “warrant a re-evaluation of therapy” without including any suggestions as to how that could be done.
10. Include duration and history of problem when useful.
11. Include the patient perspective
12. Consider medications that are generally deemed inappropriate for long-term use in the elderly.
13. Consider consistent inclusion of calculated CrCl.
14. When providing information about the possible drug causes of a symptom, include a plan for addressing the most likely cause.
15. Prioritize drug related recommendations before lifestyle or non drug related recommendations.

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v. A Family Physician Perspective

“The practical side of "charting," as family doctors will refer to it, is that the medical notes provide an opportunity to document history, physical and lab finding, and train of thoughts: impressions, differential diagnosis and a plan. My rule of thumb is that the charting should primarily serve the interests of patient care (clearly outline key finding, communicate to other team members, and set out impressions and a plan of action). Such a document will also serve to document patient contacts for medical legal and OHIP billing purposes. It is important the notes be clearly structured and concise. Consult notes and progress notes should follow familiar formats (e.g.SOA) to improve readability.

The cumulative patient profile has emerged as a key tool in primary care charting. This summary page provides at a glance key demographics, past medical history, current medical issues, drug lists, allergies, and medical risks. While progress notes may get buried in the chart, this front-page sheet or computer screen is meant to provide the health care provider with a helpful up-to-date patient summary (most Electronic Medical Records also provide a summary page). Learning to work with this summary page, if it exits in their practice, could prove helpful for patients, pharmacists and the physicians. Example: I would suspect that it would be more helpful to have medication lists and allergies updated on a summary page rather than simply providing a separate list in a consult or progress note. In each practice the pharmacist will have to work with the physicians toward effective consult letters and charting.”

- K. Pottie

vi. Considerations for initiating pharmacist documentation at IMPACT sites:

- Determine with the site (e.g. lead physician), what would be the most acceptable format and place for pharmacist documentation.
- Draft initial documentation notes and get feedback from mentors for the first few notes. Use the Documentation self-assessment checklist.
- Start with writing the level of detail that the pharmacist feels is relevant for documenting information gathered, assessment and recommendations, then ask for physician feedback when meeting for the first few consults.
- Initial notes may contain more information to start, so that physicians and other health care providers at the site can understand the pharmacist’s rationale and approach.
- Notes should be “solution-focused.” When identifying drug-related problems, specific recommendations or solutions should also be included in the note.
- If the drug-related issue and justification is discussed in person with the physician, documentation notes can be shorter and represent a brief summary of the problems and the proposed actions.
- It would be optimal for a summary of recommendations to be provided first in the note (e.g. ‘Recommendations’ or ‘problem and solution summary’). This provides them an option to read the detailed pharmacist justification only if needed.
- Specific recommendations to the patient within the pharmacist’s scope (without prior discussion with the physician) should also be documented.
vii. Legal Considerations

Complete documentation of activities in the medical record has the potential for both increasing and decreasing the liability risk of the pharmacist. The pharmacist reduces the risk of liability by omission, since activities that are completed are documented. However, documentation also indicates what has been done or is planned and puts the pharmacist at potential risk or liability if the recommendations were not based on valid information and professional judgment or are not followed up appropriately by the pharmacist. ¹

It is important for you to note that you are creating a permanent health care record every time you document. The medical record is a legal document. To ensure that the record accurately reflects the care provided to the patient the following points should be considered:¹,²

- Documentation should occur immediately after the activity. Do not add information out of sequence at a later date. If documentation of an intervention is delayed, an indication that the note is a “late entry” can be made.
- Do not omit significant information purposefully. Include all information deemed necessary to support the drug-related problem and recommendations.
- Notes should not be deleted, removed or rewritten form any part of the record.
- Do not add to another health care provider’s note.
- Ensure that writing is clear, logical and precise.
- Communication should be diplomatic with an appropriate tone.
- All abbreviations used should be clear and common to all health care providers.
- All documentation must to legible and non-erasable.
- If an error is made in a manual record, the error may be crossed out with a single line and initialed.
### viii. Documentation Self-Assessment Checklist
The following is a self-assessment checklist that can be used for reviewing documentation.

<table>
<thead>
<tr>
<th>Format</th>
<th>Descriptors</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction or Heading or Problem and Solution Summary</td>
<td>All components present and accurate.</td>
<td></td>
</tr>
<tr>
<td>Data Collection (compilation of subjective and objective data)</td>
<td>Relevant information collected is accurate, complete and supports the assessment. Only information directly related to the assessment is included. Source of information (e.g. patient, medical chart, etc) is specified. Data is presented in a logical manner.</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>Drug-related problem statement is appropriate for the audience. Drug-related problem is adequately justified. Therapeutic alternatives are adequately described (e.g. efficacy, precautions, drug interactions, side effects, cost and convenience, when relevant) and supported. Relevant clinical evidence is cited (if applicable). Level of detail is appropriate for the intended audience. Data is presented in a logical manner.</td>
<td></td>
</tr>
<tr>
<td>Recommendation</td>
<td>Recommendation(s) is(are) clear and complete (e.g. drug, dose, route frequency, duration of therapy). Recommendations are appropriate and supported by the assessment.</td>
<td></td>
</tr>
<tr>
<td>Plan</td>
<td>Patient desired outcomes are clear and appropriate (if applicable). Actions performed by the pharmacist are clear, complete and appropriate. Activities to be performed by the physician are clearly indicated. Patient instruction and education (if applicable) content is summarized. Plan for monitoring is complete (e.g. what will be monitored, who will monitor, how often monitoring will occur). Plan for follow up is complete.</td>
<td></td>
</tr>
<tr>
<td>Closing</td>
<td>All relevant components are present.</td>
<td></td>
</tr>
<tr>
<td>Expression</td>
<td>Language usage and choice of professional terminology are correct, clear and understandable to any health care professional reading this note.</td>
<td></td>
</tr>
</tbody>
</table>
ix. References


Developed by Natalie Kennie, Barbara Farrell, and Lisa Dolovich