Uncharted Waters: Getting Started & Documentation in a Family Health Team

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Our Objectives:

- To describe various opportunities for building a collaborative practice with MDs in a FHT setting.
- To provide pharmacists with an understanding of various methods of documentation used in clinical practice.
- To allow pharmacists to compare and contrast strengths and weaknesses of various charting methods.
Is a *formative* process

- Events and activities are recorded as they happen
Conventional Wisdom

“The only reason people are charting is to count workload or protect their butts.”

“It should be to tell the story of the patient.”

- Kelly Babcock, Bsc Pharm; FCHSP
- Director of Pharmacy, SCO-Elisabeth Bruyere
“If it wasn’t documented, it didn’t happen”

- Roland Halil, PharmD

(Actually, just a medical axiom)
The problem

Incomplete records
Outdated records
Illegible records
The Result:
Death or dismemberment!

(i.e. Poor patient outcomes)

See: www.ISMP.org
The Result: The Big House!

(Poor pharmacist outcomes)

(see: http://www.greenspanwhite.com)
The Result: Baldness

(Frustration, time wasted, longer time to attain goals)

(See: www.ReGrowHairBack.com or www.hairformula.com)
Philosophy of Pharmaceutical Care (PC):

- By definition, “Pharmaceutical care is the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life”
  - Hepler & Strand

Continuum of Care

- PC encompasses a **continuum of care**
  - Begins with: identifying DRPs
  - Ends with: outcomes evaluation
  - Throughout: a therapeutic relationship and continuous follow-up.

- Care plans establish a concrete process for optimizing goals, monitoring and a **written patient record**.

- The process is completed when **it is documented** throughout the care continuum.

Documentation - Why bother? (2)

- To establish accountability and responsibility for patient outcomes
  - More documentation = more or less liability?
  - BOTH!

- To demonstrate the value of pharmacist interventions
  - Otherwise the doctor did it!
  - (see Roland’s medical axiom)

- To justify reimbursement?

Kennie, N et al. Demonstrating value, documenting care – lessons learned about writing comprehensive patient medication assessments in the IMPACT project. CPJ, in review.
Types of Documentation

- Medication Assessment / Consultation
  - 1st meeting, new referral
- Progress Note
  - Follow-up notes
- Pharmacist’s Care Plan
  - ?official record?
- Pre-made intake stamps / tools
- etc
Potential Content
aka The Whole Enchilada

- Demographics
- FHx, SHx, Allergy status
- CC / RFR
- HPI / PMHx
  - ROS?
- Medication Hx
  - Past / current
  - Rx / OTC

- Lab values
- DRP’s
  - Identified by Therapeutic Thought Process*
- Care plan
  - Efficacy, Safety, Cost, Compliance
- Monitoring & Follow-up

Remember

- Internalization of process
- Concision of thought
  - (Yes, concision is a word, look it up.)
- Relevance to your audience!

- Content should include:
  - Information necessary to make decisions
  - Record of pharmacist decisions and actions
Formats

- **SOAP**
  - Subjective, objective, assessment, plan
- **DRP**
  - Drug-related problem, rationale, plan
- **DAP**
  - Data, assessment, plan
- **DDAP**
  - Drug-related problem, data, assessment, plan
- **DARE**
  - Data, assessment, response, evaluation
- **FARM**
  - Findings, assessment, resolution, monitoring
See a pattern?

- Info related to where we came from
- Statement about where we are
- Plan as to where we’re going
Formatted notes encourage completeness and consistency of data and focuses thinking.

Standardize drug names
- Generic (brand) or
- ALL CAPS

Re-read it after it’s written!

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Example

- **Title of issue:**
  - eg. Roland’s Hypertrophic ego:

- **Subjective & Objective data (S/O):**
  - “Me, me me…blah, blah, blah…me, me, me”
  - Hx of hypertrophic ego, (unchecked) noted in chart. Multiple letters of discipline from Grade 2 to Univ3 professors noted as well.
  - Recent overnight stay in jail dressed as Napoleon Bonaparte. Calm and sober as evidenced by vitals:
    - BP: 120/80mmHg; HR: 55bpm (Nov 1/09)
    - No Hx of GERD or use of anti-acid meds noted.
Assessment & Plan (A/P):

  - May consider low dose Barrage of Insults BID-TID to deflate ego.
  - May titrate up to Personal Attacks QID, then PRN thereafter to maintain control.
    - “U-G-L-Y you ain’t got no alibi. You ugly!”
    - “Hmm, that looks like a penis, only smaller.”
    - “Yo’ mama.”
  - F/U worsening inflation, as well as sx(s crying, SI, and violence 1-2 weeks post Rx. Will discuss with audience.
Style
Clear, concise, diplomatic

Avoid using:
- “Wrong”
- Run-on sentences
- Unnecessary words
- “Deadwood” expressions
- Abbrev...

Try Using:
- “May benefit from”
- “May improve with”
- “Suggest”
- “May consider”

Include options
Consider references

Try to use common / accepted abbreviations
Legible!!
Document in a *timely* manner!
Never delete, erase or obscure

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Challenges with documentation

- Concern over offending physician
- Being concise enough so the physician has time to read it, but still has enough information to make a decision
- Making sure notes are read and acted upon

Your challenges?
Improving documentation

- **Pharmacist**
  - Determine best format through practice assessment, discussion with physicians
  - Ask for feedback from physicians

- **(Peer) Mentor**
  - Review and provide constructive suggestions of anonymous documentation samples
Pharmacist note - 1st meeting
Med List Updated. Pt brought list of meds to appt.

-------------------SUMMARY-------------------
- Start SIMVASTATIN 10mg qhs
- Start RAMIPRIL 2.5mg qd
- Obtain Urine ACR

Lipids:
S/O) On EZETROL 10mg since Mar '07 - well tolerated - no ADRs. [LIPITOR 20mg d/c'd due to myalgias/weakness (D/C'd again after re-challenge)]
- LDL = 3.2 (up from 2.4 when on LIPITOR) (Above target < 2); TC/HDL = 5 (above target < 4);
- AST / ALT / CK – normal;
- Hx of MI and DM2
- pt would like to avoid large pill burden if possible.

A/P) Elevated risk of MI / CVA.
- Edu provided re: mortality benefit with statins, elevated MI / CVA risk; & combo tx with other, non-statin options.
- May consider addition of CO-ENZYME Q10 i qd po - to treat or prevent statin-induced myalgias. Pt open to idea.
- May consider new challenge with a new statin (eg. SIMVASTATIN 10mg or 20mg qhs), with F/U lipid profile in 3 months. Pt open to trial of new statin. I would be happy to F/U pt after 1-2 weeks to ensure no new myalgias.

Hx MI / DM2:
S/O) no ACEinh. BP variable (target <130/80) No microalbuminuria measured. CrCL ~ 83mL/min; K+ - normal

A/P) Pt would benefit from addition of an ACEinh (eg. RAMIPRIL 2.5mg qd, titrating up as needed/tolerated) for BP control and secondary prevention of MI and renal protection.
- May consider measurement of urine microalbumin to ensure no overt nephropathy.
- pt not opposed to idea, recognizes need.

Signed: Roland Halil, PharmD
References

- **www.napra.org**
  - Pharmacy care plan: care plan tools, documentation, documentation and integrated resources

- **www.cshp.ca**

- **www.ocpinfo.com**
  - Documentation guidelines for pharmacist 2004. Pharmacy Connection 2004 (Jan-Feb); 8-12.

Getting Started = “Catering”

1. Go native – “know our customers”
   - Learn the history
     - Where they came from
   - Learn the politics
     - Where they are & Where they’re going
   - Learn the language
     - How to communicate efficiently

2. Complement their weaknesses

3. Poll their needs

4. Balance Idealism with Pragmatism