OFFICIAL PUBLICATION

GUIDELINES

Documentation of Pharmacists' Activities in the Health Record: Guidelines

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Documentation of Pharmacists' Activities in the Health Record: Guidelines

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Introduction

This is the second edition of the Canadian Society of Hospital Pharmacists (CSHP) Official Publication entitled Documentation of Pharmacists' Activities in the Health Record: Guidelines, replacing the 1993 edition (originally entitled Pharmaceutical Care: Guidelines on the Documentation of Pharmacists' Activities in the Patient's Health Record). These consensus-based guidelines were approved by the CSHP Council in 2013.

CSHP acknowledges the contributions of a group of CSHP members in the development of these guidelines.

Documentation in the health record is the accepted practice used by healthcare providers to communicate with each other about the decisions made and clinical outcomes of patient care.[1, 2] The documentation is a record of the healthcare provider's care, professional judgment, and critical thinking.[2, 3] Failure to document actions in the patient's health record can result in many undesirable consequences for the patient or the healthcare team or both.

To ensure the rational and safe use of medications, pharmacists assess each patient's situation and treatment options, review medication history, and initiate other actions that are important in providing optimal care. Pharmacists, like other healthcare practitioners, are expected to "communicate with each other in a collaborative, responsive, and responsible manner."[4] As such, the actions that pharmacists undertake must be documented to facilitate efficient continuity of care and collaboration with other healthcare professionals. Records of such communication become part of the patient's health record.

Documentation of activities serves many purposes:[3, 5, 6] it is useful for demonstrating the level of care provided, communicating care plans, facilitating transitions between care providers, measuring workload, improving quality of care, providing data for research activities, and meeting professional and accreditation standards. In addition, the resulting records can serve as legal documents.

1 Scope

These guidelines set forth methods for establishing a practice of documenting, in the individual patient's health record, all hospital pharmacists' activities relating to the care of the patient. They have been developed to provide overall direction regarding the documentation of activities in hospitals. They serve as a complement to, not a substitute for, relevant legislative requirements and each organization's policies and procedures pertaining to documentation of patient care by pharmacists.

2 Policies and Procedures

The pharmacy department should be involved in each healthcare organization's process to create or revise its policies and procedures as they pertain to documentation by pharmacists.

Where authority or policies are absent, these shall be obtained or established by the pharmacy department. (Refer to ASHP Guidelines on Documenting Pharmaceutical Care in Patient Medical Records [2003][7] for more information on how to obtain authorization for documentation in the health record.)

Written policies and procedures shall be established to promote the consistent, high-quality documentation of a pharmacist's care of patients and to ensure that it meets the needs of patients and the organization as a whole, while complying with regulatory requirements. The policies and procedures should be kept up to date.

The policies and procedures should address the following topics:

a) use of a standard format, which will help pharmacists to succinctly complete documentation in the patient's health record and which should offer enough flexibility to allow documentation of all possible pharmacist-initiated actions;
b) recommended timing of documentation in the patient's health record;
c) implementation of an educational program specifically about documentation for pharmacists; and
d) processes to assess each pharmacist's documentation skills as a means to promote and support high-quality pharmacy practice.

3 Confidentiality and Privacy

Confidentiality of private information (e.g., patients' personal health information, certain types of information about the healthcare organization) shall be maintained according to the relevant legislative framework (e.g., the federal Personal Information Protection and Electronic Documents Act and Freedom of Information and Protection of Privacy Act, as well as the relevant provincial health information protection act) and organizational policies and procedures. At all times, care must be taken to ensure and protect the accuracy, confidentiality, and privacy of information. This expectation also applies to secondary records of patient information (see section 4.2).

If it is deemed necessary to contact persons outside the patient's circle of care, the patient's consent to either obtain or release information shall be obtained before any such contact.

Note: The reader is advised to consult the relevant provincial pharmacy regulatory authority for more information about applying the province's legislative framework regarding health information.

4 Documentation Systems for the Health Record

The pharmacist shall perform documentation in the established form of communication. In hospitals and other collaborative healthcare settings, the established line of communication among healthcare providers is the patient's health record.

The documentation system should support effective exchange of information without compromising patient confidentiality[2] or privacy.

4.1 Design of the patient's health record

Regardless of the medium (electronic system or paper) used to create the patient's health record, a pharmacist should be a member of the team designing the record to ensure that the needs and perspective of pharmacists are considered.

4.2 Secondary records of patient information

Documentation in a system that does not directly integrate with the patient's centralized health record is not a substitute for documentation in the patient's health record.

Alternative storage devices (whether the device is in electronic or paper format) should not be used to record information about the patient unless that information is also stored in the patient's health record. "Documentation that occurs in a vacuum and devoid of real-time dissemination ultimately may not benefit patient care."[8] Consolidation of information stands to aid in communicating about the patient, reducing inefficiencies, and complying with the legislative framework regarding protection of privacy and confidentiality.

4.3 Integrity of documented information

The integrity of the information documented shall be maintained. Records shall not be erased or deleted.

4.3.1 Written records

When a notation is made in handwritten form, a pen should be used. If an error in documentation is made, no attempt should be made to erase the entry; instead, the writer shall draw a line through the entry, initial the line, and make the correct notation. A person shall not alter another person's entry in the health record.

4.3.2 Electronic records

Electronic records shall be un-alterable. A person performing documentation in an electronic health record will access the electronic record using only his or her own login information.

5 Format and Writing Style for Documentation in Health Records

The format and writing style chosen for documentation should be suitable for the practice setting, the writer's own communication style, and the relevant legislative framework for the practice of pharmacy.[3]

Refer to Table 1 for examples of the formats available for documentation.

Care shall be taken to ensure that the content of any documentation is easily understood, accurate, relevant, current, clear, concise, complete, and centred on the patient and also that documentation occurs in a timely manner.[2, 3, 8]

A professional style of writing should be used, without jargon or unapproved abbreviations. It is diplomatic to avoid the word "must" and other potentially emotive language.

The level of detail and language used should take into account the estimated level of healthcare literacy of all possible readers and the level of evidence needed to support the actions or recommendations given. Plain language should be used where suitable.

Note: Refer to the Additional Resources section, below, for links to lists of dangerous abbreviations, symbols and dose designations.

The rules and style conventions of the International System of Units (Système internationale d'unités, abbreviated "SI") are to be used in documenting units of measure.

Table 1. List of Examples of Documentation Formats

Format	Elements
DAP[3]	Data, Assessment, Plan
DARP/Focus[9]	Data, Action, Response, Plan
DRP[3]	Drug-related problem, Rationale, Plan
DDAP[3]	Drug-related problem, Data, Assessment, Plan
FARM[3, 6]	Findings, Assessment, Recommendations, Monitoring
SOAP[3, 6]	Subjective, Objective, Assessment, Plan
TITR[6]	Title, Introduction, Text, Recommendation

6 Information to be Documented

Documentation in the patient's health record (on paper or in electronic form) is a critical element of the provision of patient care. The pharmacist should document any information pertaining to the patient's drug therapy.[10] Failure to document activities and outcomes can result in drug therapy problems.[8, 10, 11]

Examples of documentation of a pharmacist's activities are provided in Appendix A.

6.1 Elements to be documented

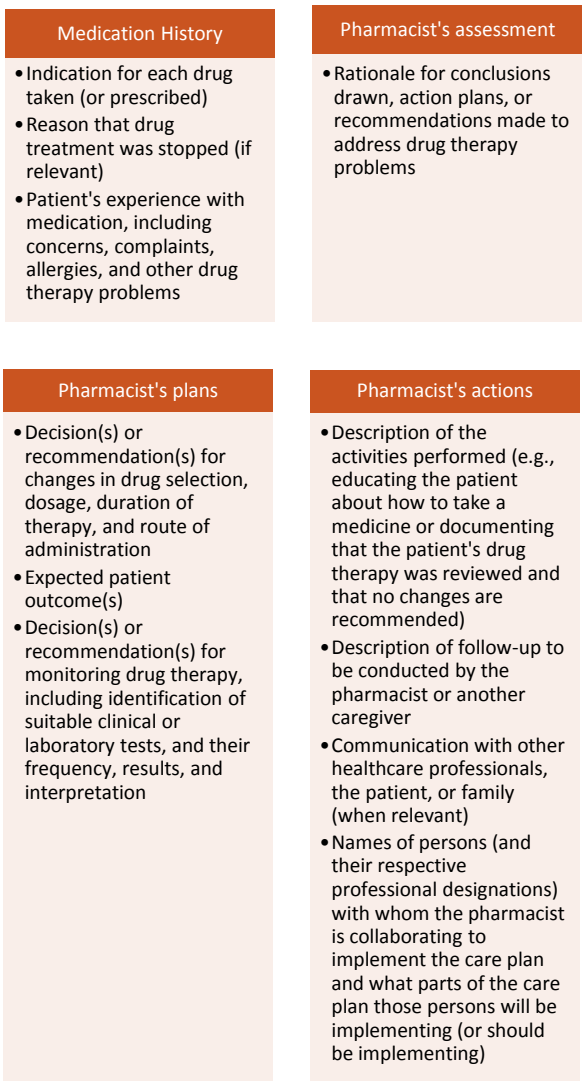
The following elements of a pharmacist's activities should be documented in the patient's chart:

a) date and time that documentation is occurring;
b) date and time of the encounter with the patient[12] (if not the same as when documentation is occurring);
c) reason for the encounter;[12]
d) any relevant subjective and objective information;
e) source of the information (e.g., from elsewhere in the chart, patient's spouse)[10]
f) patient's consent (or denial of consent) for the pharmacist to contact a person outside the patient's circle of care to either obtain or disclose information about the patient;
g) the pharmacist's assessment of the information;[2, 12]
h) the patient care that has been planned[2] and provided,[2, 12] including drug therapy problems identified;
i) factors that informed the pharmacist's conclusions, decisions, and intention,[2] including references, as applicable;
j) evidence that the pharmacist has executed his or her professional responsibilities according to the standards of care;[2]
k) communication with others within and outside the patient's circle of care, as relevant and necessary;[2]
l) factual description of significant professional disagreement regarding appropriate drug therapy (if such has occurred); and
m) identity and contact information[7] of the pharmacist recording the entry.

The link between every action plan and recommendation and the patient's health goal should be clear to the reader.

Figure 1 provides, for selected activities, additional details about the information that the pharmacist should include in the patient's chart.

Figure 1. List of Information the Pharmacist should include in the Health Record



6.2 Information about adverse drug reactions and medication incidents

Severe adverse drug reactions should be reported to Health Canada, as well as being documented in the patient's chart.

Information about medication incidents should be documented according to the hospital's policies and should be reported to the appropriate national agencies. Refer to *Medication Incidents: Guidelines on Reporting and Prevention* (2012)[13] for more information regarding the documentation and reporting of medication incidents.

6.3 Sources of information

The pharmacist may rely on a variety of sources for information to be documented in the patient's health record. It is helpful to document these sources to inform the reader about factors contributing to or informing any decision or recommendation.

The following are examples of possible sources of information:

a) interview with the patient to elicit the medication history, including a description of compliance and the patient's understanding of his or her disease(s) and therapy;
b) physical assessment;
c) interpretation of laboratory data and diagnostic tests (including drug levels);
d) other pharmacists (e.g., in the community);
e) other healthcare providers such as physicians (family practitioner, specialists) and nurses;
f) interviews with the patient's family or caregiver; and/or
g) provincial drug database.

7 What not to Document

Care should be taken to include in the health record only required and relevant information, in conformity with pharmacists' scope of practice and without extraneous details. Other channels are available to communicate matters of importance that do not belong in the health record. Matters of this nature, including concerns or conflicts with another healthcare worker, subjective accusations, concerns about resources available in the healthcare setting, and communications with the organization's legal counsel or risk manager, should be addressed through the hospital's established procedures.[6]

8 When to Document

Documentation in the health record should occur in a timely fashion,[2, 6, 8] as soon as new information is known or as soon thereafter as is practical. If timely documentation is not possible, the documentation (once recorded) should be identified as a late entry.[2]

9 Educational Programs for Pharmacists

Pharmacists should have opportunities to learn and improve their documentation skills.

The curriculum for such educational programs should include the following elements:[11]

a) guidelines for documenting - including guidance on the use of specific forms and what constitutes appropriate material for documentation within the patient's health record;
b) ways to address any barriers that pharmacists may encounter when documenting information in the patient's health record;
c) assessment of documentation skills; and
d) opportunities to practise the skill of documentation.

10 Quality Management

Quality improvement indicators should be developed to help evaluate the quality of pharmacists' documentation skills.[7]

Regular reviews of pharmacists' documentation in patients' health records should be undertaken by the pharmacy department.[2] The frequency and scope of such evaluations will vary depending on the skills, expertise, and diversity of pharmacists in the department and the nature of their documentation. Feedback shall be given to individual pharmacists regarding any assessment of documentation skills. Efforts should be undertaken to address barriers that pharmacists encounter in their attempts to perform high-quality documentation in the patient's health record.

A sample tool to assess a pharmacist's skills in documentation is provided in Appendix B.

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Additional Resources

Canadian Public Health Association Plain Language Service. Available from: http://www.cpha.ca/en/pls.aspx

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