OFFICIAL PUBLICATION

GUIDELINES

Documentation of Pharmacists' Activities in the Health Record: Guidelines

Appendix A: Examples of Documentation of a Pharmacist's Activities

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Canadian Society of Hospital Pharmacists
Société canadienne des pharmaciens d'hôpitaux

Guidelines on the Documentation of Pharmacists' Activities in the Health Record. Appendix A: Examples of Documentation of a Pharmacist's Activities

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Appendix A: Examples of Documentation of a Pharmacist's Activities

The following examples of documentation of a pharmacist's activities are provided to illustrate how documentation should occur in the patient's health record. Various standard formats are used in these examples. The most appropriate format will depend on the nature of the encounter and organizational policies for documentation. The interpretation of drug and diagnostic information provided in the examples was appropriate at the time of writing; however, these interpretations may change over time, subject to new therapeutic information, and therefore should not be used to inform clinical decisions.

Example of recommendation for cessation of antibiotic therapy for asymptomatic urinary tract infection (UTI)

[Insert date, time of writing]

Data: Patient is on day 3 of ciprofloxacin IV for presumed catheter-associated UTI. *E. coli* (urine) susceptible to ciprofloxacin.

On review of notes, no symptoms of UTI documented: no dysuria, no flank pain. WBC and temp not elevated (afebrile). Confirmed absence of symptoms with nursing staff, no documentation that catheter was removed. Approximate urine volume voided is now 300 mL/day.

Recommend:

1. Remove catheter – consider need to re-insert given voiding volume more than [XXX] mL/day.
2. Suggest stopping ciprofloxacin as patient may have asymptomatic bacteriuria. This would decrease risk of adverse drug event such as superinfection.
3. As patient is 60 yr old female, if continuation of antibiotic therapy is desired, can consider a short course (5 days) and complete course with oral amoxicillin 500 mg TID (no allergy, taking oral meds).

[Sign entry, providing professional title and contact information]

Example of note for verification of allergy status

[Insert date, time of patient encounter and/or writing]

Reason for encounter: Allergy status verification

Findings: Patient has documented an allergy to penicillin but stated no reaction. Patient recalls a skin reaction following initiation of penicillin 10 years ago, no shortness of breath or wheezing. Time to onset of rash is believed to be within or around 24 hrs. Rash described as bumpy, red patches on face and some eye swelling.

Assessment: This reaction is consistent with urticaria and angioedema. This is IgE-mediated and patient would be at risk of anaphylaxis. Have updated allergy documentation to state reaction of urticaria and eye swelling occurred around 24 hrs.

Recommendation: The implication is that the patient should not receive a penicillin or cephalosporin antibiotic. If needed, a cephalosporin could be introduced by graded challenge – the following cephalosporins are less likely to cross-react: [list drug names]

Plan: Since the reaction occurred 10 years ago, it is possible that the patient is less likely to react now. Have informed patient of significance of reaction and to question care providers if given future antibiotics. Patient's [provincial pharmacy information network] record updated.

[Sign entry, providing professional title and contact information]

Example of note regarding discontinuation of laboratory test of serum levels of a drug

[Insert date, time of writing]

Reason: Vancomycin dosing

Subjective/Objective: Patient has just started on vancomycin 1 g IV Q12H for possible hospital-acquired MRSA pneumonia. Sputum C&S, +3 pus, +3 gram positive cocci. Levels ordered, pre and post 3rd dose.

Currently, the patient is on 3 L O_2 by NP, O_2 sat is 92%.

HR 88, BP 110/70, WBC 12

The patient is 70 kg, 40 yrs old, with serum Cr 80 micromol/L.

Assessment/Plan:

- Have ordered a supplemental 500 mg dose to be given stat (to achieve a loading dose of 1.5 g or about 25 mg/kg) and increased maintenance dose to 1.25 g IV Q8H.

- Also have discontinued the post-dose level that was ordered, as this information is not necessary to allow adjustment of regimen–can assess pre-dose level only.

- Will follow patient's clinical status tomorrow for signs of early sepsis.

[Sign entry, providing professional title and contact information]

Example of note regarding discharge of a patient with new prescription for warfarin

[Insert date, time of patient encounter and/or writing]

Reason for encounter: Warfarin discharge counselling

Subjective/Objective: Patient started on warfarin Aug. 31 for stroke prevention; $CHADS_2 = 3$; is expected to be discharged today (Sept. 5).

Dosage and INR in hospital:

	Aug. 31	Sept. 1	Sept. 2	Sept. 3	Sept. 4	Sept. 5
INR	1.0	1.1	1.5	1.8	2.0	2.1
Warfarin	5 mg	5 mg	4 mg	3 mg	3 mg	3 mg

Assessment/Plan: Patient is taking no drugs with potential for interactions. Suggest repeat INR within 3 days of discharge (by Sept. 8), then weekly to confirm stable INR. Have discussed this with the patient.

[Sign entry, providing professional title and contact information]

Example of a note describing a recommendation that was not accepted

[Insert date, time of writing]

Findings: Patient is on day 3 of meropenem treatment for community-acquired pneumonia; C&S (day 1): no pus, no organisms, no growth.

Assessment: Current guidelines recommend evaluation for narrowing of antibiotic therapy when C&S of pathogen is identified. The patient received 3 days of levofloxacin prior to admission and has no medical conditions that are recognized risk factors for multi-drug resistant pathogens. Patient is on decreasing oxygen requirements by NP, HR < 100, and SBP > 90 mm Hg, temp 38.5°C (febrile).

Recommendation: At this time, ceftriaxone or piperacillin-tazobactam could be considered as alternative agents to meropenem. Either of these would decrease the risk of patient developing a superinfection and would help to preserve effectiveness of meropenem in the hospital population. These agents are also considered as first-line agents for empiric therapy of hospitalized patients with CAP because they are effective against the common causative pathogens. Guidelines recommend reserving empiric use of carbapenems for patients with known risk factors for multi-drug resistant infections.

Plan and Monitoring / Follow-up: After discussion with Dr XXXX, the plan is to continue meropenem at this time because the patient appears to have responded to this agent. A pharmacist will follow up on day 5 to evaluate whether the patient could be a candidate for oral medications (criteria are 5 days of IV antibiotic therapy, not more than one sign of CAP-associated clinical instability, and ability to take oral medications).

[Sign entry, providing professional title and contact information]

Example of a best possible medication history recorded in an Emergency Department

Data: 22 y/o male patient presented to the ED with reports of elevated glucose and N/V. Patient has been insulin dependent since childhood and diagnosed with borderline personality disorder as a teenager. Patient is on social assistance. Recently living voluntarily in a group home but left 4 days ago. Patient is well known to the emergency department and has had numerous admissions for diabetic ketoacidosis (DKA). Based on admission records patient has not been admitted since living in the group home.

No known allergies

Vitals/labs

BP 120/70, HR 100, temp 37.2°C, O_2 sat 98%

WBC 10, Hgb 180

Random glucose 34 mmol/L

pH 7.3

Anion gap 18

K = 5

Na 132mmol/L

Ketones = large

Cr 300 mmol/L (baseline 140), BUN = 23mmol/L (baseline 8)

Calculated CrCl = 33 mL/min (baseline greater than 60)

Influenza vaccine - November 2012

Denies alcohol and smokes 1/2-1 ppd in addition to the occasional marijuana joint.

Home Medications

The following information is as per the community pharmacy, patient and old chart. Patient has not had any antibiotics in last 3 months nor recent changes to his regime (see below) for at least the last 1.5 years.

<u>Diabetes</u>

Humalog 2 units/10 g carbs TID ac meals. Took 10 units this morning and yesterday.

Lantus 10 units hs - using physician sample from endocrinologist. Not covered by social assistance. Patient is unable to provide specifics on when he last took his Lantus.

<u>Borderline personality disorder</u>

Quetiapine 300mg qhs - prescribed by his psychiatrist

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Desvenlafaxine 100mg daily – using samples from psychiatrist.

Note as per old chart patient has been tried on various medications.

Renal protection

Ramipril 5mg daily - patient has not taken since leaving the group home

As per community pharmacy medications are filled in blister packs for the group home with regular refills. As per group home the patient did take his medications and insulin with him when he left.

Assessment:

- Patient has acute or chronic renal dysfunction secondary to dehydration, which may be exacerbated by restarting ramipril.

- Desvenlafaxine is renally cleared and dose adjustments are required with CrCl less than 50 mL/min.

- Patient is at risk of ongoing non-adherence if he continues to reside outside the group home. He is also at risk of interruptions in therapy due to use of physician samples and his inability to get to two different physician offices.

Plan:

- Patient is currently on the Adult DKA protocol.

- Hold ramipril until Cr returns to baseline

If CrCl does not quickly return to greater than 50 mL/min then reduce desvenlafaxine dose to 50 mg daily. If dose is reduced, monitor for withdrawal symptoms.

- On discharge, living situation needs to be determined - to ensure continuity of medications.

[Sign entry, providing professional title and contact information]

Example of a follow-up note to a physician regarding patient seen in an ambulatory clinic

RE: [Patient name]

DOB: [Date of birth]

PHN: [Patient's provincial health number]

CLIN: [Date of clinic visit]

Dear Dr. XXXX

Problem list:

1. CAD (PCI 2004)
2. Transient ischemic attacks
3. Dyslipidemia
4. Hypertension
5. Smoker (55-pack-year history)
6. Obstructive sleep apnea (on CPAP x10 years)
7. Osteoarthritis
8. Remote peptic ulcer disease
9. Left subclavian stenosis
10. Venous insufficiency

Cardiac risk factors: Age (64), male, dyslipidemia, hypertension, sedentary, obesity, premature family history (mother had an MI at 55), and smoker

Current medications (NKDA): Furosemide 40 mg daily, rosuvastatin 10 mg daily, valsartan 160 mg daily, and EC ASA 81 mg daily.

Mr. XXX was seen in the Cardiovascular Risk Reduction Clinic at the [name of clinic] for follow up. Since we last saw him he was referred to the stroke clinic and subsequently referred for an endarterectomy. A RCA microendarterectomy was performed on [date]. Since this procedure Mr. XXX denies having any symptoms of TIAs. In terms of his smoking, he successfully quit smoking for a few days post-surgery, however has now restarted. He states that he is currently smoking approximately half a pack per day. He expressed frustration with his inability to quit. While he does realize that quitting is very important, he is only in the contemplation stages of quitting. He is tolerating the rosuvastatin that we started last visit and there are no reported adverse effects such as myalgias. He stopped by the clinic in December complaining of dry cracked fingers and thought that it was from the rosuvastain. However, it resolved on its own without stopping the medication. In terms of Mr. Jones' activity level, he continues to be quite sedentary. He noted that he did receive a Wii entertainment system for Christmas and that he intends to use the fitness programs to become more active. He also has an exercise bike at home, however does not like using it for fitness. His weight has been otherwise stable. He continues to work on his diet and has met with the dietitian again today.

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On examination in clinic today his blood pressure was 112/62 mmHg in the right arm in the seated position. His weight was 104.5 kg (last visit 105 kg).

Review of laboratory parameters revealed a serum creatinine of 75, potassium of 3.9, total cholesterol 4.12, triglycerides of 2.36, HDL of 1.10, LDL of 1.95, and a TC/HDL ratio of 3.7, CK of 163, fasting blood glucose of 4.6, hemoglobin of 136, and platelets of 124.

Impression: The situation was reviewed with Mr. XXX in clinic today.

1. Smoking: Mr. XXX was once again encouraged to quit smoking. He refused to retry any smoking cessation products due to multiple intolerances or ineffectiveness. He will attempt to continue cutting back on the amount of cigarettes that he smokes daily. Positive support was given.

2. Dyslipidemia: Recent blood work reveals that Mr. XXX's LDL is 1.95 mmol/L. Given his high-risk status this is an acceptable level as the target LDL for his risk category would be less than 2 mmol/L.

3. Hypertension: Mr. XXX's blood pressure remains stable, and under good control. No changes were made today. I have encouraged him to monitor blood pressure in the right arm at home due to his blockage in his subclavian. He denies any symptoms of claudication.

4. Lifestyle changes: Mr. XXX was encouraged to increase his activity and support was provided. He will continue to work on his diet in consultation with our clinic dietitian.

Thank you for the opportunity to participate in the care of this patient. I have made arrangements to see Mr. XXX at the end of April in conjunction with his visit with the dietitian. Should you have any questions or concerns, please do not hesitate to contact our office.

Sincerely yours,

[Sign entry, providing professional title and contact information]

For more information, please contact:
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