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Pharmaceutical Care: Information Paper on the Documentation of Pharmaceutical Care in the Patient's Health Record (1996)

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Pharmaceutical Care: Information Paper on the Documentation of Pharmaceutical Care in the Patient's Health Record

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Pharmaceutical Care: Information Paper on the Documentation of Pharmaceutical Care in the Patient's Health Record

PREPARED BY THE PHARMACEUTICAL CARE ADVISORY COMMITTEE OF THE CANADIAN SOCIETY OF HOSPITAL PHARMACISTS.

PREFACE

This is the 1996 edition of the Canadian Society of Hospital Pharmacists Pharmaceutical Care: Information Paper on the Documentation of Pharmaceutical Care in the Patient's Health Record. This document was approved under the title of An Information Paper on Documentation of Pharmaceutical Care in the Health Care Record; the title was fine-tuned in 2009.

Information papers are intended to educate members and/or an external public party regarding a specific issue. It may be an end point in itself and may not necessarily lead to development of a discussion paper. An information paper may lead to development of a statement, standard or guideline. An information paper is not required to follow a standard format, but does go through the CSHP approval process (Standards and Publication Advisory Committees followed by Council approval) prior to release.

Part of this document has been previously published in Brown, G. Documentation by pharmacists in the health care record:

Justification and implementation. Can J Hosp Pharm 1994; 47:28-31

1. INTRODUCTION

As pharmacists practicing in Canadian health care settings become more involved in the provision of pharmaceutical care, the need for and benefit of documentation of activities in the patient's health care record becomes more evident. Enhancement of pharmaceutical care activities and the concurrent health care reform movement are prompting pharmacists to demonstrate their impact on the outcomes of patients and to ensure that resources (and associated expenses) are being efficiently utilized to obtain quality care of the patient. Quality health care has been defined as "the degree to which the process of care increases the probability of outcomes desired by patients and reduces the probability of undesired outcomes given the current state of knowledge."[1] Provision of quality health care involves many components relevant to the provision of pharmaceutical care, including the need for "sufficient documentation to allow continuity of care and peer evaluation.[2] The value of written documentation of pharmacists' activities in the continuity of patient care has been recognized by health care accreditation bodies. The current accreditation standards of the Canadian Council of Health Services Accreditation (C.C.H.S.A.) has listed as a standard of pharmacy services for patient care management that "drug-related patient care is documented to ensure continuity and ongoing evaluation, and to assist in discharge planning." In addition, the Law on Health Care Services of Quebec explicitly states that progress documented by a pharmacist will become part of the patient's health care record. Recognition of the importance of pharmacists' documentation by accreditation bodies provides ample ammunition for any pharmacy requesting authorization for pharmacists' documentation within any health care institution.

Therefore, this will help Canadian pharmacists to understand the needs, benefits, and processes associated with documentation of their pharmaceutical care activities.

2. BENEFITS OF DOCUMENTATION

Appropriate documentation of pharmaceutical care activities results in several beneficial effects for the patient, the pharmacist, and the health care system.

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2.1 Efficient Communication of Recommendations for Improving Individual Patient's Care

Pharmacists identify many problems with patient's therapy, offer recommendations for methods to improve the treatment, and evaluate the response to therapy to ensure positive outcomes. To achieve the desired outcome(s) from drug therapy the patient and pharmacist must involve other health care workers, such as physicians, nurses and dietitians if the therapy is to be initiated, executed and evaluated. In order to communicate the desired outcomes and therapy to all health care workers involved in the care of the patient, the most efficient method of dissemination of information is to utilize the vehicle common to all care-givers, the patient's health record. Through routine, consistent practice the pharmacist's documentation in the health care record will come to be expected by other care-givers and will be used in planning for the patient's care. Since the health record is the vehicle used by all health care workers to document plans, evaluations and assessments it is the best place for the pharmacist to communicate aspects of pharmaceutical care.

Efficiency can be enhanced by using the health record in preference to ad hoc written communication or verbal communication to all potential participants in the patient's care. Written documentation does not replace verbal communication (See 4.0 below) but rather it enhances the breadth of the communication.

2.2 Demonstration of the Role of the Pharmacist in the Patient's Care

Too frequently the pharmacist is a "hidden contributor" to patient care since a record of the pharmacist's participation is not available.3

Pharmacists must be able to demonstrate, through a permanent record, the recommendations and follow-up provided or required for individual patients to whom they provided pharmaceutical care. Many pharmacists may feel reluctant to record in a permanent document the activities they perform for fear of criticism or potential medicolegal risk. However, if the pharmacist is ever going to be acknowledged for his/her expertise and participation, such demonstration of responsibility will be required.

2.3 Peer Review of the Pharmacist's Activities by the Health Care Team

Pharmacists should be aware of the benefit of peer evaluation of their recommendations in the promotion and recognition of their contribution to patient care. By documenting activities in the patient record, the pharmacist is providing others the opportunity for both positive recognition of the pharmacist's contribution and criticism of plans and recommendations. Although it may seem desirable to avoid exposing activities to criticism, constructive comments on the actual or potential detrimental effects of the pharmacist's activities are beneficial in educating the pharmacist. Criticism also allows for discussion of opposing views on desired outcomes, methods and evaluation which frequently result in improvements in patient care. Pharmacists should be prepared to accept criticism regarding their activities, and to learn from the criticism. Hopefully, thorough documentation of activities will result in equal or greater acknowledgment of the positive effects of activities.

2.4 Promotion of Continuity of Care by Other Health Care Workers

Many pharmacists currently participate in the selection and monitoring of patient's drug therapy,

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but communication of this information is limited primarily to verbal interaction between the pharmacist and the physician or nurse. To allow for the pharmacist's plans to be followed by subsequent health care workers, written documentation is required. David Angaran has stated that "this should, at the very least, require a notation of the intervention and the associated result, but other indicators (of quality care) will require detailed pharmacy records of actions recommended, and supporting reasons."[3]

3. WHAT SHOULD BE DOCUMENTED?

The documentation should be succinct and deal only with aspects of drug therapy which are drug-related problems. Repetition of information already available in the health care record should be kept to a minimum; only information relevant to the drug-related problems should be repeated. The format of the documentation should be consistent with policies, procedures, and style of documentation of the institution. Documentation should be competed immediately after the activity. The pharmacist should have the authority to document any information pertaining to the drug therapy (actual and potential) in the individual patient:

a) actual or potential drug-related problems with the individual patient's therapy;
b) patient, drug or disease data that confirm the validity of the drug-related problem. This could include information obtained from a medication history, including description of compliance and the patient's understanding of disease(s) and therapy, or information from a pharmacokinetic assessment of the drug therapy and the patient's clinical status;
c) recommendation(s) for changes in drug selection, dosage, duration of therapy, and route of administration;
d) recommendations for monitoring of response to drug therapy, including identification of pertinent monitoring tests, frequency of monitoring, expected clinical findings of monitoring tests, and interpretation of monitoring parameters. Monitoring tests may involve clinical or laboratory data;
e) interpretation of clinical findings and laboratory data; and,
f) description of the activities and follow up that will be conducted by the pharmacist. This could include the drug-related patient education and counseling provided.

3.1 Examples of Acceptable Documentation

Example 1:

Jan 1, 1996 10:00, Pharmacy Note

S. Chest pain last night relieved by sublingual nitroglycerin. No complaints of pain yet today.

O. Current medications:
Metoprolol 25 mg tid
Nitroglycerin 0.2 mg /h top
Heparin 5000 units sc bid
ASA 325 mg daily
Nitroglycerin 0.3 mg sl prn - used 2 in 24 hours
Lorazepam 1 mg po hs prn

A. Ischemic heart disease - not controlled on current regimen.

P. Suggest increasing metoprolol to 50 mg po bid.
Monitor frequency of chest pain daily.

I. West, B. Sc. Pharm (Pager 1199)

Note: *This example uses the SOAP format, i.e., subjective, objective, assessment, plan*.

Example 2:

September 3, 1996 12:00, Pharmacy Note

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Upon review of Mr. Smith's drug profile and clinical status, the following drug-related problems were identified:

1. Potential excess dose of bedtime sedation
Mr. Smith has been receiving oxazepam 30 mg at bedtime for the last 3 days. Both he and the nursing staff report that he sleeps well, but is drowsy until approximately noon the following day. I recommend reducing the dose to oxazepam 15 mg hs prn. I will follow up with the patient to see if this provides adequate night time sedation without morning hangover.

2. Need for laxative
Mr. Smith reports no bowel movement over the last 6 days, confirmed by Nursing notes. I recommend the addition of lactulose 20 mL po daily. I will follow up with patient regarding the efficacy of this regimen.

N. Kemp, Pharmacist (pager 3232)

Note: *If the pharmacist declares responsibility for follow up with the patient, there is an obligation to do so. Notes should not include commitments which will not be fulfilled.*

4. WRITTEN VS. VERBAL COMMUNICATION

Written documentation in the health record of the pharmacist's concerns and recommendations regarding drug-related problems should not be used as an alternative to direct verbal communication between the pharmacist and the patient or health-care worker. The most efficient method of two way communication is through verbal discussion, preferably face to face. The pharmacist should not view written documentation as a method to avoid direct discussion, but rather as a method for providing documentation for subsequent planning or monitoring. Written documentation of the concern, plan, and participants serves as a prompt to all health care workers as they utilize the health care record.

5. SOLICITED AND UNSOLICITED ACTIVITIES OF PHARMACEUTICAL CARE

Pharmacists are frequently requested by members of the health care team to make recommendations regarding drug therapy. Documentation of responses to such requests should include notation of the requester, the data upon which the response was based and the recommendation.

5.1 Examples of Documentation of Solicited Pharmacy Activity

Example 1:

October 11, 1996 15:00, Pharmacy Note

I have completed a review of the current medications, as requested by Dr. Smith. During discussion with the patient several drug-related problems were identified.

1. Incorrect inhaler technique – corrected with instruction

2. Staggered administration times
Salbutamol q4h, ipratropium q6h, beclomethasone q8h
I recommend that the salbutamol and ipratropium be administered q4h, and the beclomethasone each morning and evening to simplify the regimen.

3. Hand tremor
Uncertain etiology and time of onset. Possibly due to medications (salbutamol, lithium or theophylline). I will review previous admissions to determine when the tremor began and the possible relationship to drug therapy.

A. Ready, Pharmacist (Pager 411)

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Example 2:

May 30, 1996 11:00, Pharmacy Note

S. Patient describes an itch associated with a rash on both abdomen and back. The beginning of the rash is thought to be three days after admission.

O. Asked to see patient by Dr. Smith regarding possible cause of the itch. Patient has an obvious erythematous rash on trunk and back. Scratch marks are evident.

A. The rash is consistent with a drug allergy. The time course is consistent with the use of ampicillin which was initiated on admission for possible UTI.

P. I recommend discontinuing the ampicillin since urine cultures were negative. Diphenhydramine 25 mg po q6h x 24 hours should reduce the itching with minimal toxicity. I will re-evaluate following 24 hours of therapy.

B. Lee, pharmacist (Pager 2276)

Many pharmacists feel that physicians or other health care workers would not appreciate documentation of drug-related problems in the health care record of individual patients when such documentation has not been requested by the physician. However, it seems reasonable that any patient would want drug-related problems identified and documented by **any** health care worker. David Angaran states "as to the question of unsolicited advice, physicians now receive automatic, independent opinions with any roentgenogram and ECG and some clinical laboratory tests. Shouldn't every instance of individualized pharmaceutical care for a hospitalized patient be documented?"[3] When a patient is admitted to a health care institution, a consent form is signed indicating the willingness of the patient to accept care at that institution. Implied in this agreement is consent for the provision of pharmaceutical care by pharmacists. Therefore, documentation of such care should be included in the patient's health care record.

5.2 Examples of Documentation of Unsolicited Activities

Example 1:

July 11, 1996 09:00, Pharmacy Note

Review of Mrs. Brown's drug therapy found the concurrent use of both ranitidine and sucralfate for the treatment of presumed peptic ulcer. Data to support the use of this combination of drugs for PUD is lacking. To reduce costs and toxicities I recommend that the sucralfate be discontinued and therapy be completed using ranitidine 300 mg po qhs.

A. Buckwell, pharmacist (Pager 3302)

Example 2:

December 22, 1996 10:30, Pharmacy Note

The serum theophylline concentration measured upon admission (December 21, 2100) was 123 mmol/L, reflecting preadmission therapy of theophylline 300 mg po bid (sustained release product)(Theodur®). Since this concentration is above the target range of 55-110 mmol/L, and the patient has symptoms of tachycardia and nausea, I recommend that the theophylline be held for 24 hours. If symptoms of respiratory distress appear necessitating theophylline, therapy could be re-initiated at a dose of 200 mg bid. This dose is expected to provide a predicted serum concentration of 80 mmol/L. I will reassess the patient's status tomorrow. A repeat theophylline measurement is not required at this time.

C. Leaf, pharmacist (Pager 2200)

The most difficult documentation for many pharmacists involves recommendations which are anticipated to be rejected by other team members. The pharmacist may verbally identify a problem, a

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potential solution, and potential monitoring plan which are rejected by the patient's physician or care team. After discussion with others, if the pharmacist feels the concern remains valid, documentation should still occur. Such documentation is important for identifying the pharmacist's attempt to alter potentially sub-optimal therapy if undesirable results occur with the existing therapy, or if the problem is recognized by others subsequently and the details of the pharmacist's plan are required for initiation. When it is known that other members of the care team disagree with the pharmacist's assessment of the potential drug-related problem, it is imperative that documentation be clear, unambiguous and factual, but not contain any criticism or condemnation of different views of the potential drug-related problem. The documentation requires skill and tact if other members of the health care team are not to be offended. The pharmacist should realize that other health-care workers, including physicians, nurses and dietitians, may disagree with the pharmacists' assessments and recommendation.

5.3 Example of Documentation of Controversial Recommendations

Example 1:

January 22, 1996 13:00, Pharmacy Note

Drug-related problems:
The recommended dose for IV acyclovir is 15 mg/kg/day for adults with normal renal function. This patient has been prescribed 800 mg IV five times daily (80 mg/kg/day). High doses of acyclovir have been reported to produce CNS, hematological, and renal toxicities. Recommended dosing would suggest a dose of 250 mg IV q8h for this patient. I have discussed with Dr. X who wishes to continue with the current regimen.

Given the current regimen, I would recommend ensuring adequate hydration and routine neurological observations, and measuring BUN and creatinine daily. I recommend that the current regimen not exceed 5 days of therapy. If any signs of toxicity develop, the therapy should be discontinued immediately. I will follow the patient's course.

A. Otto, Pharmacist (Pager 3399)

6. WHAT NOT TO INCORPORATE INTO DOCUMENTATION

The patient health care record should not be used for superfluous communication and should only be used for exchange of information related to drug-related problems of the specific patient. The health care record should not include non-specific recommendations that do not provide a clear indication of what specific action is needed or suggested. Suggestions to change or monitor therapy without providing specific individualized parameters including time period are not useful to other care-givers and frequently lead to confusion. The pharmacist should not document unrealistic recommendations, such as drug therapy which is not available at the institution or monitoring tests which cannot be accommodated. Unauthorized abbreviations should not be used. Generic drug names should be used rather than trade names. The pharmacist should comply with the approved style of documentation for the institution.

6.1 Examples of Unacceptable Documentation

Example 1:

September 10, 1996 14:00, Pharmacy note

Mrs. Brown is complaining about pain in her back, despite therapy with Tylenol #3. I would recommend that her analgesics be increased. In addition she should be started on a laxative to avoid constipation from the codeine.

S. Happy, pharmacist (Pager 2228)

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Example 2:

March 22, 1996 15:00, Pharmacy Note

Patient seen and problems discussed.
1. Excessive benzodiazepine use
2. Insomnia
3. Neck pain

J. Unrup, pharmacist

The health care record is a legal document. To ensure that the record accurately reflects the care provided to the patient, it is mandatory that pharmacists respect the integrity of the health care record. This includes ensuring that pharmacists:

a) do not tamper with medical records;
b) do not add information out of sequence at a later date;
c) do not place inaccurate information in the chart;
d) do not omit significant information purposefully;
e) do not rewrite any part of the record;
f) do not remove any part of the record;
g) do not add to someone else's note; and,
h) do not use the record to criticize other health care professionals.

7. LOCATION OF DOCUMENTATION IN THE HEALTH CARE RECORD

The pharmacist's documentation should be located in that part of the health record with the greatest potential for review by health care workers requiring the information. The format of the health care record will differ between institutions or patient care areas within each institution. The potential locations for pharmacists' documentation include:

7.1 Separate Section for Pharmacist's Notes

Pharmacists document activities in a separate section reserved for their use.

Advantages:
a) pharmacy information is easily retrievable by others
b) heightened awareness of pharmacist's contributions to care
c) provides a single location for drug-related information if located with the Medication Administration Record

Disadvantages:
a) medical staff may be concerned about having to locate and read a separate section
b) lack of integration into the overall picture of the patient's care
c) time required to access multiple separate sections

7.2 Interdisciplinary Section

All disciplines document findings, action and ideas in one section. This is the option recommended by C.C.H.S.A.

Advantages:
a) ease of communication between disciplines
b) no confusion over where to find information
c) reduced redundancy in documenting common findings

Disadvantages:
a) rapid accumulation of considerable amounts of information
b) difficult to pick out important information

7.3 Physician Progress Section

Pharmacists document in the section of the chart used by physicians.

Advantages:

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a) efficiency, since pharmacist's recommendations often require a physician's order for implementation
b) increased likelihood of physician seeing the note promptly

Disadvantages:
a) may reduce efficient communication with nursing staff if they do not routinely review the physician notes
b) should not be used to replace verbal communication with the physician

In summary, the pharmacist should document activities in the section of the health care record that will be most beneficial in communicating the relevant information. This could result in different locations between or within institutions based on the local practices of documentation and retrieval by the health care workers of that institution. The Health Records Department of the institution can provide guidance for the optimal location of pharmacists' documentation.

8. MEDICOLEGAL ASPECTS OF DOCUMENTATION

Complete documentation of activities in the health care 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 of liability if the recommendations were not based on valid information and professional judgment or are not followed up appropriately by the pharmacist. Readers are encouraged to review the CSHP Guidelines for Liability and Risk Management.

9. OBTAINING RESULTS WITH DOCUMENTATION

Without clear policies and procedures for documentation it is unlikely that pharmacists will maximize the benefits of good documentation. The Pharmacy Department must establish practices that allow the pharmacists to have access to the health care record and time to document assessment of the individual patient's drug therapy each time the pharmacist evaluates the patient. If the pharmacist does not have adequate time for assessment or completion of documentation, both processes will be incomplete and potentially result in detrimental actions.

To ensure that information is communicated appropriately the pharmacy department should establish a standardized documentation format that will succinctly describe the drug-related problem, expected outcomes, the pharmacist's recommendations and the monitoring plan. The format should provide enough flexibility to allow documentation of all possible pharmacist initiated actions. The format will vary depending on the practice site but the information should be organized so that any other care-giver can readily extract the relevant information. Pharmacist's documentation should be compatible with the charting system used in the institution.[4]

To assist pharmacists with incorporating adequate documentation into their practice, an educational program describing the expectations for documentation and the format for recording in the medical record should be initiated. Each pharmacist should have the opportunity to demonstrate on fictional patient's health care records the types and format of drug-related problem recommendations. The pharmacist should also be able to document undesirable outcomes of previous recommendations.

A quality assurance process should be established to review the indication, content, format, and

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appropriateness of individual pharmacy documentation notes. The frequency and extent of review would depend on the skills, experience and diversity of the pharmacists and their practice settings. A feedback process is required to correct deficiencies identified in any individual's documentation.

The availability of the pharmacist's documentation in the health care record should be promoted to other members of the health care team in order to enhance the utilization of the information. The pharmacist should also be encouraged to discuss the content of the pharmacy note with key members of the individual patient's care team in order to improve communication. Nurses can play an important role in obtaining results from proposed changes in drug therapy, since the nurse is frequently in direct contact with all members of the team. However, the pharmacist should not over-utilize the nurse as a messenger at the expense of direct involvement with the patient or other team members. The pharmacist's goal is to be an active, recognized provider of direct patient care.

Documentation of pharmacists' activities in the health care record can be a valuable process in the care of the patient and in establishing the pharmacist as an essential member of the health care team.

10. LITERATURE CITED

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