GUIDELINES FOR DOCUMENTATION OF PHARMACISTS' ACTIVITIES IN THE PATIENT'S HEALTH RECORD

PREFACE

To ensure that patients experience the desired therapeutic outcome of drug therapy pharmacists may initiate actions or make recommendations which could be important in determining subsequent drug therapy and resulting patient outcome. These actions or recommendations must be documented in order to achieve an efficient continuity of care. Such documentation should occur in the patients health care record. This activity is required by the Canadian Council on Health Facilities Accreditation standards, as well as the CSHP Standards of Practice.

1. SCOPE

1.1
These guidelines set forth methods for establishing a practice of documenting all activities of the pharmacist relating to the care of the patient in that individual's health record.

2. AUTHORIZATION FOR DOCUMENTATION

2.1
The pharmacist shall determine the existing organizational and medical staff policies regarding authority for health record entries as they apply to pharmacists. This should be indicated in the organizational policy and procedures or in the medical staff by-laws.

2.2
Where authority or policies are absent, these shall be obtained or established by the pharmacist. (refer to Appendix 1 for guidelines)

3. INFORMATION TO BE DOCUMENTED

The pharmacist should have the authority to document in the health record any information pertaining to drug therapy (actual or potential) of the individual patient. Such information could include but, is not limited to:

(a) Actual or potential drug related problems with the individual patient's therapy; and
(b) Patient, drug or disease data that confirm the drug related problem. This could include information obtained from:
    (i) a medication history, such as a description of compliance and patient understanding of disease(s) and therapy;
    (ii) a physical assessment;
    (iii) a pharmacokinetic assessment of the drug therapy; and/or
    (iv) the patients clinical status;
(c) Recommendation(s) for changes in drug selection, dosage, duration of therapy, and route of administration;
(d) Recommendation(s) for monitoring drug therapy including identification of clinical or laboratory tests, and their frequency, results, and interpretation;
(e) Verbal orders subsequent to a discussion with the prescriber;
(f) Description of the activities and the follow up that will be conducted by the pharmacist. (This could include drug related patient education and counseling, or documentation that the patient's medication therapy was reviewed with no changes recommended.); and/or
(g) Factual description of significant professional disagreement regarding appropriate drug therapy.

4. PROCEDURE FOR DOCUMENTATION

To achieve the desired utilization of the pharmacists' documentation, departmental practice standards should include:

4.1
The pharmacist documents in the patient's record the assessment of the individual patient's drug therapy each time the pharmacists evaluates such therapy.

4.2
A standardized documentation format that will succinctly describe the drug related problem, expected outcomes, the pharmacist's recommendation(s), and the monitoring plan. The format should provide enough flexibility to allow documentation of all possible pharmacist initiated actions

4.3
An educational program for the pharmacists which includes the expectations for the documentation, the format for recording in the health record, and methods for receiving guidance from pharmacy administration.

4.4
A quality assurance process to review the indication, content, format, and appropriateness of individual pharmacist documentation in the health record . The frequency and scope of the quality assurance evaluation would vary depending on the skills, expertise and diversity of the pharmacists and their documentation. A process of feedback to the individual pharmacist regarding documentation is required.

5. REFERENCES

1. American Society of Hospital Pharmacists, ASHP guidelines for obtaining authorization for documenting pharmaceutical care in patient medical records. Am J Hosp Pharm 1989;46:338-9.

APPENDIX 1

Obtaining Authority for Documentation

1. Identify, within the organization, the specific organizational and medical staff committees whose recommendations or decisions will be required to establish authority for pharmacists to make health care record entries. Determine the necessary sequence of these approvals. Committees typically involved are the pharmacy and therapeutics committee, the executive committee of the medical staff, a quality assurance committee, and a health records committee. The health records department can be a valuable resource in describing the approval process and key participants.

2. Determine if other health care workers, apart from physicians and nurses, currently have authority to document in the health care record. If so, consult with them regarding the process used to obtain authority.

3. Determine the required information and format (written or verbal) for obtaining authority from the approving committee(s).

4. Prepare a written proposal describing the reason(s) for the request, the type of information to be documented, and the proposed location of documentation within the record.

5. Review the proposal with the chairperson of the pharmacy and therapeutics committee, the director of nursing, the director of health records, and a member of the organization's administration responsible for pharmacy.

6. In appropriate sequence, seek the endorsement or decision of all committees necessary for approval. The pharmacy and therapeutic committee is the usual initial committee to review the proposal. Monitor the proposal's progress through the approval mechanism and offer assistance, as required, to each chairperson to clarify information or provide any necessary supplemental materials.

7. When final approval has been obtained, communicate the outcome to all those affected by the decision(medical staff, nursing, health records, etc.). Incorporate this authority into written pharmacy policies and procedures.