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**PHARMACY PRACTICE**

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# Documentation by Pharmacists in the Health Care Record: Justification and Implementation

Glen Brown

The current health care reform movement has prompted an evaluation of the role of all health care workers in the care of patients. Pharmacists are being required to demonstrate their impact on the outcome of patients as a result of the activities that they complete. This movement is aimed at ensuring 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".<sup>1</sup> Provision of quality health care involves many components relevant to hospital pharmacists, but for this discussion, it is important to recognize the need for "sufficient documentation to allow continuity of care and peer evaluation".<sup>2</sup> This statement incorporates the two key reasons for establishing a procedure for pharmacists to document their patient care activities in the health care record, namely:

- i) To allow for continuity of care by the pharmacist, by other pharmacists subsequently involved in the patient's care, or by other health care workers, and
- ii) To allow peer review of the

pharmacists' activities to ensure evaluation, criticism and acknowledgment of the pharmacists' activities.

Many pharmacists currently participate in the selection and monitoring of patients' drug therapy, but communication of this information is limited to verbal interaction between the pharmacist and the physician or nurse. This prevents subsequent health care workers from being aware of the pharmacist's plans since no permanent document is available. 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...".<sup>3</sup> 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 Facilities Accreditation (C.C.H.F.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". Recognition by accreditation bodies of the importance of documentation by pharmacists provides ample support to any pharmacy requesting authorization for pharmacists' documentation within any health care institution. Resistance to such documentation should be counteracted by demonstrating the recognition of benefits of such documentation in the continuity of care of the individual patient.

Pharmacists should be aware of the benefit of peer evaluation of their recommendations in the promotion and recognition of their contribution to patient care. Too frequently the pharmacist is a "hidden contributor" to patient care since no record of the pharmacist's participation is available. David Angaran has bluntly stated, "I am convinced that lack of adequate documentation is one of the major impediments to achieving the goals of pharmaceutical care and proving the added value pharmacy brings to the medication-use process. If we are ever to establish ourselves as an independent profession and accept our shared responsibility for patient outcomes, we must record our recommendations, their supporting reasons, and the expected outcomes."<sup>3</sup> Pharmacists must be able to demonstrate, through a permanent record, those

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individual patients for which they provide pharmaceutical care, and the recommendations and follow-up provided or required, and the outcomes which were achieved. 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. If the pharmacist is not recognized and acknowledged for such activities, the pharmacist is unlikely to be employed to provide this activity!

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, if the wishes of the patient are considered, it would seem reasonable that any patient would want drug-related problems identified and documented by any health care worker. David Angaran also discusses "as to the question of unsolicited advice, physicians now commonly receive automatic independent opinions with each roentgenogram and ECG and some clinical laboratory tests. Shouldn't every instance of individualized pharmaceutical care for a hospitalized patient be documented?"<sup>3</sup>. When any patient is admitted to any health care institution for care, a consent form is signed indicating a willingness of the patient to accept care at that institution. Implied in this agreement is for provision of pharmaceutical care by pharmacists. If such care is agreed upon by the patient, documentation of such care should be included in the patient's health care record.

### Obtaining Authorization

Demonstration of the benefits of documentation of pharmacists' activities on continuity of care and for evaluation by others should provide the Pharmacy Director with the justification for a request for authorization within the institution. Resistance should be addressed upon patient care grounds. However, in order for authorization to be obtained, the Pharmacy Director must ensure that all relevant institutional groups are informed and in agreement. The Clinical Pharmacy Advisory Committee has prepared a document to assist individual departments plan for obtaining authorization<sup>4</sup>. It is important to remember that the pathway through the bureaucracy of each institution will differ. However, an initial step would include determining the existing organizational and medical staff policies regarding authority for medical record entries as they apply to pharmacists. This should be indicated in the organizational policy and procedures or the medical staff by-laws<sup>5</sup>. By knowing the hospital's organizational structure, the Pharmacy Directory should identify the specific organizational and medical staff committees whose recommendations or decisions will be required and the necessary sequencing of their approval. Committees typically involved are the pharmacy and therapeutics committee, the executive committee of the medical staff, and quality-assurance committee. The health records department of the organization can be a valuable resource in describing the approval process and key participants. It may save time and effort to first identify which other health care workers, apart from physicians and nurses, currently have authority to document in the health care record and to determine the

process they used to obtain authority.

To assist these committees or individuals in understanding the merits and need of pharmacists' documentation, a written proposal describing the reason(s) for the request, the types of information to be documented, and the proposed location of documentation within the health care record is recommended. This should provide a clear indication of all aspects of documentation required by the pharmacist. The Pharmacy Director should use his/her knowledge of the institution political climate to ensure that sufficient lobbying has been done of individuals with influence on the authorization process. As a minimum, the Director should review the proposal with the chairperson of the pharmacy and therapeutics committee, the director of nursing, the director of medical records, and member of the organization's administration responsible for Pharmacy. The Director must monitor the proposal's progress through the approval pathway and offer assistance, as required, to each chairperson to clarify information or provide any necessary supplementary materials. An important final step in the authorization process is to publicize widely within the institution when the final approval has been obtained. Any group or individual within the institution which may be affected by the decision (medical staff, nursing, medical records, etc.) should be informed prior to initiating the policy. Incorporation of the authorization into the written pharmacy policies and procedures should be completed immediately to ensure that pharmacy staff are aware of the development.

### Ensuring That Documentation Obtains Results

Just obtaining authorization for

documenting activities and having the pharmacist "document" will not guarantee that the process will contribute to continuity of care and enhanced recognition of the pharmacists' participation in patient care. Without clear guidance as to the policy and procedure for documentation, it is unlikely that the pharmacist will maximize the benefit of documentation. The Pharmacy Department must establish practices that allow the pharmacist to have time to document the assessment of the individual patient's drug therapy each time the pharmacist evaluates a 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 outcomes. To ensure that information is communicated appropriately, the Pharmacy should establish 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. The format will vary depending on the practice site, but the information should be organized in a manner to allow other individuals to readily extract relevant information. The pharmacists' documentation should be compatible with the charting systems used in the institution<sup>6</sup>.

To assist the pharmacists in 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 patients' health care

records, the types and format of drug-related problem recommendations. The pharmacist should also be able to appropriately document undesirable outcomes from previous recommendations. To ensure on-going monitoring of the appropriateness of the pharmacists' documentation, a quality assurance process to review the indication, content, format, and appropriateness of individual pharmacy documentation notes in the medical record should be established. The frequency and breadth of the quality assurance evaluation would vary depending on the skills, experience, and diversity of the pharmacists and their documentation. A process of feedback to the individual pharmacists regarding documentation is required to correct deficiencies in any individual's procedures.

#### **What Should Be Documented**

The pharmacist should have the authority to document any information pertaining to the drug therapy (actual or potential) of the individual patient. This would include the indication of the actual or potential drug-related problem(s) with the individual patient's therapy. The documentation should also include the patient, drug or disease data that confirm the validity of the drug-related problem. This could include information obtained from a medication history, including a description of compliance and patient understanding of disease(s) and therapy; information obtained from other health care workers or physical assessment; information from a pharmacokinetic assessment of the drug therapy, and the patients' clinical status. The documentation should succinctly state the specific recommendation(s) of the pharmacist for changes in drug selection, dosage, duration of therapy, and route of administra-

tion. It is important for the pharmacist to be specific, whenever possible, regarding the action required to prevent or rectify the drug-related problem. Recommendations for monitoring of the response to drug therapy including identification of monitoring tests, frequency of monitoring, findings of monitoring tests, and interpretation of monitoring parameters should also be included. To assist the subsequent reader of the health care record in determining the future actions of the pharmacist and to prevent redundant action by other health care workers, a description of the activities and follow-up that will be conducted by the pharmacist should be included. This could include the drug-related patient education and counselling provided. Any other information that is pertinent to the understanding of the merits, consequences, and remedies for the drug-related problem(s) should also be incorporated into the documentation.

#### **What Not To Incorporate Into Documentation**

The pharmacists should realize that the patient health care record should not be used for superfluous communication and should only be used for the 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 action is needed or suggested. Suggestions to change or monitor therapy without providing specific individualized parameters are not useful to other care-givers and frequently lead to confusion. The pharmacists should not document unrealistic recommendations, such as drug therapy which is not available within the institution or for monitoring tests which can not be

accommodated. To encourage other health care workers to comply with hospital policies, only authorized abbreviations and generic drug names should be used. Each institution has a local "etiquette" of what and how to document information in the health care record. The pharmacist should attempt to comply with local customs while maintaining appropriate documentation.

It is important for pharmacists to recognize that the health care record is a legal document, and, as such, can be used to demonstrate the activities involved in the patient's care. To ensure that the record accurately reflects the care provided to the patient, it is mandatory that the pharmacist respect the integrity of the health care record. This includes ensuring that the pharmacists:

1. Do not tamper with medical records;
2. Do not add information at a later date;
3. Do not place inaccurate information in the record;

4. Do not omit significant information purposefully;
5. Do not re-write part of the record;
6. Do not remove any part of the record;
7. Do not add to someone else's note; and
8. Do not use the record to criticize other health care professionals<sup>7</sup>.

Documentation of the pharmacists' activities in the patient health care record can be a valuable process in the care of the patient, and in establishing the pharmacist as a contributing member of the health care team. By establishing a practice expectation involving complete documentation of patient care activities, and through ongoing assurance assessment of the practice, the Pharmacy Department can establish the pharmacist as a key care-giver within the institution. ☐

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