

PLOTTING THE “CHART”

SUPPORTING ASSESSMENTS AND MAINTAINING STANDARDS TO PROTECT YOU AND YOUR PATIENTS

Maintaining current and complete patient profiles is essential to managing patients and providing continuity of care between encounters and among your team members.

BUILDING CONSENSUS

HOW COULD I DISCUSS DOCUMENTATION WITH MY TEAM?

- Meet to discuss a time when charting helped your team to remember or track important patient information
- Discuss how documentation fits into the patient care model and the practice framework

EFFECTIVE DOCUMENTATION CAN HELP:

- Support patient assessments and the development of care plans
- Facilitate monitoring and follow-ups
- Reduce the potential abuse of medications
- Streamline workflow and eliminate redundancy among your team
- Protect you in cases of liability

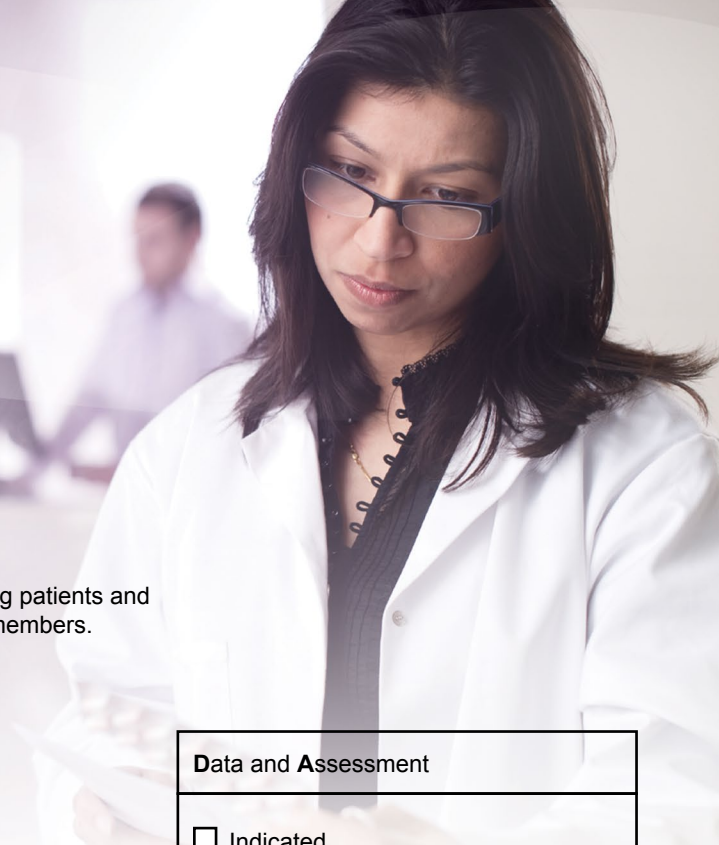
DETERMINING HOW AND WHERE TO DOCUMENT

WHAT ARE YOUR INITIAL GOALS?

- Determine situations when documentation is necessary
- Decide how you plan to enhance documentation within your pharmacy practice
- Set a goal and monitor your progress as a team (e.g. are you going to start documenting prescriptions with problems, new prescriptions, or prescriptions filled during quiet times?)

HOW AND WHERE SHOULD YOU DOCUMENT?

- There are multiple ways of documenting patient care. To ensure consistency, your team should agree on how and where to document information.
- One way to do this is to determine a consistent place on the software system where all team members should document.



Data and Assessment	
<input type="checkbox"/> Indicated _____	(e.g., condition will benefit)
<input type="checkbox"/> Effective _____	(e.g., medication, dose)
<input type="checkbox"/> Safe _____	(e.g., contraindications, interactions, s/e, toxicity, dose)
<input type="checkbox"/> Useable _____	(patient is willing and able to take drug)
Is the therapy appropriate?	
Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No



An innovative example of how one pharmacy team documents is illustrated above. The template is stamped on the prescription, completed by the pharmacist, and then scanned into the patient database.

Guirguis, Lisa and Shao Lee. "Patient assessment and documentation integrated in community practice: chat, check, and chart." *JAPhA* Volume 52, Issue 6 (2012): 241-251.

Guirguis, Lisa, Shao Lee, and Ravina Sanghera. "Impact of an interactive workshop on community pharmacists' beliefs toward patient care." *IJCP* Volume 34, Issue 3 (2012): 460-467.

WHAT SHOULD YOU DOCUMENT?

Regardless of the documentation style used, the following information should be included:

Data

What information did you gather and check?

- Relevant subjective information: patient's concerns, goals, and preferences
- Relevant objective information: vital signs, lab test results
- Identify which references were checked

Assessment

What is your assessment of the patient and therapy?

- Appropriateness of therapy: is therapy indicated, effective, safe? Is patient willing to use/adhere to therapy?
- Any drug therapy problems
- Supporting rationale

Plan

What steps did you/will you take?

- Recommendations (drug/non-drug)
- Instructions given to patient
- Monitoring plan and follow up (when and by whom)

EXAMPLE

Scenario: JD, a 45-year-old man, requests a renewal for ramipril 5 mg (no refills left); refilling regularly since 2009 for hypertension; no other medications or medical conditions; last saw doctor June 2015

13/08/2015

Rx 227568 Original Rx 226543

Phm: KE

D: blood pressure 123/85; K: 4.1 mmol/L; CrCl: 118 ml/min; no cough/dizziness

A: Tx appropriate; patient tolerating and compliant; blood pressure controlled

P: Renewed ramipril 5 mg daily for 3 months; confirmed patient's understanding of therapy; patient to continue monitoring bp and will schedule appointment with Dr. Jones in 3 months.

13/08/2015 - Notified Dr. Jones by fax regarding renewal of ramipril 5 mg.

TIPS FOR CHARTING

Documentation should be:

- **Consistent:** Is everyone on the team documenting in the same place?
- **Accessible:** Are notes easy to find and accessible to others?
- **Relevant:** Is the information relevant and patient-specific?
- **Concise:** Are notes "short and sweet" and easy to read? Do not document information that can be found in other places in the patient's profile (e.g., allergies, medical conditions, and/or medications).



The more frequently you document, the easier it will become and the more you will gain an appreciation for how effective documentation can help you manage your patients.