

ASHP Guidelines on Documenting Pharmaceutical Care in Patient Medical Records

DEVELOPED THROUGH THE ASHP COUNCIL ON PROFESSIONAL AFFAIRS AND APPROVED BY THE ASHP BOARD OF DIRECTORS ON FEBRUARY 20, 2003

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Purpose

The professional actions of pharmacists that are intended to ensure safe and effective use of drugs and that may affect patient outcomes should be documented in the patient medical record (PMR). These guidelines describe the kinds of information pharmacists should document in the PMR, how that information should be documented, methods for obtaining authorization for pharmacist documentation, and the important role of training and continuous quality improvement (CQI) in documentation.

Background

Pharmaceutical care is the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient's quality of life.¹ A core principle of pharmaceutical care is that the pharmacist accepts professional responsibility for patient outcomes.² Integrating pharmaceutical care into a patient's overall health care plan requires effective and efficient communication among health care professionals. As an integral member of the

health care team, the pharmacist must document the care provided. Such documentation is vital to a patient's continuity of care and demonstrates both the accountability of the pharmacist and the value of the pharmacist's services. Moreover, because clinical services (e.g., those incident to a physician's services) are generally considered reimbursable only when they are necessary for the medical management of a patient and when the service provided and the patient's response are carefully documented, thorough documentation may increase the likelihood of reimbursement. Early implementation of such documentation practices may help health-system pharmacies cope with documentation requirements in the event pharmacists' clinical services become reimbursable.

The PMR's primary purpose is to convey information for use in patient care; it serves as a tool for communication among health care professionals. Information in the PMR may also be used in legal proceedings (e.g., as evidence), education (e.g., for training students), research (e.g., for evaluating

clinical drug use), and quality assurance evaluations (e.g., to ascertain adherence to practice standards).³

Clinical recommendations made by a pharmacist on behalf of the patient, as well as actions taken in accordance with these recommendations, should be documented in a permanent manner that makes the information available to all the health care professionals caring for the patient. ASHP believes that, to ensure proper coordination of patients' medication therapies, health care systems must be designed to enable, foster, and facilitate communication and collaboration among health care providers.² Health care systems must not erect barriers to that communication or to the exercise of the professional judgment of health care providers.

Although telephone calls and other oral communication may be necessary for immediate interventions, they do not allow for the dissemination of information to care providers who are not a part of the conversation. Such interventions should be documented in the PMR as soon as

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possible after the acute situation has settled. For less urgent and routine recommendations, timely documentation is also preferred, because delays in response to telephone calls or pager messages may lead to miscommunicated or undocumented recommendations. Unofficial, temporary, or removable notes placed in the PMR do not provide a standard of acceptable communication or documentation and therefore are discouraged. Documentation that is not a part of the PMR (e.g., documentation in pharmacy records) may provide a degree of risk reduction; however, such documentation does not provide important information to other care providers and can interrupt continuity of care when the patient is discharged or transferred.

Documenting pharmaceutical care

Pharmacists should be authorized and encouraged to make notations in the PMR for the purpose of documenting their findings, assessments, conclusions, and recommendations.² ASHP believes that all significant clinical recommendations and resulting actions should be documented in the appropriate section of the PMR. The pharmacy department should establish policies and procedures for documenting information in the PMR. Such policies and procedures will help pharmacists exercise good judgment in determining what information to document in the PMR and how to present it.

Examples of information a pharmacist may need to document in the PMR include, but are not limited to, the following:

1. A summary of the patient's medication history on admission, including medication allergies and their manifestations.
2. Oral and written consultations provided to other health care professionals regarding the patient's drug therapy selection and management.

3. Physicians' oral orders received directly by the pharmacist.
4. Clarification of drug orders.
5. Adjustments made to drug dosage, dosage frequency, dosage form, or route of administration.
6. Drugs, including investigational drugs, administered.
7. Actual and potential drug-related problems that warrant surveillance.
8. Drug therapy-monitoring findings, including
 - a. The therapeutic appropriateness of the patient's drug regimen, including the route and method of administration.
 - b. Therapeutic duplication in the patient's drug regimen.
 - c. The degree of patient compliance with the prescribed drug regimen.
 - d. Actual and potential drug-drug, drug-food, drug-laboratory test, and drug-disease interactions.
 - e. Clinical and pharmacokinetic laboratory data pertinent to the drug regimen.
 - f. Actual and potential drug toxicity and adverse effects.
 - g. Physical signs and clinical symptoms relevant to the patient's drug therapy.
9. Drug-related patient education and counseling provided.

Documentation by pharmacists should meet established criteria for legibility, clarity, lack of judgmental language, completeness, need for inclusion in the PMR (versus an alternative form of communication), appropriate use of a standard format (e.g., SOAP [subjective, objective, assessment, and plan] or TITRS [title, introduction, text, recommendation, and signature]), and how to contact the pharmacist (e.g., a telephone or pager number).⁴

The authority to document pharmaceutical care in the PMR comes with a responsibility to ensure that patient privacy and confidentiality are safeguarded and the communication is concise and accurate. Local, state, and federal guidelines and laws

(including the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) and risk management sensitivities should be considered. Nonjudgmental language should be used, with care taken to avoid words that imply blame (e.g., *error, mistake, misadventure, and inadvertent*) or substandard care (e.g., *bad, defective, inadequate, inappropriate, incorrect, insufficient, poor, problem, and unsatisfactory*).³ Facts should be documented accurately, concisely, and objectively; such documentation should reflect the goals established by the medical team.

Documentation of a formal consultation solicited by a physician or other health care provider may include direct recommendations or suggestions as appropriate. However, unsolicited informal consultations, clinical impressions, findings, suggestions, and recommendations should generally be documented more subtly, with indirect recommendations presented in a way that allows the provider to decline the suggestion without incurring a liability. For example, the phrase "may want to consider" creates an opportunity for the suggestion to be acted upon or not, depending on presenting clinical factors.

Obtaining authorization to document pharmaceutical care

The authority to document pharmaceutical care in the PMR is granted by the health care organization in accordance with organizational and medical staff policies. Although documenting pharmaceutical care in the PMR is a pharmacist's professional responsibility, physicians and other health care professionals may not be accustomed to or open to this practice.

The following steps are recommended for obtaining authorization to document pharmaceutical care in the PMR:

1. Determine the existing organizational and medical staff policies regarding authority for documentation in

- the PMR. These policies may provide specific guidance on how to proceed.
2. Ascertain whether other nonphysician and nonnurse providers in the organization or affiliated organizations have been granted authority to document patient care activities in the PMR. If so, consult them regarding the process used to establish the authority.
 3. Identify physicians in the organization who are willing to support documentation of pharmaceutical care in the PMR.
 4. Identify the committees in the organization whose recommendations or decisions will be required to establish authority for pharmacists to document pharmaceutical care in the PMR. Determine the necessary sequence of these approvals. Committees typically involved include the pharmacy and therapeutics (P&T) committee, the executive committee of the medical staff, a quality-assurance committee (e.g., the CQI committee), and the medical records committee.
 5. Determine the accepted method and format for submitting a proposal requesting authority to document pharmaceutical care in the PMR. In some organizations, a written proposal may be required. If so, determine the desired format (length, style, and necessary justification) and deadlines for proposal submission. An oral presentation to the deciding bodies may be required. If so, determine in advance the desired presentation format and supporting materials desired by these bodies.
 6. Draft a written plan describing
 - a. Examples of information to be documented in the PMR. It may be helpful to describe how this important information may be lost or miscommunicated if it is not documented in the PMR.
 - b. The locations within the PMR where documentation will be made and any special format or forms proposed. New forms will have to comply with HIPAA regulations and will require review and approval by specific organiza-

tional or medical staff committees. To achieve the goal of effective communication among all the members of the health care team, compartmentalization of the PMR should be avoided.

- c. The persons who will be documenting pharmaceutical care in the PMR (i.e., pharmacists, residents, or students). If pharmacy residents or students will be making notations in the PMR, procedures regarding authority and cosignatures will also have to be described.
7. Review the draft plan with the chair of the P&T committee, the director of nursing, the director of medical records, and other appropriate administrative personnel, such as the organization's risk management officer and legal counsel.
8. Seek the endorsement and recommendation of the P&T committee.
9. In appropriate sequence, seek the endorsement or decision of any other committees necessary for ultimate approval. Monitor the proposal's course through the various committees and provide assistance, clarification, or additional data as necessary.
10. When the final approving body grants PMR documentation authority, participate in the required policy development and the communication of the new policy to the individuals or departments in the organization that will be affected by the change (e.g., nurses, the medical staff, the quality-assurance staff, and the medical records department).

Training and CQI

Pharmacist documentation in the PMR is a skill that requires ongoing training and evaluation.⁴ A temporary committee may be formed to manage the initial training required to implement pharmacist documentation in the PMR. That committee may consider offering presentations by physicians or other members of the health care team to provide their perspective on how to effectively communicate using the PMR. The information in those presentations

may be reinforced by workshops on documentation skills. Presentation and workshop topics may include the choice of communication method (i.e., when documentation in the PMR is preferred to other means of communication), the documentation format (e.g., SOAP or TITRS), documentation etiquette, and legal requirements.⁴ Documentation skills should be demonstrated before a pharmacist is allowed to make notations in the PMR.⁴ The ASHP Clinical Skills Program is another tool for training pharmacists to use the PMR.³

Documentation of pharmaceutical care should also be one of the many functions addressed in CQI efforts. Pharmacy department CQI efforts should include the development of quality indicators that can be used to evaluate pharmacist documentation in the PMR.⁴ Other CQI efforts might analyze and improve systemwide policies and procedures for documenting medication use.⁵ Periodic review of organizational policies and procedures will allow for their revision in response to changes in health care and advances in technology, including the availability of an electronic PMR.^{6,7}

References

1. Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. *Am J Hosp Pharm.* 1990; 47:533-43.
2. American Society of Hospital Pharmacists. ASHP statement on pharmaceutical care. *Am J Hosp Pharm.* 1993; 50:1720-3.
3. Shepherd MF. Professional conduct and use of patient medical records. In: ASHP Clinical Skills Program, module 1: reviewing patient medical charts. Bethesda, MD: American Society of Hospital Pharmacists; 1992:38-41.
4. Lacy CF, Saya FG, Shane RR. Quality of pharmacists' documentations in patients' medical records. *Am J Health-Syst Pharm.* 1996; 53:2171-5.
5. Matuschka P. Improving documentation of preoperative antimicrobial prophylaxis. *Am J Health-Syst Pharm.* 1998; 55:993-4.
6. Lau A, Balen RM, Lam R et al. Using a personal digital assistant to document clinical pharmacy services in an intensive care unit. *Am J Health-Syst Pharm.* 2001; 58:1229-32.
7. Gordon W, Malyuk D, Taki J. Use of health-record abstracting to document pharmaceutical care activities. *Can J Hosp Pharm.* 2000; 53:199-205.