This single copy is for your personal, non-commercial use only.
For permission to reprint multiple copies or to order presentation-ready copies for distribution, contact *CJHP* at publications@cshp.ca

Appendix 1 (part 1 of 3): Tool for assessing pharmacists' competency for documentation in the patient health record

Document Attributes

Element	Element Descriptor		
1a	Date	Yes	No
1b	Time	Yes	No
2a	Identity of the pharmacist recording the entry	Yes	No
2b	Contact information of the pharmacist recording the entry	Yes	No
3	Note is legible	Yes	No
4	Appropriate use of abbreviations, acronyms, and jargon	Yes	No

		Know	Comprehend	Apply
5	Note is concise	States information relevant to the purpose of the note but includes excessive non-relevant information, which is distracting.	Summarizes information relevant to the purpose of the note, but includes a minimal amount of additional information that is not directly relevant to the assessment and plan of the specific DRP.	Produces information important to the purpose of the note, without including irrelevant data.
6	Clarity (organization of note, not content)	Outlines note in an unorganized manner.	Selects appropriate organization of data that enables subjective and objective information to support the assessment, and the recommendation(s).	Produces a well-articulated note that contains relevant information to support clear recommendations and time-lines that ensure accountability for actions required (e.g. states who will monitor and follow up, and when).
7	Written in a diplomatic tone, using appropriate language for the audience	Avoids the use of inappropriate terms such as: wrong, unnecessary, must, should, inappropriate/not appropriate, patient does not want.	Uses appropriate terms such as: may benefit from, may improve with, may no longer require, suggest, recommend, consider, patient would prefer, patient unlikely to adhere to, patient stated.	Avoids being judgmental (e.g. avoids inappropriate terms listed in "Know" of this section, and instead uses appropriate terms listed in "Comprehend"), and focuses on solutions rather than problems.
8	Reason for note (e.g. titled)	Defines a generic reason for the note in the title (e.g. "drug related problem", "medication change", "patient education").	The title identifies the drug-related concern, or specific pharmacist activity (e.g. "Drug interaction with warfarin and azithromycin").	The title illustrates why the drug-related concern or activity is important (e.g. "Potential increased bleed risk due to drug interaction with warfarin and azithromycin").

Elements of Care

		Missing	Know	Comprehend	Apply	NA
9	Overall data/ information to support assessment and plan		Lists subjective and objective information that is relevant to the assessment and plan. Includes irrelevant information AND is missing important information.	Summarizes subjective and objective information to support the assessment and plan with either including irrelevant information OR missing important information (i.e. not both).	Produces subjective and objective information to support the assessment and plan without including irrelevant information, or missing important information.	
10	Medication list	X	Lists current (and previous) medications pertinent to the note, but lacks information about dose, dosage form and frequency. Includes medications not relevant to the DRP.	Describes medications pertinent to the note including dose, dosage form, and frequency (e.g. lists all current medications patient is on for HF if the note is regarding a HF DRP/activity).	Produces list of medications pertinent to the note and indicates information relevant to assessment and plan (e.g. loading doses provided, dose titrations, when medication started, and actual usage of prns).	NA (e.g. patient non-drug education)

Supplementary material for Baranski B, Bolt J, Albers L, Siddiqui R, Bell A, Semchuk W. Development of a documentation rubric and assessment of pharmacists' competency for documentation in the patient health record. *Can J Hosp Pharm*. 2017;70(6):423-9.

This single copy is for your personal, non-commercial use only.
For permission to reprint multiple copies or to order presentation-ready copies for distribution, contact *CJHP* at publications@cshp.ca

Appendix 1 (part 2 of 3): Tool for assessing pharmacists' competency for documentation in the patient health record

	Elements of Care					
		Missing	**Know**	**Comprehend**	**Apply**	**NA**
11	Reason that the drug treatment was stopped (if relevant i.e. in the medication list, not one of the recommend-ations)	X	States that drug treatment was stopped.	Explains why drug treatment was stopped and when (provides date).	Produces a list of active and recently discontinued mediations with rationale.	NA
12	Patient's subjective experience with medication, with regards to a potential or actual DRP	X	States whether patient or caregiver was consulted.	Describes patient's medication experience, and includes additional information that is not directly relevant to the specific DRP.	Produces relevant information regarding patient's experience with medication. No unnecessary information is included.	NA (e.g. there are no adverse events relevant to the DRP)
13	Drug therapy problems identified	X	States drug therapy problems (or potential problems), including drugs that are involved.	Produces clear drug therapy problem statements including: drug, how it is involved OR what is the impact on the patient (e.g. "Patient receiving azithromycin and warfarin which interact" OR "Patient is at increased risk of bleeding").	Identifies current drug therapy problem(s) and describes their impact on the patient /disease state (e.g. "Patient is receiving azithromycin and warfarin which interact and increase the risk of bleeding").	NA
14	Rationale for conclusions drawn, action plans, or recommend-ations made	X	States conclusions, action plans, or recommendations (e.g. "Patient would benefit from an increased dose of beta-blocker).	Describes the rationale for conclusions, action plans, or recommendations made (e.g. "Patient's blood pressure is not well controlled on current dose of beta-blocker and would benefit from an increased dose").	Produces rationale that supports drug recommendations. Identifies therapeutic goals/targets/ desired outcomes. ("BP=150/95, target is BP less than 140/90. Patient's blood pressure is not well controlled on current dose of beta-blocker and would benefit from increasing metoprolol to 25mg BID today.)	NA (e.g. patient educated)
15	Decision(s) or recommend-ations for changing drug therapy (adding, stopping or changing)	X	Lists drug and non-drug recommendations in very general statements. Orders may be unclear or lack decisiveness (e.g. "Re-evaluation of blood pressure medications required", "Stop opioid analgesics", "Re-evaluate need for zopiclone").	Describes recommendations for drug therapy that are complete; recommendations include drug, dose, dosage form, route, and duration (if appropriate).	Produces drug and non-drug recommendations, which include: drug, dose, dosage form, route, and duration (if appropriate). Includes timing of when to start new medications, as well as stop and change existing medications.	NA (e.g. patient teaching)
16	Decision(s) or recommend-ation(s) for monitoring drug therapy and follow-up	X	Lists recommendations for monitoring drug therapy including identification of suitable clinical or laboratory tests.	Describes the desired range of clinical and lab values (e.g. change in SCr >30%).	Identifies desired ranges of clinical and lab values, their frequency and who will follow-up on these values and what to do at given values (e.g. Physician to monitor SCr every 5 days and hold ACEi if change in SCr >30% from baseline).	NA

Supplementary material for Baranski B, Bolt J, Albers L, Siddiqui R, Bell A, Semchuk W. Development of a documentation rubric and assessment of pharmacists' competency for documentation in the patient health record. *Can J Hosp Pharm*. 2017;70(6):423-9.

This single copy is for your personal, non-commercial use only.
For permission to reprint multiple copies or to order presentation-ready copies for distribution, contact *CJHP* at publications@cshp.ca

Appendix 1 (part 3 of 3): Tool for assessing pharmacists' competency for documentation in the patient health record

		Elements of Care				
		Missing	**Know**	**Comprehend**	**Apply**	**NA**
17	Description of activities performed by pharmacist (e.g. patient education, applying for special access, applying for EDS, continuity of care activities)	X	Lists activities performed by pharmacist in very general terms (e.g. "Educated patient on heart failure medications").	Describes the activities performed by pharmacist in detail, providing more information than required (e.g. "Educated patient about HF medications including how to take them, benefits including preventing hospitalization and progression of HF, side effects including fatigue, decreased exercise capacity that will improve with time, and when to seek medical attention including gaining weight >2lbs in 2 days or 5lbs in one week").	Identifies assessment of patient understanding, i.e. any concerns arising from activities that require further action, and how activities may impact future drug therapy (e.g. "Patient is capable of monitoring daily weights and showed a good understanding of how to adjust Lasix accordingly", "Patient appeared to lack understanding of medication administration").	NA
18	Lists communication with other healthcare professionals	X	Communications with other healthcare professionals are listed, if appropriate (e.g. "discussed above with attending physician").	Describes the consult and includes either the specific practitioner consulted OR what was discussed regarding drug therapy (e.g. "Discussed with Dr X" OR "Discussed concerns about drug interaction with attending physician").	Identifies specific practitioner consulted, and what was discussed regarding drug therapy (e.g. "Discussed with Dr. X the current barriers to patient receiving regular blood work and thus why warfarin is not a viable option").	NA

ACEi = angiotensin-converting enzyme inhibitor, BP = blood pressure, DRP = drug-related problem, EDS = Exception Drug Status, HF = heart failure, NA = not applicable, SCr = serum creatinine

Supplementary material for Baranski B, Bolt J, Albers L, Siddiqui R, Bell A, Semchuk W. Development of a documentation rubric and assessment of pharmacists' competency for documentation in the patient health record. *Can J Hosp Pharm*. 2017;70(6):423-9.