Appendix 1 (part 1 of 3): Work standard for pharmacist documentation in patient progress notes.

Work Standard Summary:

This work standard outlines the pharmacist interventions requiring documentation into the Progress Notes of the patient medical record. The components of a note are also specified. The format and structure for a note is left to pharmacist discretion.

Background:

Documentation of pharmacist activities within the patient medical record improves efficiency and safety through enhanced communication. This documentation:

- Improves quality of care through increased transparency and provision of information relevant to the immediate and ongoing care of the patient
- Ensures communication of care plans (eg: aminoglycoside and vancomycin monitoring)
- Facilitates transitions between care providers (including between pharmacists)
- Highlights care provided by pharmacists

Documentation is a professional and accreditation standard for health care providers.

- Written documentation is a legal record of care provided.
- Pharmacists are accountable for ensuring they provide accurate and timely documentation of the care they provide.

Documentation provides data for research activities, quality improvement initiatives, and measuring workload.

- Comprehensive, accurate documentation by pharmacists provides a basis for: appropriate measurement of quality of care, evaluation of the patient's progress, evaluation of services provided, and ongoing risk management.

I. Pharmacist interventions requiring documentation:

1.	**Any Level Two prescribing activity** As required for Level Two Prescribing Authority by pharmacists.
2.	Level 1 prescribing, where pharmacist believes further information is required to ensure clarity of the order, without changing intent or specifics of the order.
3.	Patient counselling or patient interactions relating to their medication–related care.
4.	Communication of information not available in chart used for decision making where the pharmacist is directly involved. This includes documentation of recommendations made by pharmacist but not accepted by physician that pharmacist deems clinically significant and/or with potential for harm.
5.	Pharmacist recommendations for consideration by the multidisciplinary team where direct communication cannot occur or when changing patient factors necessitate action when the pharmacist may not be present.
6.	Complex situations where pharmacist is directly involved in decision making and where rationale for decisions may not be intuitive.
7.	"Pharmacy Consults" received for patients on wards receiving enhanced services will be addressed during specified hours (0730-1600H Mon-Friday, not including STAT holidays), will be documented in the progress note, once pharmacist able to review patient and chart and complete the consult.
8.	Seamless care activities, Exceptional Drug status (EDS) requests, patient-specific special access product (SAP) applications, Adverse Drug Reaction reports that have been obtained by or involved the pharmacist, with updates on status if pertinent so rest of care team aware.

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm.* 2019;72(2):151-4.

Appendix 1 (part 2 of 3): Work standard for pharmacist documentation in patient progress notes.

II. Expectations of information to be included in notes written by pharmacists:

Documentation Expectations: General identification components that must appear in ALL notes
1. Date and time
2. Identity of the pharmacist, including first initial and last name minimally
3. Contact information of the pharmacist recording the entry
4. Appropriate use of abbreviations, acronyms, and jargon

Documentation Expectations: Attributes that apply to ALL notes

1. Note is concise	Produces information important to the purpose of the note, without including irrelevant data.
2. Note is legible	
3. Clarity (Organization of note, not content)	Produces a well-articulated note that contains relevant information to support clear recommendations and timelines that ensure accountability for actions required (e.g. states who will monitor and follow up, and when).
4. Written in a diplomatic tone, using appropriate language for the audience	Avoids being judgmental (e.g. avoids inappropriate terms such as "wrong, unnecessary, must, should, inappropriate/not appropriate, patient does not want" and utilizes words like: "may benefit from, may no longer require, suggest, recommend, consider, patient would prefer, patient unlikely to adhere to, patient stated". Focuses on solutions rather than problems.
5. Reason for note (Titled)	The title illustrates why the drug-related concern or activity is important. (e.g. "Pharmacist note re: Potential increased bleed risk due to drug interaction with warfarin and azithromycin").

Documentation Expectations: Elements of Care
Components included AS APPLICABLE to specific intervention/patient situation

1. Overall data/information to support assessment and plan	Produces subjective and objective information to support the assessment and plan without including irrelevant information, or missing important information.
2. Medication list	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).
3. Reason that the drug treatment was stopped if relevant to the problem	Produces a list of active and recently discontinued mediations with rationale if relevant to the drug related problem being addressed.
4. Patient's subjective experience with medication, with regards to a potential or actual drug related problem	Produces relevant information regarding patient's experience with medication. No unnecessary information is included.
5. Drug therapy problems identified	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".)*
6. Rationale for conclusions drawn, action plans, or recommendations made	Produces rationale that supports drug recommendations. Identifies therapeutic goals/targets/desired outcomes. *(eg: "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".)*

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm.* 2019;72(2):151-4.

Appendix 1 (part 3 of 3): Work standard for pharmacist documentation in patient progress notes.

7. Decision(s) or recommendations for changing drug therapy (adding, stopping or changing)	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.
8. Decision(s) or recommendation(s) for monitoring drug therapy and follow-up	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 greater than 30% from baseline).
9 Description of concerns/ issues identified by the patient during intervention	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")*.
10. Lists communication with other healthcare professionals	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")*.
11. Cites any relevant work standard applicable to the intervention as related to the documentation	Work standards should be cited where specific work standard applies to the activity or intervention and where citing helps making documentation complete and concise.

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm.* 2019;72(2):151-4.

Appendix 2: Work standard for medication education provided by pharmacists.

Work Standard Summary:

Pharmacists may provide medication–related education to patient/caregiver populations per Saskatchewan Health Authority Pharmacy Clinical Practice Standards.

Pharmacists will routinely verbally discuss or provide written information addressing ALL of the following during patient (and/or caregiver) medication education sessions as relates to the individual patient

- Drug name and class
- Indication and expected benefits
- Expected effects, which may include onset of action, effectiveness, side effects and how to manage, and self-monitoring
- Route, dosage form, dosage, and administration schedule (including duration of therapy)
- Directions for administering the medication
    - For pediatrics: include any specific age-related issues (eg: compounding and diluting techniques, measuring and administration instructions)
- Action to be taken in case of a missed dose
- Potential significant or common drug interactions, and alternative, safe option(s)
    - Advise to seek community pharmacist input for OTC product selection
- Need for laboratory testing
- Proper storage and disposal of the medication
- Supply, cost, and coverage
- Any other information unique to an individual patient or medication
- Pharmacists will document in the progress notes section of the medical record citing this work standard ("Medication Education by Pharmacists Work standard") as well as the following points:
    - Name and indication of medication for which education was provided
    - Individuals to whom education was provided
    - If education was offered but refused
    - Any content relevant to individual situation (per list above) that was not reviewed, including rationale and plan for completion and/or follow-up
    - Any questions, concerns, or issues arising, including a plan for resolution. If no concerns identified, will document same
    - The perceived level of the patient's /caregiver's understanding
    - If supplemental written material provided including source of the material
    - Any additional patient specific information benefiting from documentation in legal record at pharmacist's discretion

References

American Society of Health-System Pharmacists. ASHP guidelines on pharmacist-conducted patient education and counselling. *Am J Health Syst Pharm*. 1997;54(4):431-4.

American Society of Health-System Pharmacists. ASHP guidelines for providing pediatric pharmaceutical services in organized health care systems. *Am J Health Syst Pharm.* 1994;51(11):1690-2.

Documentation of pharmacists' activities in the health record: guidelines. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2013.

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm.* 2019;72(2):151-4.

Appendix 3 (part 1 of 3): Pharmacist documentation in patient medical record – quality improvement assessment tool.

Assessor: _____ Note written by: _____

Date: _____

Assessor to review progress note or each component on the expectation list below, with assessment made if note meets criteria (Yes), does not meet (NO, with comment), or N/A and suggestions for improvement. Strengths of the note should also be highlighted. Verbal discussion of feedback is optimal.

General identification components that MUST APPEAR FOR ALL NOTES			**Y**	**N**	**N/A**	**Comments**
1	Date					
2	Time					
3	Identity of the pharmacist recording the entry, including first initial and last name minimally					
4	Contact information of the pharmacist recording the entry.					
Document attributes – apply to ALL notes		**Description of Documentation Quality**				
1	Note is concise	Produces information important to the purpose of the note, without including irrelevant data.				
2	Note is legible					
3	Approriate use of abbreviations, acronyms, and jargon					
4	Clarity (Organization of note, not content)	Produces a well-articulated note that contains relevant information to support clear recommendations and timelines that ensure accountability for actions required (e.g. states who will monitor and follow up, and when).				
5	Written in a diplomatic tone, using appropriate language for the audience	Avoids being judgmental (e.g. avoids inappropriate terms usch as "wrong, unnecessary, must, should, inappropriate/not appropriate, patient does not want" and utilizes words like: "may benefit from, may no longer require, suggest, recommend, consider, patient would prefer, patient unlikely to adhere to, patient stated". Focuses on solutions rather than problems.				
6	Reason for note (e.g. titled)	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"*).				

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm*. 2019;72(2):151-4.

Appendix 3 (part 2 of 3): Pharmacist documentation in patient medical record – quality improvement assessment tool.

Elements of Care – component AS APPLIES to the intervention/patient situation		**Description of Elements of Care Attribute**				
1	Overall data/information to support assessment and plan	Produces subjective and objective information to support the assessment and plan without including irrelevant information, or missing important information.				
2	Medication list	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).				
3	Reason that the drug treatment was stopped if relevant to the problem	Produces a list of active and recently discontinued mediations with rationale if relevant to the drug related problem being addressed.				
4	Patient's subjective experience with medication, with regards to a potential or actual drug related problem	Produces relevant information regarding patient's experience with medication. No unnecessary information is included.				
5	Drug therapy problems identified	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"*.)				
6	Rationale for conclusions drawn, action plans, or recommendations made	Produces rationale that supports drug recommendations. Identifies therapeutic goals/ targets/desired outcomes. (eg: *"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*.")				
7	Decision(s) or recommendations for changing drug therapy (adding, stopping or changing)	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.				
8	Decision(s) or recommendation(s) for monitoring drug therapy and follow-up	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).				

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm*. 2019;72(2):151-4.

Appendix 3 (part 3 of 3): Pharmacist documentation in patient medical record – quality improvement assessment tool. © 2017 Regina Qu'Appelle Health Region. Reproduced by permission.

9	Description of concerns/ issues identified by the patient during intervention	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"*).				
10	Lists communication with other healthcare professionals	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"*).				
11	Cites any relevant work standard applicable to the intervention	Work standards should be cited where specific work standard applies to the activity or intervention and where citing helps making documentation complete and concise.				

Supplementary material for Zimmer S, Gray C, Roy C, Semchuk WM. Departmental initiative to improve documentation in the medical record by acute care pharmacists. *Can J Hosp Pharm*. 2019;72(2):151-4.