College of Pharmacists of British Columbia

PRACTICE REVIEW PROGRAM

Documentation (Hospital)

Documentation

Health Professions Act (HPA) bylaws require that all activities and information pertaining to the drug therapy of a patient be directly documented in the patient record.

Documentation provides a complete picture of a patient's drug therapy during their hospital stay. A complete patient record can only be established when documentation takes place; simply, when there is no documentation, there is no record. This is why it's important to be vigilant in documenting along the way to be able to piece together the entire drug therapy picture in the future, if needed.

This documentation must include but is not limited to:

- Actual or potential drug-related problems that warrant monitoring,
- Recommendations for changes in drug selection, dosage, duration of therapy, and route of administration,
- Recommendations for monitoring the response to drug therapy,
- Notations of consultations provided to other health care professionals about the patient's drug therapy selection and management,
- Notations of drug-related patient education and/or consultation provided,
- Clarification of drug orders and practitioner's telephone orders received directly by the registrant, and
- Allergies, adverse drug reactions and intolerances.

While pharmacists will be responsible for documenting clinical issues and recommendations, both pharmacists and pharmacy technicians are responsible for documenting their identity when they prepare or perform a final check of a prescription. This documentation must be in writing, readily available, and retained for at least three years.

Depending on how the pharmacy is set up, it is possible for only one pharmacist or multiple pharmacy professionals to be involved in the dispensing process.

- Each pharmacy professional must clearly document in order to identify the step(s) for which they are responsible. For instance, it's possible for one pharmacist to review the patient record and recommend a change in therapy to the prescriber, a second pharmacist or a pharmacy technician to prepare the prescription, a third pharmacist or pharmacy technician to perform the final check on the product, and a fourth pharmacist to provide drug-related patient education to the patient. Each pharmacy professional needs to clearly understand for which step(s) they are responsible and document accordingly.

Written confirmation and identification of each pharmacist or pharmacy technician involved in each step of the dispensing process is required for every prescription.

It is also important to note that a hospital pharmacy providing prescriptions to outpatients must follow the *HPA Bylaws - Community Pharmacy Standards of Practice* when it comes to labelling and dispensing; this includes documentation.

Who can document for these activities?

	Pharmacist	Pharmacy Technician
Identify & Resolve Drug Therapy Problems, If Any	√	
Recommendations for Changes to Drug Therapy & Monitoring	√	
Notations of Consultations to Health Care Professionals & Patients	√	
Clarification of Drug Orders and Receiving Telephone Orders	√	√
Prepare a Prescription	√	√
Perform Final Check	√	√
Updating Allergies, Adverse Drug Reactions, and Intolerances.	√	√

For more information, please refer to: HPA Bylaws Schedule F Part 1, section 6, HPA Bylaws Schedule F Part 2, section 16 & 17, and PODSA Bylaws, section 35.

Why is this a fundamental standard?

Case in point:

An elderly woman presented to hospital with mild fever and a 3- to 4-day history of feeling unwell. She was taking several medications including, citalopram 40 mg daily. While in hospital one of the medications given to her as part of her pneumonia treatment included azithromycin. An electrocardiogram (ECG) conducted during her stay showed atrial fibrillation and a prolonged QT interval. A health record notation questioned the possibility of a drug effect; however, no changes to the medication regimen were instituted. In the subsequent days, the

patient experienced a series of fainting episodes, ultimately followed by cardiac arrest. The patient died shortly after with prolonged QT syndrome secondary to azithromycin and citalopram deemed to have contributed to the death.

Although there may have been clinical reasons for continuing the prescribed treatment, the rationale for continuing both azithromycin and citalopram after the patient's QT prolongation was first identified was not documented and could not be determined retrospectively.

https://www.ismp-canada.org/download/safetyBulletins/2014/ISMPCSB2014-5_KnownDrugInteractions.pdf

Documentation provides a record of what is being done and who is responsible at each step of filling a prescription. It's important to regularly document what you have done, so if anyone looks at the prescription at a future time, it's clear what steps you completed and are responsible for.

You can use a standard documentation format such as DAP to record any ***additional relevant*** information:

D	Data	Information obtained from patient, practitioner, PharmaNet, local profile, lab records, diagnostic tests, vital signs
A	Assessment	Clinical reasoning or rationale, including NESA assessment for drug therapy problems
P	Plan	Any action taken including contacting physician, adapting, recommendations to patient, monitoring, referrals

In deciding what to document, ask yourself: if an issue arises in the future and the prescription is retrieved, can you or another person clearly identify the steps you took, including the information you collected, the clinical assessment you completed, and any additional interventions you provided?

Remember, the more information that is documented, the more complete the record.

Keeping PharmaNet Up to date

When filling prescriptions for outpatients, it is your responsibility to make sure the PharmaNet patient record is also kept current.

Update any:

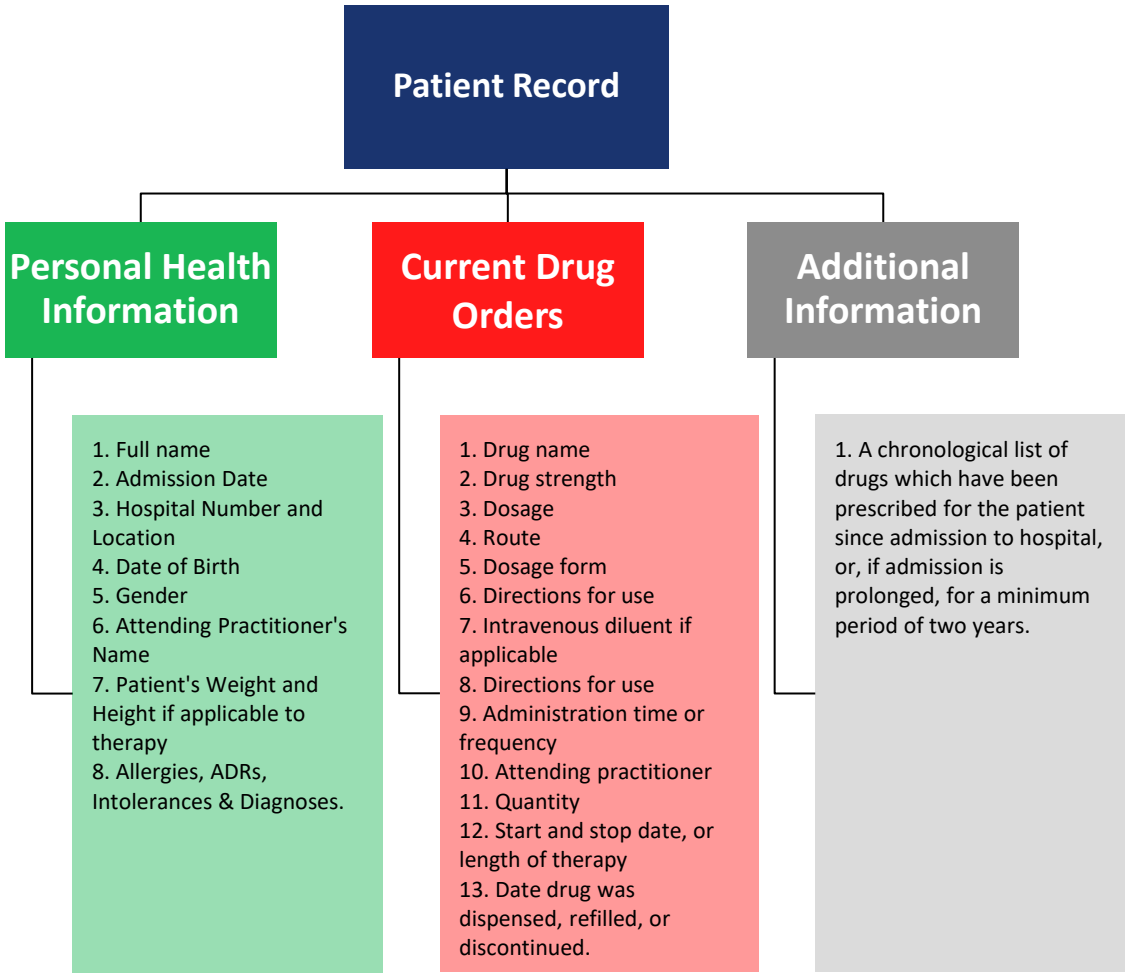
- Address and phone number changes
- Clinical conditions
- Allergies, and adverse drug events and intolerances including date and source collected
- Schedule II and III drugs if applicable

PharmaNet can be updated without filling a prescription. For example, updating allergy information in the absence of a prescription. As per regulations, always verify patient ID when necessary before updating any information on PharmaNet.

Be precise in documenting a drug allergy or intolerance. Include the symptoms of the reaction (e.g. rash or shortness of breath), and any other pertinent details reported by the patient.

For more information, please refer to: PODSA Bylaws, Section 35 & HPA Bylaws Schedule F Part 1, section 11.

Legislative Requirements



For more information, please refer to: HPA Bylaws Schedule F Part 2, section 12.