

# Chapter 13. Documenting Clinical Activities

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## INTRODUCTION

Documenting clinical activities is required for one or more of the following:

- clinical care of individual patients
  - sharing information with other health professionals to contribute to the quality use of medicines using patient-specific forms and health records, e.g. medication reconciliation
  - documenting patient-specific activities for professional accountability, e.g. signing off the National Inpatient Medication Chart (NIMC) and the medication management plan (MMP)
- management of clinical pharmacy activities or incidents
  - recording clinical pharmacist interventions and incidents for risk management and accountability purposes
  - workload statistics and key performance indicators (KPIs) to determine efficiency and quality of service as well as to assist in strategic planning.

Documenting clinical activities provides a permanent record of identified actual and potential medicines-related problems, clinical decisions made and suggested changes to medicine therapy for individual patients.

Documenting clinical interventions and incidents can also identify areas for quality improvement by revealing trends in medicines-related problems.

## OBJECTIVE AND DEFINITION

### Objective

The primary reason for documenting clinical activities is to improve the quality of each patient's care. Documenting clinical activities in the patient's permanent health record is a way of communicating with other health professionals to support the continuity of care of the patient.

Documentation demonstrates the accountability of the pharmacist and the evidence of impact of the pharmacist's services. The continuous and periodic documenting of workload statistics and KPIs aims to assess efficiency and quality of pharmacy service provision and may assist in strategic planning.

### Definition

Documenting activities is an essential element of providing clinical pharmacy services, it involves a standardised process of recording patient-specific information, clinical interventions or incidents, professional actions as well as workload statistics, quality improvement activities and KPIs. This information may be collected and recorded manually or via an electronic medication management system.

## EXTENT AND OPERATION

Clinical activities documented include:

- information in the patient's permanent health record, i.e. NIMC, MMP, health record or organisation-specific form that is filed in the patient's health record
- patient-specific information as part of a departmental record, e.g. patient meets funding criteria for medicine.

Attempts should be made to document clinical pharmacy activities using terms consistent with organisational and national systems for classification of services for coding purposes.

Documenting clinical interventions and incidents, workload statistics and KPIs should be carried out in accordance with local policy and service agreements. See *Chapter 14: Improving the quality of clinical pharmacy services*.

Other clinical activities should be recorded when the information is useful in determining the efficiency and quality of the clinical service and to assist in strategic planning. Documenting non-patient-specific activities should not detract from providing patient-centred care. It may be collected on a continuous basis or periodically depending on service agreements.

## POLICY AND PROCEDURE

How information is documented will be dependent on local policy and will be influenced by the nature of the information and who the information is intended for. This is applicable to all forms of documentation, manual and electronic. Patient-specific information may be documented:

- on the NIMC and associated medication charts
- on the MMP or equivalent
- directly in the patient's health record.

Documented patient-specific information must comply with the user guides of the NIMC and MMP and the provisions of privacy legislation including the relevant state privacy laws and the National Privacy Principles in the *Privacy Act*.<sup>1,3</sup> Ideally, recorded patient-specific information is linked to pharmacy workload data, e.g. recording clinical interventions and changes to medicines in the patient's health record as well as in workload documentation.

## Inpatient Medication Administration Order

The NIMC is intended to ensure best practice and assist in improving the steps in the medication management cycle through safer prescribing, dispensing and administration of medicines and minimising the risk of adverse medication events.<sup>1</sup> Pharmacists should be familiar with the *NIMC User Guide*. The NIMC is appropriate for most hospital settings, however there will be occasions when organisation-specific medication orders or charts are used. These standards are applicable regardless of the form used (paper-based or electronic).

Any annotations by the pharmacist should be easily identified as being distinct from the prescriber. Organisation policy may allow for the use of coloured ink, which should be easily visible when charts are photocopied, faxed or scanned. If an annotation is made the pharmacist's signature, designation and contact details should be clearly identifiable on that page.

Ensure the NIMC or order has been correctly completed. If appropriate, the pharmacist should document omitted information.

Use only accepted abbreviations as defined in the *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines*.<sup>4</sup>

Check that adverse drug reactions (ADRs) have been annotated appropriately on the chart. Ensure the ADR sticker is also on the chart if ADRs are listed. If the patient is not aware of previous ADRs, then the 'nil known' box should be ticked and the person documenting must sign, print their name and date the entry.

The pharmacy section for each individual order is for use by the pharmacist to clarify the order, indicate source of supply or provide administration instructions. There are suggested annotations for supply.<sup>1</sup> The pharmacist should sign the pharmaceutical review section at the bottom of the NIMC to indicate the appropriateness of all medicines ordered for that patient, e.g. doses, drug interactions.

The medication history documentation section may be completed by the admitting medical officer, nurse, pharmacist or other clinician trained in medication history documentation. The NIMC provides space for minimum information to be documented on admission. Health service organisations may choose to implement a more comprehensive approach to documentation such as using a MMP or local equivalent. If the medication history is recorded on both forms then the information should be the same. See *Chapter 1: Medication reconciliation*. Ideally, the medication history is only recorded in one place and the NIMC should be annotated to indicate where the medication history is recorded.

It is also helpful to document the indication for each medicine in the medication history section of the NIMC, use a checklist such as the one on the *National Medication Management Plan* to ensure a comprehensive history is obtained. See *Chapter 1: Medication reconciliation*.

Document the quantity of medicine supplied to the patient on discharge/transfer on the form used by the health service organisation.

### Medication Management Plan

It is essential that information relating to the management of a patient's medicines is documented in a routine manner that enable all healthcare team members (medical, nursing, pharmacists) to have timely and full access to assist in decision making. This information should be documented using a standardised format that forms part of the patient's health record. This information may be documented in either a paper-based or electronic format.

All healthcare team members should use this primary document to record the patient's MMP and assist with their clinical decision making. This document will be constantly updated during the episode of care and forms the basis of information provided at discharge or transfer. Duplicating this information in clinician-specific tools is not encouraged.

Decisions regarding the use and format of MMPs will depend on the organisation, the clinical service being offered and the ability to obtain information in a timely manner from other sources. Local policy may dictate the use of an organisation-specific medication history and reconciliation or MMP forms. These forms may be either paper-based or electronic and after discharge are filed in the patient's health record.

The *National Medication Management Plan* is a national standardised document that can be used to improve the accuracy and completeness of documented

medicines information and the continuity of medicines management. It may be used to record:

- medicines taken before admission
- changes to medicines
- patient-specific risks regarding medicines
- medication reconciliation on admission, intra-hospital transfer and discharge.

Pharmacists using the *National Medication Management Plan* should be familiar with the *National Medication Management Plan User Guide*.<sup>3</sup>

The MMP or equivalent should be kept with the active medication chart(s) throughout the patient's admission. It should be available to and used by other health professionals and the patient/carer when possible. After discharge it should be filed with the patient's permanent health record.

Specific information documented on a MMP or other report could include:

- history of presenting complaint and reason for current admission
- assessment of the patient's clinical problems
- plan for the management of the patient's clinical problems and therapeutic goals
- past and current medical and surgical problems
- list of medicines at time of admission and past medication history
- details of allergies and ADRs, including dates and descriptions of reactions and re-exposure to the drug
- relevant laboratory parameters
- medication risk identification including actual or potential medicines-related problems and management
- plans for patient care, e.g. outcome monitoring, discharge planning
- patient medicine education planned and dates when performed, e.g. warfarin, inhaler technique
- changes to the patient's medicines regimen. An assessment of adherence and plans for the provision of adherence aids and review dates and deadlines
- Home Medicines Review referral checklist.

Any documented comments should be objective, respectful and non-critical of the patient and other health professionals. Choose words such as 'suggest' or 'consider' rather than 'do' or 'needs'.

### Patient Health Record

Information documented in the health record is intended to form a permanent record and to supplement, not replace, verbal communication. When making an entry in the health record:

- identify discipline (i.e. pharmacist), date and time
- follow a logical sequence, e.g. SOAP method:<sup>5</sup>
  - subjective relevant patient details
  - objective clinical findings
  - assessment of the situation or clinical problem
  - proposed management plan
- limit comments to 'recommendations' to allow scope for discussion
- document relevant discussion of the issue with prescriber or nursing staff
- use only well-recognised abbreviations (refer to an appropriate medical abbreviations document)
- document the strategy for clinical review and monitoring
- sign the entry, print name and designation alongside the signature and provide contact details.

Consider documenting the following details or activities relating to medicines-related problems and potential actions in the patient's MMP or health record:

- information obtained from an accurate medication history including an assessment of patient adherence with the prescribed medicines regimen
- medication reconciliation record to form part of the patient health record where not recorded in a organisation-specific form
- identification of serious clinical problems with discussion of the pharmacist's assessment
- details of patient education and administration and adherence aids provided
- response to patient-specific questions from other staff e.g. recommended doses
- provision of patient-specific medicines information and specific therapeutic information, e.g. potential drug interactions
- recommendations for therapeutic drug monitoring and evaluation of therapeutic drug monitoring data
- ADR assessment and management recommendations
- serious concerns about medicine therapy that cannot be verbally communicated to a medical officer (or which has not been addressed by medical staff, or which would potentially imply negligence by the pharmacist if not documented).

### Organisation-Specific Forms

Organisations may choose to develop their own standardised forms for recording patient-specific information. It is important that patient-specific information is accessible to all members of the healthcare team during the patient admission and filed in the health record at discharge.

### Clinical Interventions or Addressed Medicine-Related Problems

Previous versions of these standards have defined a pharmacist intervention as any action that directly results in a change in patient management or therapy.

The *Standard and Guidelines for Pharmacists Performing Clinical Interventions* defines a drug-related problem (DRP) as 'an event or circumstance involving drug treatment that actually or potentially interferes with the patient experiencing an optimum outcome of medical care'.<sup>6</sup> It goes on to define pharmacist clinical interventions as: 'the process of a pharmacist identifying, and making a recommendation in an attempt to prevent or resolve, a DRP. It can be defined as 'any professional activity by the pharmacist directed towards improving the quality use of medicines and resulting in a recommendation for a change in the patient's medication therapy, means of administration or medication-taking behaviour.'<sup>6</sup>

Departments should have a formalised policy on documenting pharmacist interventions. Ideally, information on the setting and service being provided, e.g. medication reconciliation on admission, medication review in residential aged-care facility, should be recorded along with:

- medicine(s) involved
- date and patient demographic data
- treating unit/provider
- pharmacist identifier
- category of the DRP
- category of the pharmacist recommendation
- category of the action taken in response to the DRP.

The following categories can be used to record the DRPs (adopted from the DOCUMENT system, detailed definitions in *Standard and Guidelines for Pharmacists Performing Clinical Interventions*):<sup>6</sup>

- drug selection – duplication
- drug selection – drug interaction
- drug selection – wrong drug
- drug selection – incorrect strength
- drug selection – inappropriate dose form
- drug selection – contraindications apparent
- drug selection – no indication apparent
- drug selection – other drug selection problem
- drug selection – drug should have been ceased
- over or underdose – prescribed dose too high
- over or underdose – prescribed dose too low
- over or underdose – incorrect or unclear dosing instructions
- over or underdose – other dose problem
- compliance – under-use by consumer
- compliance – over-use by consumer
- compliance – erratic use of medication
- compliance – intentional drug misuse
- compliance – difficulty using dosage form
- compliance – other compliance problem
- undertreated – condition undertreated
- undertreated – condition untreated
- undertreated – preventive therapy required
- undertreated – other untreated indication problem
- monitoring – laboratory monitoring
- monitoring – non-laboratory monitoring
- monitoring – other monitoring problem
- education or information – consumer requests drug information
- education or information – consumer requests disease management advice
- education or information – other education or information problem
- non-classifiable
- toxicity, allergic reaction or adverse effect present.

The following categories can be used to record the pharmacist recommendations (adopted from and detailed definitions in *Standard and Guidelines for Pharmacists Performing Clinical Interventions*):<sup>6</sup>

- change of therapy – dose increase
- change of therapy – dose decrease
- change of therapy – drug change
- change of therapy – drug formulation change
- change of therapy – drug brand change
- change of therapy – dose frequency/schedule change
- change of therapy – prescription not dispensed
- change of therapy – other changes to therapy
- referral required – refer to prescriber
- referral required – refer to hospital
- referral required – refer for medication review
- referral required – other referral required
- provision of information – education or counselling session
- provision of information – written summary of medications
- provision of information – recommended adherence aid
- provision of information – information documented for patient's permanent record
- provision of information – other written information
- monitoring – monitoring laboratory
- monitoring – monitoring non-laboratory test
- no recommendation necessary.

Table 13.1 Risk classification of pharmacy interventions using a consequence/probability matrix <sup>9</sup>					
Consequence or impact					
Level	Descriptor	Description: assume intervention not made, probable scenario (not worse case)			
1	Insignificant	No harm or injuries, low financial loss			
2	Minor	Minor injuries, minor treatment required, no increased length of stay or re-admission, minor financial loss			
3	Moderate	Major temporary injury, increased length of stay or re-admission, cancellation or delay in planned treatment/procedure. Potential for financial loss			
4	Major	Major permanent injury, increased length of stay or re-admission, morbidity at discharge, potential for significant financial loss			
5	Catastrophic	Death, large financial loss and/or threat to goodwill/good name			
Likelihood of occurrence					
Level	Descriptor	Description: likelihood of impact occurring without intervention and scenario occurring in the future			
A	Almost certain	Is expected to occur in most circumstances			
B	Likely	Will probably occur in most circumstances			
C	Possible	Might occur at some time			
D	Unlikely	Could occur at some time			
E	Rare	May occur only in exceptional circumstances			
Risk (consequence x likelihood)					
Likelihood	Insignificant	Minor	Moderate	Major	Catastrophic
A (almost certain)	H	H	E	E	E
B (likely )	M	H	H	E	E
C (possible)	L	M	H	E	E
D (unlikely)	L	L	M	H	E
E (rare)	L	L	M	H	H
E = extreme risk; H = high risk; M = moderate risk; L = low risk.					

The following categories can be used to record the action taken in response to the DRP:

- prescriber has accepted pharmacist recommendation
- prescriber has not accepted pharmacist recommendation
- pharmacist has provided service as recommended
- patient has accepted pharmacist recommendation
- patient has not accepted pharmacist recommendation
- unknown at time of recording DRP.

In many instances, clinical interventions by pharmacists are examples of 'near-miss' incidents. It is recommended that reporting of clinical interventions be linked to incident monitoring to identify areas for performance improvement throughout the organisation. This will provide guidance for the best method of documenting clinical interventions.

Where possible, assign a risk assessment by using guidelines, such as the *Australian Standards for Risk Management* that includes a description of the consequence (impact) and likelihood of occurrence happening again.<sup>7</sup> It should involve formal reporting to selected organisation quality forums and incident monitoring systems, especially those interventions classified as high and extreme risk. See Table 13.1.

Using trends in clinical intervention data, the activities of pharmacists can be optimised to focus on the activities that have the greatest impact and identify the medicines that should be targeted to result in positive changes.<sup>8</sup> Additional reasons for recording interventions include:

- education and training of pharmacy staff regarding their performance and identification of actual and potential problems
- providing information to hospital management regarding the performance of the pharmacy services
- local and national benchmarking activities.

### Pharmacy Patient Profiles

The health record is the definitive document of a patient's care and must always be the key reference point. There is no specific requirement for the need to maintain separate or additional pharmacy patient profiles beyond the episode of care.

If separate or additional records are maintained, the pharmacy service must ensure the privacy and security of the records are maintained.

### Workload Data

Non-patient-specific activities, including clinical workload data, may be documented using a variety of formats. Use strategies to ensure that workload documenting does not take up a large component of clinical pharmacists' time and distract from providing clinical services, e.g. support staff, pharmacy software, risk management software.

Table 13.2 lists the competencies and accreditation frameworks that are relevant to this chapter.

### References

1. Australian Commission on Safety and Quality in Health Care. National inpatient medication chart user guide. Sydney: The Commission; 2009.
2. Australian Commission on Safety and Quality in Health Care. National medication management plan user guide. Sydney: The Commission; 2011.
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5. Hughes J, Donnelly R, James-Chatgilaou G. Clinical pharmacy – a practical approach. 2nd ed. South Yarra: McMillan Publishers Australia Pty Ltd; 2001.
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9. Tenni P. Clinical interventions: documenting, defining and developing clinical pharmacist activities [abstract]. Aust J Hosp Pharm 1996; 26: 154.
10. Society of Hospital Pharmacists of Australia. Clinical competency assessment tool (shpaclinCAT version 2). In: SHPA standards of practice for clinical pharmacy services. J Pharm Pract Res 2013; 43 (suppl): S50-S67.
11. Australian Pharmacy Profession Consultative Forum. National competency standards framework for pharmacists in Australia. Deakin: Pharmaceutical Society of Australia; 2010.
12. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney: The Commission; 2011.

<b>Table 13.2 Competencies and accreditation frameworks</b>
<b>Relevant national competencies and accreditation standards and shpaclinCAT competencies</b>
<b>shpaclinCAT<sup>10</sup></b>
<b>Competency unit 1.1 Medication history</b> 1.1.5 Allergy and adverse drug reaction review 1.1.9 Documentation of medication history
<b>Competency unit 1.2 Assessment of current medication management and clinical review</b> 1.2.1 Medication reconciliation 1.2.1.1 Selection of formulation, concentration or rate 1.2.1.3 Therapeutic drug concentration monitoring
<b>Competency unit 1.3 Identification, prioritisation and resolution of medicines-related problems</b> 1.3.5 Documentation of medicines-related problems 1.3.7 Documentation of clinical pharmacy activities
<b>Competency unit 2.7 Professional qualities</b> 2.7.2 Confidentiality
<b>National competency standards framework for pharmacists<sup>11</sup></b>
<b>Standard 2.2 Work to resolve problems</b> 2 Act to resolve the problem/potential problem
<b>Standard 7.1 Contribute to therapeutic decision-making</b> 1 Obtain accurate medication history 3 Recommend change in medication management
<b>Standard 7.2 Provide ongoing medication management</b> 2 Review clinical progress 3 Initiate monitoring and intervention 4 Manage medication management records
<b>National safety and quality health service standards<sup>12</sup></b>
<b>Standard 4 Medication safety: documentation of patient information</b> 4.6 Accurate medication history 4.7 Documentation of adverse drug reactions 4.8 Review and reconciliation on admission and transfer