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### Preface:

The Patient Care Process Working Group was formed in July 2010 with pharmacy representation from the Faculty of Pharmacy & Pharmaceutical Sciences at the University of Alberta, Alberta Health Services, community practice, and primary care. The purpose of the Patient Care Process document is to outline a systematic and standardized approach to teach the provision of direct patient care in the practice of pharmacy (for undergraduate students, residents, experiential learners, preceptors and practitioners). In addition, in the undergraduate pharmacy curriculum, a need was identified to help link independent components of patient care in the context of the whole patient care process.

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Approved by: Curriculum Committee, Faculty of Pharmacy & Pharmaceutical Sciences, April 2011

Updated July 2012 by Working Group

Updated August 2013 by Pharm 314/330/430 Course Coordinators and discussed with Practice Division (September 2013), Faculty of Pharmacy and Pharmaceutical Sciences
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Patient Care Process

- Is therapy indicated, effective, and safe?
- Is the patient able to adhere?

Follow-up/monitoring plan

Develop a care plan

Communication

Documentation

Patient Assessment

Gather information - create database

Evaluate information

Reason for patient assessment

Open the interaction & develop the relationship

Medical History
Medication History

Goals of therapy
Alternatives
Recommendations
Monitoring
Follow-up

Figure adapted from Practice Development Practice Skills Bootcamp
Faculty of Pharmacy & Pharmaceutical Sciences, University of Alberta
Patient Assessment-Database-Medical History

- Create a patient database using information gathered in the patient’s Medical History and Medication History.
- Examples of information sources to consult include the patient, family/agent, chart or medical record, pharmacy, Netcare/PIN, and other health care workers.
- The scope of information gathered depends on practice site, setting of interview (home, clinic, hospital, community pharmacy), type of assessment, relevance of information, and a realistic timeframe.

Demographics
- Name, DOB, PHN, gender, address, telephone, marital status, language, health care workers
- Height, weight, ideal body weight (IBW), body mass index (BMI) (if relevant)

Reason for Assessment
- Why is patient seeking care? Describe condition/problem and duration.
- What is the reason for the referral or assessment?
- What is the patient agenda? (obtain complete list; negotiate what will be addressed today vs. future visits)
- Note: There may not always be a new medical problem or issues with therapy (i.e. routine refill or follow-up)

History of Present Illness (HPI)
- The HPI refers to a more detailed assessment of the patient’s presenting symptom(s).
- The table below illustrates the type of questioning required for symptom assessment.

<table>
<thead>
<tr>
<th>Location</th>
<th>Where is the symptom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Severity</td>
<td>What is the symptom like? Does it interfere with the patient’s lifestyle? Describe it further. What is the severity of the symptom? (mild, moderate, severe)</td>
</tr>
<tr>
<td>Quantity</td>
<td>What is the frequency of the symptom?</td>
</tr>
<tr>
<td>Timing</td>
<td>What is the duration of the symptom? When did it first present?</td>
</tr>
<tr>
<td>Setting</td>
<td>What was the patient doing when the symptom first presented?</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Are there any relieving or aggravating factors? What makes it better or worse?</td>
</tr>
<tr>
<td>Associated Symptoms</td>
<td>Are there any associated symptoms? (Include absence of symptoms if relevant-i.e. no fever, no cough, no dyspnea, etc.)</td>
</tr>
</tbody>
</table>

There are also other tools used to characterize a patient’s presenting symptom(s). Examples of these mnemonics include SCHOLAR, SOCRATES, OPQRST, and LOCQSMAT.

- **SCHOLAR**: Symptoms, Characteristics, History, Onset, Location, Aggravating & Remitting Factors
- **SOCRATES**: Site, Onset, Character, Radiation, Associations, Time Course, Exacerbating & Relieving Factors, Severity
- **OPQRST**: Onset, Provokes or Palliates, Quality, Radiates, Severity, Time
- **LOCQSMAT**: Location, Onset, Chronology, Quality, Severity, Modifying Factors, Additional Symptoms, Treatment

**Past Medical History (PMH)**

- List medical conditions/problems (dates and duration)
- Hospitalizations, surgeries, accidents, injuries (if relevant)
- Recent specialist visits; other clinics/caregivers

**Medication History (see separate template)**

**Family History (FH)**

- Illnesses of first degree relatives (status of living and causes of death/age)
- Attention to heart disease, hypertension, hyperlipidemia, diabetes, cancer, osteoporosis, alcoholism, mental illness

**Functional History** (if relevant- i.e. geriatrics, stroke patient, homeless, new immigrant, etc.)

- Ability to do Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Describe functional decline (onset, activity impacted); Supports?

**Social History (SH)**

- Nutrition, exercise, education, occupation/work history, marital status, living conditions (where and with whom?)
- Substance use (caffeine, alcohol, tobacco, illicit drugs): type, amount, pattern, duration, date/time last intake or history of use
- Tobacco products: type [for a smoker: # ppd and/or pack-years (#ppd x # yrs smoked)]
- Sexual History (if relevant- i.e. functional, pregnancy, STIs)

**Review of Systems (ROS)**

- Identify any further problems (i.e. medical problems, adverse effects); note presence/absence of symptoms
- Head to toe assessment (keep questions relevant and brief; not all systems need to be reviewed)
As part of the ROS, the following serve as examples to consider for each body system

<table>
<thead>
<tr>
<th>Body System</th>
<th>Symptoms and Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>energy levels, weight changes, ailments, pain</td>
</tr>
<tr>
<td>Integument</td>
<td>rashes, dryness, pruritus, hair loss, nails</td>
</tr>
<tr>
<td>Head/Neurologic</td>
<td>mental status, headache, syncope, seizures, tremor, weakness, vertigo</td>
</tr>
<tr>
<td>Eyes</td>
<td>redness, discharge, blurring, vision, pain, glaucoma, cataracts</td>
</tr>
<tr>
<td>Ears</td>
<td>hearing loss, tinnitus, earache, discharge</td>
</tr>
<tr>
<td>Nose/Sinuses-</td>
<td>rhinitis, sinus congestion, discharge</td>
</tr>
<tr>
<td>Mouth/Pharynx</td>
<td>dentition, hoarseness, pharyngitis, ulcerations</td>
</tr>
<tr>
<td>Neck</td>
<td>swollen lymph nodes/glands, goiter, pain</td>
</tr>
<tr>
<td>Chest/Lungs</td>
<td>cough, dyspnea, wheezing, sputum, asthma, bronchitis, pneumonia</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>chest pain, murmurs, palpitations, hypertension, myocardial infarction</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>dysphagia, odynophagia, reflux, nausea, vomiting, bowel movements, stool</td>
</tr>
<tr>
<td>Urinary</td>
<td>pain, frequency, urgency, incontinence, retention, bleeding</td>
</tr>
<tr>
<td>Hepatic/Renal</td>
<td>organ function, infection (hepatitis, pyelonephritis)</td>
</tr>
<tr>
<td>Reproductive</td>
<td>libido, discharge, infection, menstrual, menopause</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>stiffness, pain, motion, swelling, redness, deformities</td>
</tr>
<tr>
<td>Endocrine</td>
<td>thyroid, diabetes, adrenals, estrogen, testosterone</td>
</tr>
</tbody>
</table>


Physical Exam (PE), Vital Signs (VS), Investigations/Diagnostics

Laboratory findings (Labs)

- Review relevant laboratory findings in groupings (CBC, electrolytes, renal function/creatinine clearance, liver function, coagulation tests, microbiology results, etc.)
Other common terms involving Medication Histories are “Best Possible Medication History” (BPMH) and “Medication Reconciliation” (see www.saferhealthcarenow.ca).

Create a patient database using information gathered in the patient’s Medical History and Medication History.

Examples of information sources to consult include the patient, family/agent, chart or medical record, pharmacy, Netcare/PIN, and other health care workers.

The scope of information gathered depends on practice site, setting of interview (home, clinic, hospital, community pharmacy), type of assessment, relevance of information, and a realistic timeframe.

Allergies

- List medication/food allergies
- Describe reaction (date, onset, signs/symptoms, management [pharmacologic/non-pharmacologic], outcome)
- Any reactions to other medications in the same class?

Adverse Effects

- As described by patient, abnormal laboratory findings, documented adverse effects
- Describe adverse effect (date, onset, signs/symptoms, management [pharmacologic/non-pharmacologic], outcome)
- Tolerability to other medications in the same class?

Current Medications

- List current medications (include patient, family/agent, chart, pharmacy, Netcare/PIN, health care workers)
- Indication, dosage, schedule, duration, outcome
- Quantify use of prn medication (check on refills, ask patient)
- See section on “Medication Adherence” for more details on adherence assessment

Past Medications

- List past medications (this will depend on relevance of medical history and indication for new therapies)
- Indication, dosage, schedule, duration, outcome
- Why was drug discontinued?
- Antibiotic use in past 3 months (if relevant to the medical history)

Non-prescription Medications

- OTC, CAMs, vitamins, minerals, other supplements
Other Medications & Immunizations

- Eye/Ear/Nose products
- Inhalers/Patches/Creams/Ointments/Injectables/Medication samples
- Consider using prompts to question for specific drugs commonly used in a given patient population (i.e. analgesics, antiemetics, laxatives, sedative, etc.)
- Immunization History

Medication Experience

- “The medication experience is an individual’s subjective experience of taking a medication in his daily life.” (Shoemaker, 2008)
- A patient's medication experience may shape the patient's attitudes, preferences about drug therapy, and drug taking behavior.
- Be attentive to patient’s general attitude to medications, preferences, concerns, understanding, and cultural and ethical beliefs.
- Often this information is gathered indirectly in the patient interview.

Medication Adherence

- How is the medication prescribed vs. how does patient actually take the medication? (consider times, frequency, food; verify refill frequency)
- Describe daily routine (open-ended, non-judgemental); how medication is taken/where is it stored?
- How often in a week does patient miss a dose of medication?
- What is the system used to manage/remember medication (i.e. supports, reminders, calendars, certain cues/times of day, blister packs, dosettes)
- Reasons for nonadherence/ potential solutions? (i.e. patient preference/beliefs, adverse effects, cost, drug formulation, dosing schedule, health literacy, memory, technique, functional ability)

Other Medication Considerations

- Community Pharmacy, Medication Payment Plan; concerns with cost of medication?
- Prescribing physicians/ other health care workers involved in patient’s care
- Confidentiality (i.e. who knows about medical conditions and therapies?)
- Medication sharing (i.e. does the patient share or borrow medications from others?)
- How is the following done?
  - Ordering medication refills, pick-up/delivery
  - Organization & administration (e.g. dosette, ability to self-medicate, given by caregiver)
  - Use/functional ability (e.g. dexterity (opening vials), vision, swallowing, memory)
  - Monitoring (e.g. hypertension, blood glucose, laboratory work)
  - Storage (e.g. where/how are they stored?)
Pharmacotherapy Workup Flow Sheet

**Medical Condition/Problem**

Is therapy indicated? (Consider non-drug management and patient preferences)

- **Yes**  
  Is drug therapy optimal (first-line) for that specific condition?
  - Yes: Move on to Efficacy Evaluation
  - No: Explore reasons for use of alternate drug therapy

Is drug therapy effective for each indication?

- **No**
  - Why? Additional therapy required, Non-adherence, Low dose/dosing frequency/dose titration, Interaction, Onset of action, Malabsorption, Formulation, Expired drug
  - Move on to Adherence and Safety Evaluation

- **Yes**: Move on to Efficacy Evaluation

**Indication**

**Efficacy**

Is the patient able to take drug therapy as prescribed?

- **No**
  - Why? Incorrect dosage form/frequency, Directions not understood (consider culture, language, education/health literacy), Cost/Drug access, Patient preference, beliefs, motivators, Patient ability to self-administer drugs (age, dexterity, vision, swallowing, memory)
  - Move on to Safety Evaluation

- **Yes**: Move on to Adherence and Safety Evaluation

**Adherence**

**Safety**

Is the patient at risk of or experiencing any adverse effects?

- **No**: Is the dose appropriate? (Consider weight, organ function, age) Is the patient being monitored appropriately?

  - Yes:
    - Is the dose too high? (Consider weight, organ function, age) Can the adverse effect be managed? Is a change in therapy indicated?

  - No: Can the interaction be managed? Is a change in therapy indicated?

- **Yes**: Continue therapy, it appears appropriate for this patient.
Patient Care Process

1. Perform a Patient Assessment:

- Before starting to work through the process of assessing drug therapy it is important to:
  - Observe the patient’s presentation (i.e. physical appearance, emotional state)
  - Gather relevant patient information
- Create a Patient Database
  - Examples of information sources to consult include the patient, family/agent, chart or medical record, pharmacy, Netcare/PIN, and other health care workers.
  - Critical components of the database include a Medical History and Medication History
    - Medical History
      - Review medical record, Netcare, interview the patient or family/agent, discuss with other health care workers
    - Medication History
      - Review medical record, Netcare/PIN, interview the patient/caregivers, contact community/hospital pharmacy as appropriate

2. Perform a Pharmacotherapy Workup (Assess Drug Therapy):

- Keep in mind types of Drug-Related Problems (DRPs) when assessing drug therapy.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Type of DRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication</td>
<td>Unnecessary Drug</td>
</tr>
<tr>
<td></td>
<td>Additional Drug Therapy Required</td>
</tr>
<tr>
<td>Efficacy</td>
<td>Ineffective Drug- incorrect drug or drug product</td>
</tr>
<tr>
<td></td>
<td>Dose too Low (correct drug, wrong dose)</td>
</tr>
<tr>
<td>Adherence</td>
<td>Non-adherence (not taking enough drug)</td>
</tr>
<tr>
<td></td>
<td>Over-adherence (taking too much drug)</td>
</tr>
<tr>
<td>Safety</td>
<td>Adverse Drug Reaction</td>
</tr>
<tr>
<td></td>
<td>Dose too High (toxicity)</td>
</tr>
<tr>
<td></td>
<td>Drug Interaction</td>
</tr>
<tr>
<td>No DRPs identified</td>
<td>Drug therapy is appropriate for a specific patient; ongoing monitoring required</td>
</tr>
</tbody>
</table>
Evaluate the following parameters (Indication, Efficacy, Adherence, and Safety).

### INDICATION

<table>
<thead>
<tr>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical History</td>
</tr>
<tr>
<td>o Obtain complete list of medical conditions/problems (consider patient symptoms, diseases, laboratory data, physical examination findings, other investigations)</td>
</tr>
<tr>
<td>o Consider patient demographics (i.e. age, gender, ethnicity, height, weight) and organ function (i.e. hepatic, renal function)</td>
</tr>
<tr>
<td>o Consider need for prophylactic/preventative therapies (including immunizations) based on medical history</td>
</tr>
<tr>
<td>o Consider possibility of the medical problem being caused by a drug adverse effect? (review Safety assessment below)</td>
</tr>
<tr>
<td>• Medication History</td>
</tr>
<tr>
<td>o Consider contraindications to therapy, drug allergies, adverse effects when initially assessing for appropriateness</td>
</tr>
<tr>
<td>• Patient preferences and goals of therapy</td>
</tr>
<tr>
<td>o Does the patient even want drug therapy?</td>
</tr>
<tr>
<td>o Are there non-drug measures that can be considered?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inquire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is drug therapy indicated?</td>
</tr>
<tr>
<td>NO: If drug therapy is not indicated, can it be discontinued?</td>
</tr>
<tr>
<td>YES: If drug therapy is indicated, has it been initiated?</td>
</tr>
<tr>
<td>If drug therapy is indicated, but has not been initiated, why?</td>
</tr>
<tr>
<td>o Consider patient factors such as preference, beliefs, lifestyle; unintentional omission; deferred therapy; competing priorities; cost, etc.)</td>
</tr>
<tr>
<td>Is drug therapy optimal (is it considered the best/first-line therapy for a given condition)?</td>
</tr>
<tr>
<td>NO: Explore reasons for use of alternate drug therapy (i.e. optimal therapy is contraindicated, patient preference/needs, drug efficacy, drug safety, adherence and cost)</td>
</tr>
<tr>
<td>o Consider switching to optimal therapy if appropriate</td>
</tr>
<tr>
<td>YES: Move on to efficacy evaluation</td>
</tr>
</tbody>
</table>

### EFFICACY

<table>
<thead>
<tr>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Goals of therapy and timeframes to achieve these goals for each medical problem</td>
</tr>
<tr>
<td>• Efficacy Monitoring Parameters for drug therapy</td>
</tr>
<tr>
<td>o Consider drug efficacy, subjective/objective parameters; timeframe anticipated to achieve the desired outcome.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inquire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is drug therapy effective for each indication?</td>
</tr>
<tr>
<td>NO: Consider additional therapies, non-adherence, low dose/dosing frequency/titration, interaction, onset of action, malabsorption, formulation, expired drug</td>
</tr>
<tr>
<td>YES: Move on to Adherence and Safety Evaluation</td>
</tr>
</tbody>
</table>

### ADHERENCE

<table>
<thead>
<tr>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication History/Refill History</td>
</tr>
<tr>
<td>• Medical History</td>
</tr>
<tr>
<td>• Patient factors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inquire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient able to take drug therapy as prescribed?</td>
</tr>
<tr>
<td>NO: Consider adverse effects, incorrect dosage form/frequency, directions not understood, cost/drug access, patient preference, beliefs, motivators, ability to self-administer drugs (i.e. age, dexterity, vision, swallowing, memory)</td>
</tr>
<tr>
<td>• Can the medication adherence be improved?</td>
</tr>
<tr>
<td>o Consider medication packaging, caretaker support, drug substitution, motivational interviewing, scheduling, and addressing patient specific barriers</td>
</tr>
<tr>
<td>YES: Move to Safety Evaluation</td>
</tr>
</tbody>
</table>
### SAFETY

<table>
<thead>
<tr>
<th>Review</th>
<th>Inquire</th>
</tr>
</thead>
</table>
| - Safety Monitoring Parameters for drug therapy  
- Signs & symptoms experienced by the patient  
- Medication History  
  - Review past and current medication history  
  - Review allergy history and past adverse effects to medications  
- Medical History  
  - Consider possibility of the medical problem and/or laboratory data abnormality being caused by drug therapy (review likelihood of drug vs. disease-related causes)  
- Patient factors (diseases, when drugs are taken relative to meals, spacing medications, etc.)  
- Drug interactions (drug-drug, drug-disease, drug-food, drug-laboratory)  |
| **ADVERSE EFFECTS**  
Is the patient at risk of or experiencing a medical problem/adverse effect that could be caused by drug therapy?  
- Consider safety monitoring parameters  
- Consider causality, onset, timeframe, dose, and type of reaction [i.e. dose-related, idiosyncratic, hypersensitivity]  

**NO:** Ensure that the dose is appropriate to prevent future adverse effects (consider weight, organ function, age). Ensure the patient is being monitored appropriately.  

**YES:**  
- Is the drug dose too high?  
  - Consider weight, organ function, age, drug kinetics/therapeutic index, duration of therapy  
- Can the adverse effect be managed?  
  - Consider dose decrease, patient education, timeframe, need for additional drug therapy, nonpharmacologic intervention  
  - If the drug is discontinued, is there another appropriate therapy instead?  

**DRUG INTERACTIONS**  
Is the patient at risk of or experiencing any significant drug interactions?  
- Consider drug-drug, drug-food, drug-disease, drug-laboratory test value interactions  

**NO:** Continue therapy; it appears appropriate for this patient  

**YES:** Can the drug interaction be managed?  
- Consider onset/offset, dosage adjustment, spacing apart, food effect, drug substitution, increased monitoring, therapeutic drug monitoring (TDM)  
- If the drug is discontinued, is there another appropriate therapy instead?
Develop a Pharmacy Care Plan - Pharmacy Care Plan Worksheet

<table>
<thead>
<tr>
<th>MEDICAL CONDITIONS &amp; MED-RELATED NEEDS</th>
<th>GOALS OF THERAPY</th>
<th>ALTERNATIVES</th>
<th>RECOMMENDATIONS/PLAN</th>
<th>MONITORING PLAN</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>List and prioritize each medical condition first, followed by any DRPs identified for a given condition. Although some medical conditions may not have a DRP, a care plan is still necessary for ongoing patient monitoring. <strong>DRP Categories:</strong> unnecessary drug • additional drug required • ineffective drug • dose too low • adverse drug reaction/interaction • dose too high • nonadherence</td>
<td>For each medical condition and/or DRP state desired goals of therapy/timeframe. <strong>Goals:</strong> cure, prevent, slow/stop progression, reduce/eliminate symptoms, normalize a lab value. <strong>Consider:</strong> realistic goals determined through patient discussion. Goals of therapy are measurable or observable parameters that are used to evaluate the efficacy and safety of therapy.</td>
<td>Compare relevant drug and non-drug therapies that will produce desired goals. List the <strong>pros</strong> and <strong>cons</strong> of each therapy as well as rationale for each being included. <strong>Consider:</strong> Indication Efficacy Adherence Safety Cost/coverage</td>
<td>In collaboration with the patient and other health care providers, select the best alternative and implement the plan. Provide a rationale for the chosen plan relative to the other alternatives considered</td>
<td>Determine the parameters for monitoring <strong>efficacy</strong> and <strong>safety</strong> for each therapy. <strong>Provide rationale for including this and how you expect the parameter to change.</strong></td>
<td>Determine <strong>who, how and when</strong> follow-up will occur.</td>
</tr>
</tbody>
</table>

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Documentation Guidelines

Initial Considerations:
- Reason for patient assessment/consultation
  - Comprehensive assessment
  - Consult letter
  - Medication history/reconciliation
  - Allergy assessment
  - Therapeutic drug monitoring
  - Patient follow-up
  - Patient education
  - Interventions
- Practice setting (i.e. community, ambulatory, hospital)
- Timeframe (i.e. urgency, quick chart note, detailed assessment)
- Documentation Systems (i.e. patient profile computer entry, free-hand note in a chart, type-written consult note)

General Considerations:
- Scope
  - Keep notes focused on the problem/purpose of the note
  - Keep documentation notes within the scope of your practice
  - Avoid making unrealistic suggestions- tailor the note to your patient
- Writing
  - legible, clear, concise, logical, objective, professional
  - black ink in charts
  - Errors- cross out errors with a single line and initial
  - Avoid rewriting, deleting, or removing any part of the record
  - Avoid leaving blank spaces/lines when possible
  - Clearly indicate if documentation extends to another page
- Communication- diplomatic, appropriate tone
  - Appropriate terms: may benefit from, may improve with, may no longer require, suggest, recommend, consider, patient would prefer, patient unlikely to adhere to, patient stated
  - Avoid these terms: wrong, unnecessary, must, should, inappropriate/ not appropriate, patient does not want
  - Avoid being judgmental, criticizing or blaming others for errors in documentation
  - Focus on solutions, not problems
  - If relaying quotes stated by patient, ensure to indicate this clearly with quotation marks
- Include significant and relevant information only
• **Abbreviations** - use common or approved abbreviations only
  o Spell out drug names, directions (i.e. spell out IU, U, QD, qd)
  o Zeros: do not include a zero after a decimal point; always put a zero before a decimal point
  o Avoid other dangerous abbreviations

• **Generics vs. Brand Names**
  o Generic names are preferred whenever possible; consider setting, intent, and recipient of documentation
  o Do not capitalize in the middle of a sentence
  o Use of Brand names only for longer combination products (e.g. triamterene/hydrochlorothiazide- Dyazide®) or to clarify a specific product/dosage form (i.e. Cardizem CD® vs. Tiazac®)
  o If a brand name is used, follow it by ®

• **Document in a timely manner** (proximate to encounter)

**Documentation Styles:**
• Need to be flexible about different types of documentation styles depending on purpose of documentation and practice site. The DAP format should be used at the Faculty unless otherwise specified.

  **In Practice**

• **Unstructured and semi-structured notes** - may be appropriate for a clarification, routine follow-up, patient care activities (i.e. education), an intervention (i.e. IV to PO conversion, dosage adjustment for renal/hepatic dysfunction, use of a non-formulary drug, a drug interaction or adverse effect, a contraindication, therapeutic duplication)

• **Pre-printed forms** (i.e. medication reconciliation, consultation note, clinic visit sheet, history intake form)

• **Systematic documentation**
  o DAP (data, assessment, plan)
  o SOAP (subjective, objective, assessment, plan)
  o FARM (findings, assessment, recommendations, monitoring)
  o DRP (drug-related problem, recommendation, plan)
  o DDAP (drug-related problem, data, assessment, plan)

**Documentation Tips:**
• Before documentation, refer to the pharmacy care plan worksheet you have made for your patient. Decide what is necessary and relevant to document. Not all components of a detailed care plan are necessary to document in the patient’s medical record. Depending on type of issues identified, the practice site and the recipient(s) of the note, components of documentation may vary.

• It is generally recommended that documentation be structured as a DAP note (includes sections on data, assessment and plan), however it should be noted that the DAP format of documentation is not always amenable to every type of activity that a pharmacist needs to document.

• Avoid irrelevant repetition of information already documented in the patient record. Ensure to include only the relevant and necessary information required to support your recommendations.

• When dealing with multiple problems:
- Ensure to prioritize problems and list primary issue first
- Organize notes well
- Those with inter-related themes may be merged in one DAP segment
- Avoid repetition of the same data for multiple problems
- Avoid lengthy notes

### DAP Note Components:

<table>
<thead>
<tr>
<th>D- DATA (or description of problem)</th>
<th>A- ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient concerns/goals/preferences</td>
<td></td>
</tr>
<tr>
<td>• Relevant subjective and objective data about the patient using structured format* for presenting patient data</td>
<td></td>
</tr>
<tr>
<td>• Includes only pertinent information based on the type of patient assessment being completed</td>
<td></td>
</tr>
<tr>
<td>• Assessment of the data (what is your professional interpretation of the data presented above)?</td>
<td></td>
</tr>
<tr>
<td>• Were there any drug-related problems/issues identified? If so, they should be listed here with supporting rationale. Are medical conditions optimally managed? What additional information/education does the patient require?</td>
<td></td>
</tr>
<tr>
<td>• Identification of relevant therapeutic goals/targets/desired outcomes are also appropriate to list in this section</td>
<td></td>
</tr>
<tr>
<td>• Avoid introducing new data here</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P-PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clearly number items in plan in appropriate order (e.g. priority, temporal sequence or by disease state groupings)</td>
</tr>
<tr>
<td>• Recommendations (drug and non-drug)</td>
</tr>
<tr>
<td>• Include drug regimen/product, dose, dosage form, route, duration</td>
</tr>
<tr>
<td>• Necessary patient education or referrals</td>
</tr>
<tr>
<td>• Monitoring plan and follow-up (tailor to practice site)</td>
</tr>
<tr>
<td>o The degree of detail required in the monitoring plan depends on to whom the note is addressed, their familiarity with the diseases/drugs, practice site, etc.</td>
</tr>
</tbody>
</table>

* use the section headings of the Patient Assessment Process (Medical & Medication History) if applicable to the Pharmacotherapy Workup

### How to Structure a DAP Note:

- Date of encounter and title of note (i.e. Pharmacist Note)
- Time written (depending on setting)
- Patient identifier (i.e. name, DOB, PHN)
- Purpose for assessment/consultation
- DATA
- ASSESSMENT
- PLAN
- Pharmacist identifier (i.e. name, signature, contact number)
Patient Care Process:


Documentation:
Peters Institute for Pharmaceutical Care. College of Pharmacy, University of Minnesota. 


NAPRA. Documentation Resources.