Clinical Documentation and The Patient Record

A Note from Randy McDonough, Director of Practice Transformation

*We have coined the phrase "**make every encounter count**" as pharmacists need to be intentional and deliberate with each patient encounter as it relates to data collection, identifying and resolving medication-related problems (MRPs), interventions made, communication with the care team, and **documentation**. As we transition back to our progressions (e.g.: Diabetes and Social Determinants of Health) format, we need to be intentional on how we optimize each encounter with the patient. Documentation is a crucial part of caring for our patients.*

Reasons we document patient care activities:

1. *Legal record of care that supports your work/activities*
2. *Proof for auditing purposes for payer programs*

The first reason we document patient care is the most important. Clinical documentation is your ongoing record of care for patients—in essence "your work-up" of patients. As part of your "work-up," data collection is key in that it provides you with the information needed to appropriately clinically evaluate your patients. Data collection is on an ongoing process that can happen in workflow—but it needs to be in a format or platform that allows you to not only add new information, but also access

1. *previous interventions that pharmacists have made (MRPs identified and resolved),*
2. *actions that need to be completed (follow up and monitoring), and*
3. *other supplemental information that completes the patient record (labs, vitals, discharge summaries, physician/stakeholder progress notes, etc.).*

*At Towncrest Pharmacy, we ask our patients with diabetes about their blood sugars, hypoglycemic events, appropriateness of therapy (e.g.: statins, ACEI/ARBs), A1Cs, and other diabetes related information. Given that diabetes is associated with an increased risk of cardiovascular events ensuring assessing your patients' cardiovascular status also becomes important (BPs, lipid panels, etc.). It is important that you start to create your "record" of the patient – a record that is **easily accessible** during your "encounter" with the patient and that you **review it** and **add to it with each encounter**. As part of your pharmacist responsibilities, the record should also include your professional assessment to determine if the patient has a medication-related problem and what interventions/recommendations you made (including your clinical note to the prescriber). All this information is housed in the clinical record—the record you should be accessing and reviewing whenever you encounter the patient.*

By doing this consistently and repeatedly, you will find as I have, that patients do have medication-related problems that require your attention and expertise. By developing your process (including e-care plan submission), you'll find it becomes a routine aspect of your day-to-day activities.