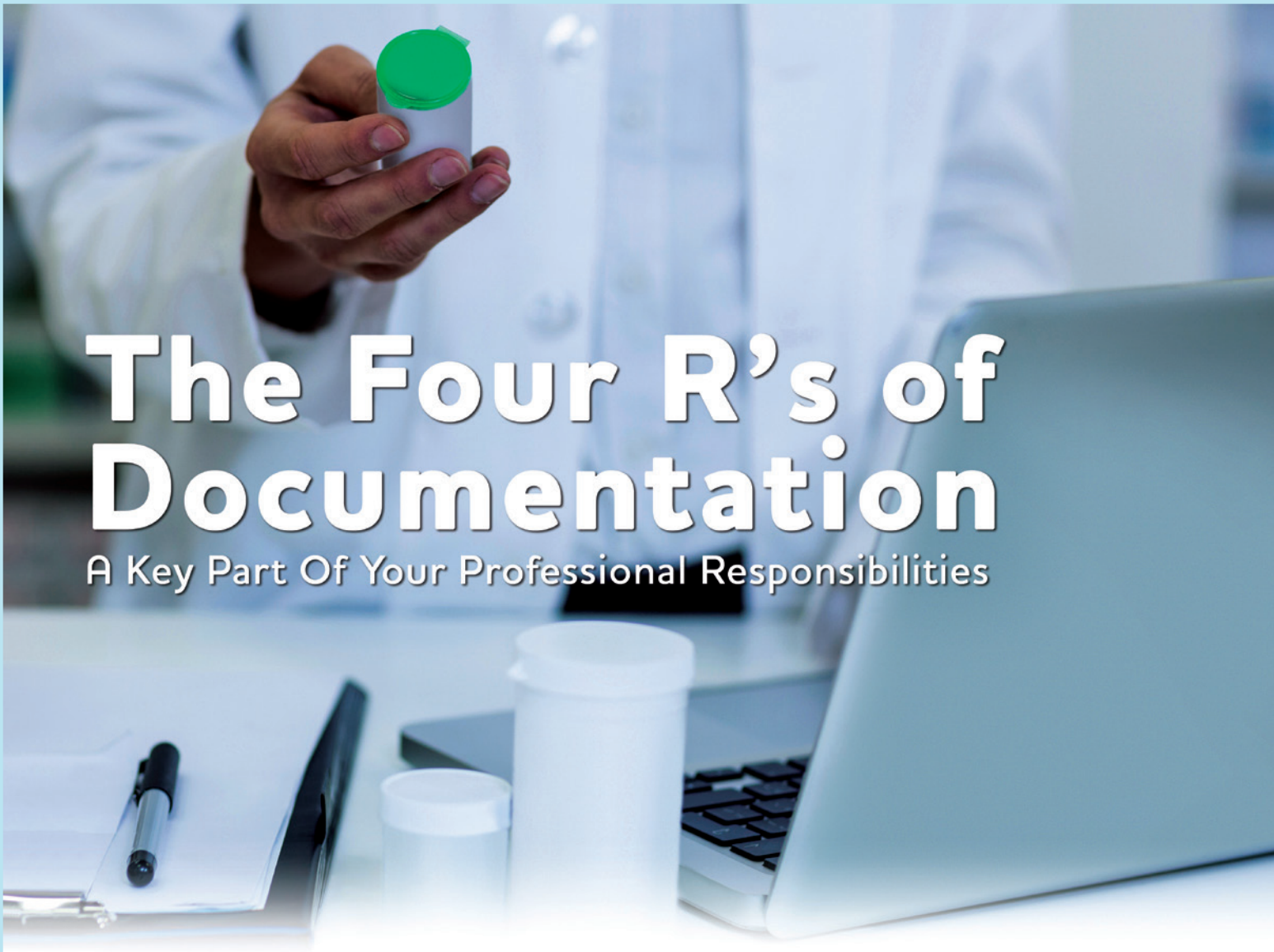

The Four R's of Documentation

A Key Part Of Your Professional Responsibilities

RELIABLE

Documentation is a fundamental component of a pharmacy professional's responsibilities. Pharmacists and pharmacy technicians must know and understand when and how to document their actions related to dispensing and therapeutic activities.

For all prescriptions, both new and refill, documentation should reliably demonstrate that each prescription has been reviewed for both technical and clinical aspects before it is dispensed to the patient. Each completed prescription record must contain the signature, or some other identifying mechanism, from the pharmacy professional(s) involved in the dispensing process. Where a technician and pharmacist are working collaboratively, the documentation must reflect each professional's responsibilities.

There is no set manner for how this must be achieved, as workflow may vary depending on the nature of the practice. Designated Managers are encouraged to emphasize consistency by establishing operational processes for documentation on both the patient record and the prescription hardcopy.

RETRIEVABLE AND USEABLE

Continuity of care is extremely important for patient safety, whether between different health care settings, or between different pharmacy professionals within the same pharmacy. In order to enable effective and efficient communication, documentation must be clear and available.

Pharmacy professionals should document information in a manner that is timely, readily retrievable and easily accessible by staff. Pharmacies are encouraged to have a standardized process in place to maintain patient-specific, and not only transaction-specific, records

The ease of retrieval for patient records, including those that may be stored off-site or with a third party, must be balanced with the need to maintain confidentiality. The pharmacy's record keeping system must be secure enough to protect personal health information against theft, loss, and unauthorized use or disclosure.

ROBUST

A thorough and complete patient record will demonstrate accountability for a pharmacy professional's decisions and actions.

Pharmacists should exercise professional judgment when determining the appropriate amount of documentation. There should be sufficient information to effectively manage a patient's drug therapy, monitor their progress, and ensure continuity of care. The exact content and level of detail will vary depending on the situation; thus, the lists below are provided as a guideline only.

Effective documentation on the patient record should include:

- ☑ Patient information gathered, such as allergies, medical conditions, medications, changes in health, monitoring information and relevant patient characteristics or circumstances;
- ☑ Indication for medication, where relevant, to facilitate monitoring and future assessment and continuity of care; and
- ☑ Collaboration with other healthcare providers, if relevant.

For adaptations, renewals and medication reviews, documentation should include the following (if applicable) in addition to the above list:

- ☑ Consent;
- ☑ Patient assessment;
- ☑ Decisions made and rationale;
- ☑ Follow up; and
- ☑ Communication with patient/agent.

Documentation without these important details is at risk of being misinterpreted, not accurately reflecting the actual care provided, and impeding collaboration or follow-up.[1]

RETAINED

Documentation may be maintained electronically, as scanned originals. Once scanned, the decision to destroy paper based records is left to the discretion of the Designated Manager, who should evaluate the systems and backup processes in place.

Patient records must be kept for at least 10 years from the last recorded professional pharmacy service provided, or 10 years after the day on which the patient reached (or would have reached) 18 years or age, if longer. As long as a patient continues to use a pharmacy, their entire record would need to be retained indefinitely. When a pharmacy is sold or closed, the Designated Manager is responsible for transferring complete custody and control of the records to another pharmacy. Pc

REFERENCES

1. CMPA (1991) *Why Good Documentation Matters*, retrieved from http://www.cpso.on.ca/cpso/media/uploadedfiles/members/peerassessment/documentation-cmpa.pdf

RESOURCES

- OCP Documentation Guideline
- OCP Record Retention, Disclosure and Disposal Guideline
- Documentation Practice Tool