Pharmacist Practice Assessment Criteria - Documentation

This document is focused on the Documentation Domain. To view instructions for use and review all of the domains, see the full Pharmacist Practice Assessment Criteria.

Domain: Documentation	
PERFORMANCE INDICATOR(S)	**GUIDANCE**
➢ Documents information gathered in patient profile ➢ Documents decisions made, rationale and follow up ➢ Documents communication with patients/healthcare team	**New Prescriptions** ☐ I document relevant patient information in the patient record, including information gathered from the patient such as allergies, medical conditions, medications, changes in health and monitoring information (e.g. blood pressure, A1C, pain control, etc.). ☐ I document indication where relevant to facilitate monitoring and future assessment and continuity of care. ☐ I document communication with the patient and healthcare team where appropriate. ☐ I ensure that information needed for continuity of care is documented in a manner that is timely, readily retrievable and easily accessible by other pharmacy team members (i.e. documentation is completed and saved in a standardized fashion like a "patient chart" – patient specific and not only transaction specific). ☐ The information I document is accurate, complete and appropriate.
	Refill Prescriptions ☐ I follow up on issues previously identified in the patient's profile. ☐ I document relevant information in the patient's record as required, including: • Issues identified • Decisions made • Rationale for decisions • Follow up provided • Communication with patients/healthcare professionals ☐ I document if further follow up is required.

Domain: Documentation (continued)	
PERFORMANCE INDICATOR(S)	**GUIDANCE**
➢ Documents information gathered in patient profile ➢ Documents decisions made, rationale and follow up ➢ Documents communication with patients/healthcare team	**<u>Adaptations, Renewals, Prescribing</u>** ☐ I document relevant patient information in the patient record, including information gathered from the patient such as allergies, medical conditions, medications, changes in health and monitoring information (e.g. blood pressure, A1C, pain control, etc.). ☐ I document indication where relevant to facilitate monitoring and future assessment and continuity of care. ☐ I document relevant information for adaptations, including consent, issues identified, decisions made, rationale and follow up. ☐ I document relevant information for renewals, including consent, patient assessment, decisions made and rationale. ☐ I document communication with the patient and healthcare team where appropriate. ☐ I ensure that information needed for continuity of care is documented in a manner that is timely, readily retrievable and easily accessible by other pharmacy team members (i.e. documentation is completed and saved in a standardized fashion like a "patient chart" – patient specific and not only transaction specific). ☐ The information I document is accurate, complete and appropriate.

Domain: Documentation (continued)	
PERFORMANCE INDICATOR(S)	**GUIDANCE**
➢ Documents information gathered in patient profile ➢ Documents decisions made, rationale and follow up ➢ Documents communication with patients/ healthcare team	**Comprehensive Medication Reviews** ☐ I document relevant patient information in the patient record, including information gathered from the patient such as allergies, medical conditions, medications, changes in health and monitoring information (e.g. blood pressure, A1C, pain control, etc.). ☐ I document indication where relevant to facilitate monitoring and future assessment and continuity of care. ☐ I document relevant information for comprehensive medication reviews, including consent, issues identified, decisions made, rationale and follow up. ☐ I document communication with the patient and healthcare team where appropriate. ☐ I ensure that information needed for continuity of care is documented in a manner that is timely, readily retrievable and easily accessible by other pharmacy team members (i.e. documentation is completed and saved in a standardized fashion like a "patient chart" – patient specific and not only transaction specific). ☐ The information I document is accurate, complete and appropriate.