Important notice: The College has adopted the NAPRA Model Standards of Practice for documentation. The standards were updated in 2022 – NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada – and are currently under review by the College.

DRAFT Documentation Guidelines

Purpose

Proper documentation is essential to demonstrating your accountability and responsibility for providing safe and effective care to patients. It also facilitates efficient communication with other healthcare professionals, promotes continuity of care, and helps fulfill your professional and legal obligations.[i,ii] Additionally, proper documentation benefits patients by keeping track of their care and telling their healthcare story.[iii]

This guideline should be read in conjunction with applicable regulatory, legislative, and workplace requirements. The Ontario College of Pharmacists' (the College's) expectations for documentation are described in the NAPRA Model Standards of Practice (NAPRA MSOP) and Code of Ethics. The standards are informed by the NAPRA Entry-to-Practice Competencies. Failing to keep records as required is considered professional misconduct under the *Pharmacy Act, 1991*. Records include clinical documentation.

The Documentation Guidelines provide general guidance, but they do not cover specific documentation requirements for certain pharmacy activities or practice environments. They are intended to complement, not replace, any specific requirements for documentation set out in other College policies or guidelines that apply to specific professional activities or pharmacy services.

The documentation requirements for recordkeeping related to dispensing can be found in the *Drug and Pharmacies Regulation Act* (O. Reg. 264/16*)* (DPRA) and are not addressed in this guideline. The College also has a separate Record Retention, Disclosure and Disposal Guideline to assist pharmacy professionals and designated managers/owners in understanding how to manage personal health information in pharmacies; it also includes information on record retention under the DPRA.

Definitions

Patient record – The patient record contains all of the documentation required to effectively access and manage a patient's drug therapy. It is the complete account of the care and services provided to the patient, including the patient profile; patient and health professionals' identifying information; data collected; assessment; clinical notes documenting care, actions, decisions, or rationale; relevant discussions between registrants, other health professionals, and patients; and prescriptions, records, and reports that pertain to the patient's care.

Pharmacy professional (PP) – A person who has been issued a certificate of registration by the College to practice pharmacy in the province.

Guideline

1. Why Document?

As a regulated health professional, you are responsible for the quality of your practice; pharmacy professionals are obliged to document the care, actions, and decisions they've provided to enable collaboration and continuity of care.[iv] Ensuring that documentation is complete, accurate, timely, and concise can increase the likelihood that other healthcare professionals will use the information to provide ongoing care. These expectations apply regardless of how the records are retained (paper or electronic records).

1.1 Benefits of Effective Documentation

Effective documentation does the following:

- Captures a record of the patient interaction, including important details such as relevant patient information, drug therapy rationale, decisions made, and actions taken
- Promotes continuity of care and collaboration by assisting subsequent health professionals in their care of the patient
- Provides evidence that you are practicing according to the standards of care, code of ethics, and legal requirements
- Demonstrates your accountability for the care you provided to the patient
- Facilitates the transition of care when patients transfer between different care settings[v]
- Allows for more timely and efficient care, including minimizing duplication and risk of errors

> *GUIDANCE NOTE: A record of the care you provide to a patient only exists if you document it.*

1.2 Documentation and the College's Code of Ethics

As pharmacy professionals, it is essential to document information correctly in the patient record. It is not only a matter of professional standards but also your ethical responsibility. Two core principles demonstrate this duty:

- The **Principle of Accountability**, which requires pharmacy professionals to maintain accurate documentation in line with practice standards. This responsibility extends to your colleagues as well as yourself.
- The **Principle of Beneficence**, which requires pharmacy professionals to do what is best for their patients and be committed to their well-being. As such, any consultations, communication, and recommendations you make to facilitate quality care for your patients should be documented.

2.0 What to Document?

2.1 Documentation Expectations

To meet the College's documentation expectations, knowing what needs to be documented is important. The level of detail in the record may vary depending on the nature of the patient interaction or the services. However, the record should consistently reflect the care provided, actions taken, and decisions made. It should contain sufficient information to support the patient's ongoing treatment.

The Quality Assurance program of the College periodically evaluates the performance of individual Part A pharmacists or pharmacy technicians. To learn more about the practice assessment criteria, please visit https://www.ocpinfo.com/practice-education/qa-program/practice-assessments/criteria/.

The tables below outline the documentation-related performance indicators against which pharmacy technicians (Table 1) and pharmacists (Table 2) are measured during their practice assessments. These indicators describe the minimum practice requirements for these pharmacy professionals, respectively.

Every practice area and patient encounter is unique, so the extent to which these can apply may vary.

Table 1. Documentation Performance Indicators for Pharmacy Technicians

Performance Indicator	Description
Documents information gathered or verified Documents relevant supporting information for activities and decisions	*What to routinely document:* • Patient's name, contact, and identifying information • Patients' health information, such as medical conditions, allergies, prescribed medications, OTC medication (non-prescription drugs, herbal supplements, vitamins and minerals), alternative therapies, drug interactions, pregnancy, weight (if applicable; for example, a child), and – to inform the pharmacist's assessment – indication • Best possible medication histories (BPMH; **see Appendix A for details**) • Results of relevant laboratory, point-of-care, and/or diagnostic tests and other clinical assessments to inform the pharmacist's assessment • All required information for the dispensing process • All required information for the compounding process • Relevant patient education information provided to patient (including documentation of device training) • Identified medication discrepancies (i.e., near misses or medication incidents)

Abbreviation: OTC, over the counter.

Table 2. Documentation Performance Indicators for Pharmacists

Performance Indicator	Description
Documents information gathered as part of the patient profile	*What to routinely document:* • Patient's name, contact, and identifying information • Patient health information, such as medical conditions, allergies, prescribed medications, OTC medication (non-prescription drugs, herbal

	supplements, vitamins and minerals), indication, changes in health, and resulting changes to medications • Best possible medication history (BPMH) and medication reconciliation (MedRec) to support decision-making (**see Appendix A for details**) • Results of relevant laboratory, point-of-care, and diagnostic tests, and other clinical assessments and monitoring parameters to inform assessment
Documents decisions made, rationale, and follow-up	*What to routinely document:* • Rationale for care and/or actions for drug therapy and other pharmacy services, such as minor ailments, injections, and inhalations • Decision made when applying the Pharmaceutical Care Model* for: o Identifying DTPs – actual or potential (**see Appendix B for details**) o Assessment of routine care, such as refills, new prescriptions and other pharmacy activities, such as renewals, and adaptations • Monitoring plan, including follow-up/continuity of care for a subsequent encounter (state what to monitor, by whom, and the expected timeframe)
Documents communication with patients/healthcare team	*What to routinely document:* • Who you interacted with, such as patients, caregivers, or health professionals • Description of activities when engaging with the patient, such as patient education, pertinent discussions, counselling, medication review, recommendations (e.g., adjunct therapy, separate medications) • Any significant outcome of the health professional interaction, including whether or not a care recommendation was accepted • Ongoing monitoring of outcomes and any necessary follow-up • Communication method, if relevant, such as in person, by phone, virtual

Abbreviations: DTP – drug therapy problem; IESA – indication, effectiveness, safety, and adherence; OTC – over the counter.
*Cipolle RJ, Strand LM, Morley PC. *Pharmaceutical care practice*. 3rd ed. New York (NY): McGraw-Hill; 2012.

GUIDANCE NOTE: The importance of "I" in the Pharmaceutical Care Model (IESA)

I – Is the drug indicated?

- *The first step in the Pharmaceutical Care Model is to assess whether a patient would benefit from a medication or if their current medication is suitable for their condition.*
- *To accomplish this, pharmacists need to gather information from the patient to better understand the patient's health issues and concerns.*
- *This assessment enables pharmacists to recognize cases where a drug is necessary (indicated) but not yet prescribed or where it has been prescribed but with no apparent indication.*

2.2 Date and Signature

> Ensure that records of care, actions, and decisions are documented in the patient record and indicate the pharmacy professionals involved, the nature of the care/action/decision, the evidence-informed rationale, the time and date, and the location, where appropriate.
>
> **Source: NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada (2022)**

Key points:

- All documentation in the patient record must have a date and signature. In the case of electronic records, a timestamp and unique identifier produced by the Pharmacy's software system can be used.
- By signing your clinical documentation, you demonstrate accountability for the care and services you provide to patients.
- Adding your identifier to a patient record promotes collaboration with other healthcare professionals involved in the patient's treatment.
- It's important to document your interactions with a patient promptly. If you're entering the record on a later date, make sure to include the date of the interaction.

> Every software system must provide authorized users with the capability to:
> - Display the date(s) and time(s) of any change(s) made to pharmacy records and the user(s) responsible for the changes
> - Allow a reason for changes made to data to be entered by the user updating the record
>
> **Source: NAPRA Pharmacy Practice Management Systems (PPMS) : Requirements to Support NAPRA's "Model Standards of Practice for Canadian Pharmacists" (2013)**

3.How to Document

Pharmacy professionals are responsible for maintaining a complete record for each patient. Patient care is not limited to just one visit but can involve multiple interactions over time. Whenever a patient seeks help from a pharmacist, it's essential to review their record, including documentation from prior interactions.[vi]

> Best practice is to document patient care, services, actions, and decisions in a timely and effective fashion; a complete patient record supports collaboration and continuity of care.
>
> **Source: NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada (2022)**

3.1 Key Qualities of a Well-Executed Clinical Note

A well-executed clinical note:

- Enables collaboration and continuity of care
- Avoids the use of jargon and unconventional abbreviations
- Is clear and concise
- Is a permanent record that can be easily accessible and retrieved whenever needed
- Maintains patient confidentiality
- Uses a professional tone and avoids judgemental language
- Is entered in a timely manner, either concomitant with performing a task or as soon as possible afterwards
- Is stored as part of the patient record

3.2 Documentation Formats

The College does not require a specific format for documentation, but it is important to opt for one that suits your practice setting. Regardless of format, your documentation should be accurate, legible, complete, and timely to ensure that others can easily access and understand the care provided.[iv]

> Document the following in a timely and effective fashion, using recognized formats that are easily understood by pharmacy professionals and other health professionals: a) decisions/recommendations and rationale; b) interactions with, and care provided to, patients; and c) interactions with other health professionals.
>
> **Source: NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada (2022)**

Structured Formats

One way to make a clinical note effective is to use a structured documentation format, such as those in Table 3. This approach allows for relevant information, such as drug-related issues, patient details, assessments, and plans, to be presented in a clear and consistent manner. Table 4 illustrates how to develop a note using a DAP format.

Table 3: Recognized Structured Formats

Format	Documentation Categories
DAP	Data, Assessment, and Plan
DDAP	Drug-Related Problem, Data, Assessment, and Plan
DRP	Drug-Related Problem, Rationale, and Plan
FARM	Findings, Assessment, Recommendations, and Monitoring (and follow-up)
SOAP	Subjective (findings), Objective (findings), Assessment, and Plan

Table 4: Developing a Clinical Note Using DAP[vii]

Category	Question	Example
Data	What information did you gather and check?	• Relevant subjective information: patient's concerns, goals, and preferences • Relevant objective information: vital signs, lab test results • Identify which references were checked
Assessment	What is your assessment of the patient and therapy?	• Appropriateness of therapy: Is therapy indicated, effective, safe? Is the patient willing to use/adhere to therapy? • Any drug therapy problems • Supporting rationale
Plan	What steps did you/will you take?	• Recommendations (drug/non-drug) • Instructions given to patient • Monitoring plan and follow-up (when and by whom)

Abbreviation: DAP – data, assessment, and plan.

Free-Form Clinical Notes

In practice, it's recognized that pharmacy professionals often aim to document information quickly and efficiently. While a structured format is an option, a free-form approach is also acceptable as long as it captures the patient interaction or specific drug therapy problem accurately. It's important to remember that other healthcare professionals depend on these notes to make informed clinical decisions and provide continuity of care to patients. Having a mental or written checklist can be useful in ensuring that you gather all the required information.

3.3 Electronic Documentation

When documenting information, electronic records must adhere to the same standards as paper records. While electronic records offer several benefits over paper ones, there are also specific challenges associated with electronic records that require careful consideration (Table 6).

> Contribute to the patient's provincial/territorial health records using appropriate technology and in a manner that facilitates collaboration and continuity of care.
>
> **Source: NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada (2022)**

Table 6: Electronic Documentation – Opportunities and Obstacles

Opportunities	Documentation created by the computer is generally more legible than handwritten patient notes, making information easier to comprehend
	Finding a clinical note in the pharmacy's computer system may be quicker than looking for a handwritten note that is kept separately. This is particularly true if all electronic clinical documentation is kept in a specific area within the software system
	Patient information can be quickly scanned or uploaded to patient records in a software system
	Many computer systems have a vast capacity for data storage, which simplifies the process of retaining records for the required length of time

	In order to effectively organize and manage an accurate patient record, it is crucial to thoughtfully determine which documents need to be scanned and which ones can be discarded
	A patient's record can be accessed from multiple stations within the pharmacy
	When a DM implements standardized operational processes for managing records, such as consistent file naming and storage procedures, patient records become easier to locate when needed
	Authorized users can access information simultaneously, which makes it very convenient
Obstacles	It can be challenging to enter detailed clinical notes if the clinical documentation features of your pharmacy's software are not added, turned on, or functional.
	Storing clinical documentation without a designated location in the computer software can impede continuity of care by making it challenging and time consuming for pharmacy staff to locate previously entered clinical notes
	When adding documents to a patient record, it's important to be selective and scan only relevant or required ones to avoid bloating the record and making it harder to find necessary information.
	In certain systems, it may be possible to delete or modify information without the changes being traceable, which means that a permanent patient record cannot be established
	When documenting work under someone else's unique identifier (such as a username), you cannot demonstrate responsibility for your own work

Abbreviations: DM – designated manager.

GUIDANCE NOTE: It is advisable to create a documentation plan for your pharmacy team to enhance the quality of care. The plan should clearly define the team's strategy for recording and storing patient interactions data in the software system.

4. Recordkeeping Privacy

Although this guidance does not focus on recordkeeping management, it is important to share some basic information about this. As a pharmacy professional, it is essential to adhere to the College's standards, relevant regulations, and laws, such as the *Personal Health Information Protection Act, 2004 (PHIPA)* when handling patient records, whether electronic or paper.

Here are the fundamental points:

- Documentation in the patient record should be non-erasable
- Clinical notes should not be deleted or rewritten; however, corrections are allowable to ensure accuracy
- Any incorrect information must be clearly marked as such if changes are made — corrections in a paper record should be crossed out with a single line and initialed, and in electronic records, changes must be authenticated electronically and the original entry should be traceable
- Notes made by other health professionals or registrants cannot be altered
- The record must be easily accessible and retrievable
- Patients have a legal right to access their patient record
- Proper disposal of patient health information is essential to maintain patient confidentiality
- Transferring patient information to other health professionals must be shared confidentially

> All records and documents relating to the care of a patient, including the original prescriptions, must be maintained for a period of at least 10 years from the last recorded professional pharmacy service provided to the patient, or until 10 years after the day on which the patient reached, or would have reached, the age of 18 years, whichever is longer.
>
> **Source: *Drug and Pharmacies Regulation Act, General, O Reg 264/16* s21**

Refer to the College's Record Retention, Disclosure and Disposal Guideline for more information.

Legislative References:

- *Pharmacy Act, 1991*; O. Reg. 130/17: PROFESSIONAL MISCONDUCT AND CONFLICT OF INTEREST
- *Drug and Pharmacies Regulation Act, 1990*; O. Reg. 264/16: GENERAL

Additional References:

- Code of Ethics
- NAPRA Professional Competencies for Canadian Pharmacists at Entry to Practice
- NAPRA Professional Competencies for Canadian Pharmacy Technicians at Entry to Practice
- NAPRA Pharmacy Practice Management Systems: Requirements to Support NAPRA's "Model Standards of Practice for Canadian Pharmacists"
- NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada (2022) (currently under review)
- Record Retention, Disclosure, and Disposal Guideline

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1.00	**2004**	**New**
1.01	**2012**	**Revision**
1.02	**2015**	**Review**
2.00	**2023**	

Appendix A - Medication Management

Medication management is patient-centred care to optimize safe, effective, and appropriate drug therapy. Care is provided through collaboration with patients and their healthcare teams[viii] Two key activities in medication management are collecting the best possible medication history (BPMH) and completing a medication reconciliation (MedRec).

Both pharmacists and pharmacy technicians can collect a BPMH from patients, which provides crucial medication history for use during a MedRec. However, it's important to note that MedRec is a clinical process that requires assessment and decision-making skills. This activity falls under the scope of practice of pharmacists only.

- **Best possible medication history (BPMH)** is a complete and accurate list of all the medications a patient is taking that is created using at least two sources of information, including a client and/or family interview.[ix] The BPMH includes all prescribed and non-prescribed medications, with complete documentation of the drug name, dosage, route, and frequency. It is more extensive than a routine medication history, which is often a brief initial medication history that may only rely on one source of information.

- **Medication reconciliation (MedRec)** is a formal process in which healthcare professionals work together with patients to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.[ix] The cornerstone of the MedRec process is the BPMH, which provides a comprehensive list of all medications a patient is taking. This list is crucial to evaluate any changes in medication and to ensure the most appropriate prescribing decisions are made by healthcare professionals for the patient's benefit.

Appendix B – The Pharmaceutical Care Model

The Pharmaceutical Care Model, as described by Cipolle et al,[ix] is an approach to medication management that aims to improve patient outcomes by identifying and resolving drug therapy problems (DTPs). DTPs are negative outcomes related to medication therapy that may prevent the desired treatment response. These problems can occur at any stage of the treatment process, such as during prescribing, transcribing, dispensing, and patient use of medication therapy.

When assessing the appropriateness of a medication, pharmacists can use the IESA method. This method provides a systematic approach to identifying and resolving potential DTPs. IESA stands for *Indication, Effectiveness, Safety,* and *Adherence.*

Assessment Parameter	Drug Therapy Problem
I – Indication**:** *Is the drug indicated for the patient?*	Unnecessary drug therapy
	Needs additional drug therapy
E – Effectiveness: *Is the drug effective for the patient?*	Ineffective drug
	Dosage incorrect or too low
S – Safety: *Is the drug safe for the patient?*	Adverse drug reaction
	Dosage too high
A – Adherence: *Is the patient taking the drug correctly?*	Nonadherence or noncompliance

[i] Kennie N, Farrell B, Dolovich L. Demonstrating value, documenting care: Lessons learned about writing comprehensive patient medication assessments in the IMPACT project PART I: Getting started with documenting medication Assessments. Canadian Pharmacists Journal. Retrieved at: http://journals.sagepub.com/doi/abs/10.3821/1913701X2008141114DVDCLL20CO2?journalCode=cphc

[ii] Zierler-Brown eta al. Clinical Documentation for Patient Care: Models, Concepts, and Liability Considerations for Pharmacists, Am J Health-Syst Pharm—Vol 64 Sep 1, 2007.

[iii] Kuhn et al. Clinical Documentation in the 21st Century: Executive Summary of a Policy Position Paper from the American College of Physicians. Annals of Internal Medicine • Vol. 162 No. 4 • 17 February 2015

[iv] NAPRA Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada. Retrieved at https://www.napra.ca/publication/model-standards-of-practice-for-pharmacists-and-pharmacy-technicians-in-canada/

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[vi] NAPRA Pharmacy Practice Management Systems: Requirements to Support NAPRA's "Model Standards of Practice for Canadian Pharmacists". Retrieved at: https://napra.ca/wp-content/uploads/2022/09/NAPRA-Pharmacy-Practice-Management-Systems-November-2013-b.pdf

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