DOCUMENTING THE CLINICAL PHARMacist'S ACTIVITIES: BACK TO BASICS

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ABSTRACT. The profession of pharmacy has applied the term "documentation" to countless activities that more closely approximate descriptive protocols or administrative reports. This extended nonclinical use of the term documentation has resulted in the profession losing sight of a necessary step in the development, justification, and successful implementation of clinical pharmacy services. An instrument that helps to standardize the documentation of a clinical pharmacist's database, patient care activities, and therapeutic plans is presented. This process, the pharmacist's workup of drug therapy (PWD), consists of the following six interrelated steps: (1) establish a comprehensive patient-specific database; (2) identify patient-specific, drug-related problems; (3) describe the goals of therapeutic outcomes; (4) for all therapeutic alternatives that might produce the desired outcomes; (5) select the drug recommendation(s) that most likely will result in the desired outcomes; and (6) establish a plan for therapeutic drug monitoring that documents how those efforts occur and unanticipated efforts are minimized. A formalistic method of documenting the clinical pharmacist's activities such as the PWD list by functional on a daily basis in order to generate meaningful summary management reports.


CLINICAL PHARMACY SERVICES have been under development and implementation for more than 20 years. Sophisticated services have been described and evaluated, and a few have survived the rigorous critique of cost-benefit and cost-effective analysis.1-3 All of this has occurred without the systematic, standardized recording of a clinical pharmacist's daily activities. The professions of medicine and nursing describe their systematic recording of professional activities as doing a workup of the patient, writing progress notes, and ordering tests. For a number of reasons, pharmacy has

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never established a standard method for recording its clinical activities. Instead, the profession has applied the term documentation to activities that more closely approximate descriptive protocols or administrative reports. We believe that the extended "nonclinical" use of the term documentation has resulted in the profession losing sight of a necessary step in the development, justification, and successful implementation of clinical pharmacy services. To meet this need we present an instrument for documenting the pharmacist's database, clinical activities, and therapeutic plans.

Traditional Approaches

Little controversy exists over whether physicians and nurses need to document routine daily clinical activities related to the care of a patient. Although dialogue did occur concerning how these interactions and interventions with the patient were to be recorded, the question of whether those needed to be recorded at all was not an issue. We feel perhaps the most significant impact on the question of how physicians were to record their clinical activities. Following the introduction of his problem-oriented medical record (POMR), both medicine and nursing were quick to explore former techniques.4,5 Today, the Weed approach to documenting both the physician's and the nurse's role in patient care is widely accepted.

With one exception pharmacists practicing clinically did not adopt, or adapt, the Weed approach in a manner that best suited their clinical needs. This exception is the work of Kishi and Watanabe. This research revealed that through the application of Weed's POMR to the pharmacist's responsibilities, students acquired improved rational therapeutic decision-making skills.6 This successful, albeit limited application of the POMR lends support to the application of similar concepts for the purpose of documenting clinical decisions and activities. Pharmacists practicing clinically have not continued to follow Kishi and Watanabe's lead.
Pharmacy's Interpretation of Documentation: Descriptive, Summative, and Formative

The profession of pharmacy has yet to resolve the issue of the need for documenting the clinical activities of the pharmacist. To understand why pharmacy ignored this key step in the development of clinical services, it is necessary to trace pharmacy's interpretation and use of the term documentation.

The current use of the concept of documentation in clinical pharmacy dates back to the late 1960s when documentation referred to descriptive reports of a clinical pharmacy practice. During this time Boechard, Smith, Franche, Godwin, Walton, Brodie, and others were discussing the roots of clinical pharmacy practice in articles with titles such as "Developing a Clinical Role for the Hospital Pharmacist," and "Towards a Clinical Practice of Pharmacy." This new role required significant definition, guidelines, policies, and procedures. These descriptions of the type of services provided, and a general account of the activities performed from the perspective of a work of description, represent the beginning of pharmacy's documentation of clinical activities.

Unfortunately, it was removed from the clinical setting. The report did not provide the necessary clinical data related to the pharmacist's ability to assist patient outcomes on a case-specific basis.

Beginning in the late 1970s, a number of external changes and issues created an environment that made it necessary, popular, and incentive to redefine the term documentation to mean justification for continued or expanded pharmacy services. Documentation of clinical pharmacy services was being solicited primarily for maintaining or broadening pharmacy's territory, and for establishing financial stability. Documentation for the purpose of justifying certain additional clinical activities certainly lies within the realm of administrative and not clinical functions. This type of administrative reporting measures pharmacy's output as either units of activity or dollars saved. Units of activity include the number of interventions made by the pharmacist and accepted by the physician. A measure of the dollars saved may be the result of formulary substitutions or the identification of inappropriate laboratory tests. This administrative use of documentation tends to serve a summative function. Summative documentation means that the documentation is retrospective to the clinical activity itself, reflects activities performed over a prolonged period of time, and includes the activities of several individuals. In these ways, the function of management report as documentation is to summarize what the pharmacist has done, with the intention of determining whether certain functions should continue or cease. The advantage of the summative function of documentation is that it provides a management report that can be presented quickly and easily to administration. Although the task of this type continues to appear in the hospital pharmacy literature, it is not always clear how the clinical activities of the pharmacist can be summarized when the daily activities are not documented on a patient-by-patient basis.

Documentation of a pharmacist's clinical activities would record the following information: the information on which the pharmacist based decisions and actions, the decisions made by the pharmacist concerning drug therapy for a specific patient, and the actions the pharmacist took to affect the patient's drug therapy. This category of documentation has as its output the generation of a database describing the patient, drug and disease information, decisions related to drug choice, dose determinations, modalities of administration, parameters for patient monitoring, and patient outcomes in terms of efficacy, length of stay, incidence of side effects, toxicity, and other drug-related behaviors. This type of documentation serves a formative function. Formative documentation is intended to improve and develop services, is performed concurrently with the pharmacist's activities and decisions, and accommodates changes when additional data become available. A distinct advantage of the formative type of documentation is the interactive nature of the process. Corrections can be made and adjustments recorded that are consistent with the changing patient status. It appears that if the objective is to document what the clinical pharmacist does, then the formative function best serves that purpose. However, if the objective is to determine whether or not a service should be continued, the management report that serves a summative function may better meet the needs.

The Pharmacist's Workup of Drug Therapy

The standard medical workup (POMR system) serves the medical student, intern, resident, and physician as a format for the efficient gathering and integrating of patient- and disease-specific information for the purpose of practicing good medicine. Just as nurses utilize a similar standardized format for the purpose of practicing good nursing, so too do pharmacists, pharmacy interns, residents, and clerkship students need a standard format to gather and integrate patient, drug, and disease information to practice good patient-oriented pharmacy. One explanation for the lack of a standard method for documenting the functions of a clinical pharmacist may be the failure of the profession to define the functions. The common function performed by pharmacist practicing clinically is to identify and solve patient-specific, drug-related problems. This activity of the clinical pharmacist suggests a high degree of commeasurable with the physician and the nurse, namely the resolution of a patient's medical problems. This also suggests that documentation of this problem-solving function must occur in the POMR system. Although pharmacists are required to process much of the same patient, drug, and disease data as physicians and nurses, they must process it in a completely different context so as to produce unique decisions and solutions. The process described below is meant to function as the standard means by which to document the pharmacist's unique database and clinical activities.

This process is the pharmacist's workup of drug therapy (PW/DT), which is illustrated in Appendix I. It must be emphasized that this workup represents a thought process that is meant to serve as a systematic guideline for the documentation of clinical pharmacy activities and not simply a form to be completed on each patient seen by a pharmacist. The thought process represented by the PW/DT occurs in a matter of minutes in the mind
of the experienced clinical pharmacist. This process represents what the clinical pharmacist does by describing how the clinical pharmacist thinks about what is and what is not, a therapeutic problem for the patient. Effective clinical reasoning requires that the pharmacist establish a strong database, including: (1) general patient data such as age, ethnicity, sex, height, weight, medical problems, present medications, risk and past medical history, medication history, allergies, smoking/alcohol history, and compliance behavior history; (2) a pharmacological review of systems including a review of vital signs and pertinent laboratory results; each organ system must be evaluated for the effect drugs may have on it and for the possible effects that organ system dysfunction may have on the disposition of drugs; and (3) an assessment of the patient's existing drug therapy, drawing on therapeutic and pathophysiological databases.

PHARMACIST'S LIST OF PATIENT-SPECIFIC, DRUG-RELATED PROBLEMS

The collection and processing of relevant data should result in a list of patient-specific, drug-related problems that the pharmacist is uniquely prepared to address and for which he assumes responsibility.

STATEMENT OF DESIRED THERAPEUTIC OUTCOME

It is necessary to identify the desired therapeutic outcome for each problem identified above.

IDENTIFYING THERAPEUTIC ALTERNATIVES

Most therapeutic problems have more than one empirically acceptable solution. The pharmacist must identify the multiple alternative solutions to each identified problem with a list of alternatives that goes beyond the commonly accepted drug-of-choice. Upon identifying and passing clinical judgment on all available options, the pharmacist applies skills in comparative analysis, which requires a critical review of the medical literature, a comparison of clinical experiences, and the application of clinical decision-making skills.

PHARMACIST'S RECOMMENDATION AND PERSONALIZATION OF THERAPY

This stage of the PDWT requires the pharmacist to select the most appropriate solution to the drug-related problem. This decision should range from no drug therapy to the best pharmacotherapy for the patient. It should also encompass the patient-specific, individualized dose of the drug, frequency of administration, appropriate method of administration, and the duration of treatment. The pharmacist's recommendation should incorporate therapeutic efficacy, safety, comfort and convenience, and adherence to the therapeutic regimen. Moreover, cost considerations must be incorporated into the chosen therapeutic action plan.

THERAPEUTIC DRUG MONITORING PLAN

Clearly, the problem-solving process is incomplete until the process of monitoring produces data that serve to empirically support the recommended solutions. The therapeutic drug monitoring process must reflect an active involvement by the pharmacist. The therapeutic drug monitoring plan for each patient consists of an active process to gather data documenting that the desired drug effects are occurring and the patient is not experiencing any undesirable drug effects. Feedback is an essential part of the problem-solving process. Data provided through comprehensive patient monitoring should be reintegrated at all stages in the process.

Discussion

In different practice settings pharmacists will have access to varying types and amounts of information. In most institutional settings the pharmacist has access to the medical record, medical staff, nursing staff, and patient. In this setting the pharmacist can collect and synthesize all of the information needed to ensure that each patient's personal drug-related problems are resolved. In many community practice settings, the source of information is limited to the patient and in some circumstances the pharmacist. This fact does not alter the reality of having to address each of the issues raised by the PDWT in order to provide a comprehensive, consistently high-quality service. In the community setting the power of observation is a very important way of gathering information. Dialogue must be established with the physician, familiarity must be achieved with the patient, and an efficient means of hypothesizing/deductive reasoning must be employed by the pharmacist. The process may be more general in various situations, but the process itself does not change.

An important attribute of the PDWT is that it facilitates the dynamic nature of the pharmacist's function. It is important to note that recommended solutions to problems tend to generate their own problems. Thus, pharmacological solutions identified to resolve therapeutic problems should not be seen as absolute or final. Therapeutic problems represent processes rather than isolated incidents. Therefore, therapeutic problem-solving is dynamic, not static. Similarly, documentation of a pharmacist's activities is a continuous process that needs to be timely, complete, and consistent. It is imperative that a common, standardized, consistent approach to therapeutic problem-solving be developed. Such a structured approach based on cognitive criteria would greatly facilitate the documentation of the clinical pharmacist's database, decisions, and impact. One such approach, the pharmacist's workup of drug therapy, is presently under study at the University of Utah and the University of Minnesota. Additional work with the PDWT will be necessary to determine its ultimate usefulness as a common struc-
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