



**Patient Care Process**

**Faculty of Pharmacy and Pharmaceutical Sciences**

**University of Alberta, Edmonton Alberta**

**Regional Pharmacy Services, Alberta Health Services**

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Approved by: Curriculum Committee, Faculty of Pharmacy, April 2011

# Patient Care Process Working Group Members

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# Patient Care Process - Diagram

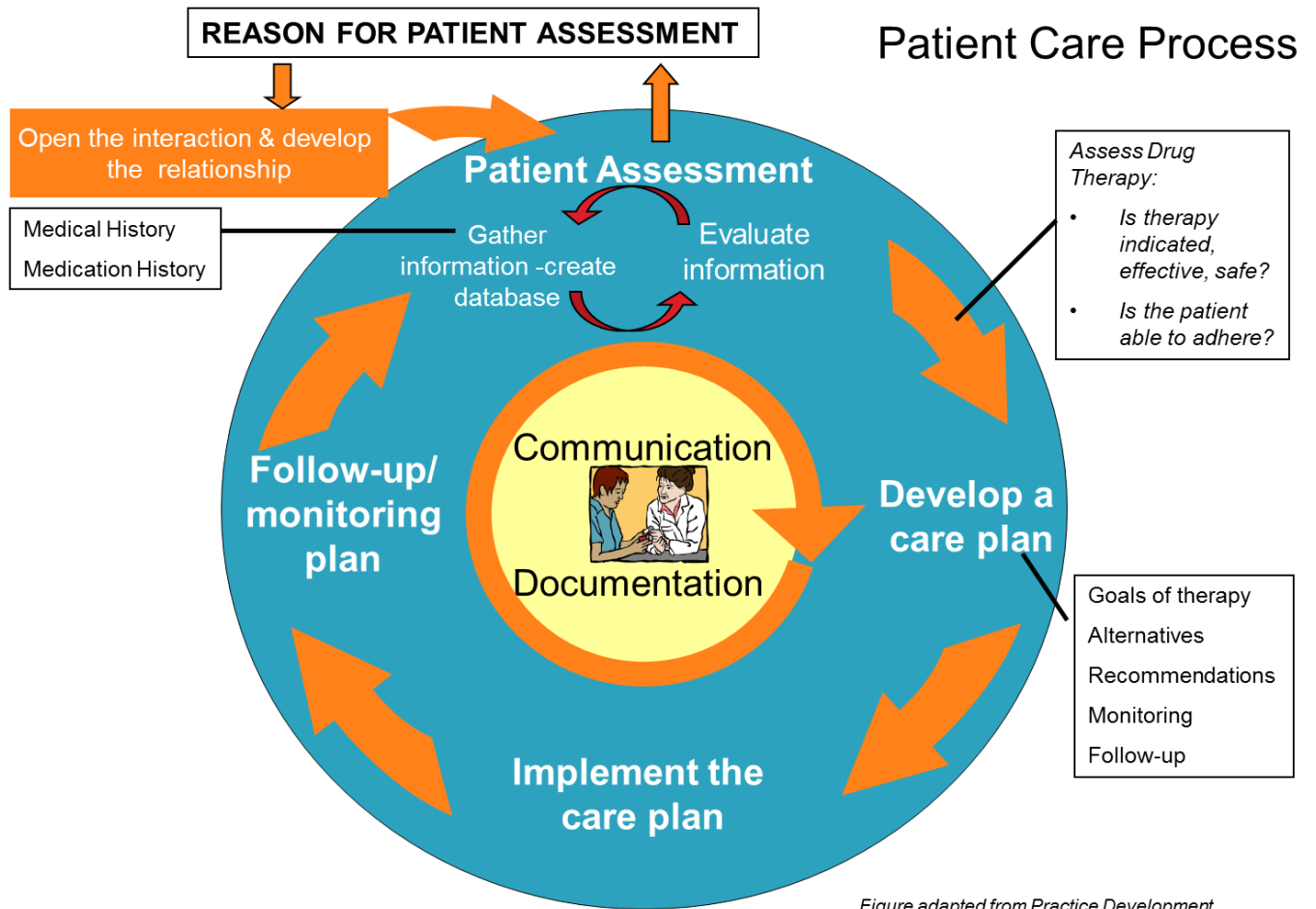


Figure adapted from Practice Development  
Practice Skills Bootcamp  
Faculty of Pharmacy & Pharmaceutical Sciences,  
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- **Obtain information from the medical record and patient interview**
- **The scope of information gathered depends on practice site, setting of interview (home, clinic, hospital, community pharmacy), type of assessment, relevance of information, and a realistic timeframe**
- **Sources of information (e.g. patient, family/agent, chart, pharmacy, Netcare/PIN, health care workers)**

## Demographics

- Name, DOB, PHN, gender, address, telephone, marital status, language, health care workers
- Height, weight, ideal body weight (IBW), body mass index (BMI) (if relevant)

## Reason for Assessment

- Why is patient seeking care? Describe condition/problem and duration.
- What is the reason for the referral or assessment?
- What is the patient agenda? (obtain complete list; negotiate what will be addressed today vs. future visits)
- Note: There may not always be a new medical problem or issues with therapy (i.e. routine refill or follow-up)

## History of Present Illness (HPI)

- Line of questioning for symptom assessment:

<b>Location</b>	Where is the symptom?
<b>Quality Severity</b>	What is the symptom like? Does it interfere with the patient's lifestyle? Describe it further. What is the severity of the symptom? (mild, moderate, severe)
<b>Quantity</b>	What is the frequency of the symptom?
<b>Timing</b>	What is the duration of the symptom? When did it first present?
<b>Setting</b>	What was the patient doing when the symptom first presented?
<b>Modifying factors</b>	Are there any relieving or aggravating factors? What makes it better or worse?
<b>Associated symptoms</b>	Are there any associated symptoms? (Include absence of symptoms if relevant- i.e. no fever, no cough, no dyspnea, etc.)

*Adapted with permission from: Giberson S, Stein E. Performing patient assessment: a pharmacy perspective. Pharmacy Times 2002;68(12):44-48.*

## Past Medical History (PMH)

- List medical conditions/problems (dates and duration)
- Hospitalizations, surgeries, accidents, injuries (if relevant)
- Recent specialist visits; other clinics/caregivers

## Medication History (see separate template)

## Family History (FH)

- Illnesses of first degree relatives (status of living and causes of death/age)
- Attention to cardiac, hypertension, hyperlipidemia, diabetes, cancer, osteoporosis, alcoholism, mental illness

## Functional History (if relevant- i.e. geriatrics, stroke patient, homeless, new immigrant, etc.)

- Ability to do Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Describe functional decline (onset, activity impacted); Supports?

## Social History (SH)

- Nutrition, exercise, education, occupation/work history, marital status, living conditions (where and with whom?)
- Substance use (caffeine, alcohol, tobacco, illicit drugs)
- Caffeine, Alcohol, Illicit Drugs: type, amount, pattern, duration, date/time last intake or history of use
- Tobacco products: type [for a smoker: # ppd and/or pack-years (#ppd x # yrs smoked)]
- Sexual History (if relevant- i.e. functional, pregnancy, STIs)

## Review of Systems (ROS)

- Identify any further problems (i.e. medical problems, adverse effects); note presence/absence of symptoms
- Head to toe assessment (keep questions relevant and brief; not all systems need to be reviewed)

- The following are just examples of considerations for each system

<b>General</b>	energy levels, weight changes, ailments, pain
<b>Integument</b>	rashes, dryness, pruritus, hair loss, nails
<b>Head/Neurologic</b>	mental status, headache, syncope, seizures, tremor, weakness, vertigo
<b>Eyes</b>	redness, discharge, blurring, vision, pain, glaucoma, cataracts
<b>Ears</b>	hearing loss, tinnitus, earache, discharge
<b>Nose/Sinuses-</b>	rhinitis, sinus congestion, discharge
<b>Mouth/Pharynx</b>	dentition, hoarseness, pharyngitis, ulcerations
<b>Neck</b>	swollen lymph nodes/glands, goiter, pain
<b>Chest/Lungs</b>	cough, dyspnea, wheezing, sputum, asthma, bronchitis, pneumonia
<b>Cardiovascular</b>	chest pain, murmurs, palpitations, hypertension, myocardial infarction
<b>Gastrointestinal</b>	dysphagia, odynophagia, reflux, nausea, vomiting, bowel movements, stool
<b>Urinary</b>	pain, frequency, urgency, incontinence, retention, bleeding
<b>Hepatic/Renal</b>	organ function, infection (hepatitis, pyelonephritis)
<b>Reproductive</b>	libido, discharge, infection, menstrual, menopause
<b>Musculoskeletal</b>	stiffness, pain, motion, swelling, redness, deformities
<b>Endocrine</b>	thyroid, diabetes, adrenals, estrogen, testosterone

*Adapted with permission from: Longe RL et al. Physical Assessment- A Guide for Evaluating Drug Therapy. Baltimore, MD: Lippincott Williams & Wilkins, 1994. Table 1.3, page 1-9 to 1-10.*

## Physical Exam (PE), Vital Signs (VS), Investigations/Diagnostics

### Laboratory findings (Labs)

- review relevant laboratory findings in groupings (CBC, electrolytes, renal function/creatinine clearance, liver function, coagulation tests, microbiology results, etc.)

- Obtain information from the medical record and patient interview
- The scope of information gathered depends on practice site, setting of interview (home, clinic, hospital, community pharmacy), type of assessment, relevance of information, and a realistic timeframe
- Sources of information (e.g. patient, family/agent, chart, pharmacy, Netcare/PIN, health care workers)

## Allergies

- List medication/ food allergies
- Describe reaction (date, onset, signs/symptoms, management [pharmacologic/non-pharmacologic], outcome)
- Reaction to other medications in the same class?

## Adverse Effects

- As described by patient, abnormal laboratory findings, documented adverse effects
- Describe adverse effect (date, onset, signs/symptoms, management [pharmacologic/non-pharmacologic], outcome)
- Tolerability to other medications in the same class?

## Current Medications

- List current medications (include patient, family/agent, chart, pharmacy, Netcare/PIN, health care workers)
- Indication, dosage, schedule, duration, outcome
- Quantify use of prn medication (check on refills, ask patient)
- See section on “Medication Adherence” for more details on adherence assessment

## Past Medications

- List past medications (this will depend on relevance of medical history and indication for new therapies)
- Indication, dosage, schedule, duration, outcome
- Why was drug discontinued?
- Antibiotic use in past 3 months (if relevant to the medical history)

## Non-prescription Medications

- OTC, CAMs, vitamins, minerals, other supplements
- Indication, dosage, schedule, duration, outcome



## Other Medications

- Eye/Ear/Nose products
- Inhalers/Patches/Creams/Ointments/Injectables/Medication samples
- Consider using prompts to question for specific drugs commonly used in a given patient population (i.e. analgesics, antiemetics, laxatives, sedative, etc.)

## Immunization History

## Medication Experience

- “The medication experience is an individual’s subjective experience of taking a medication in his daily life.” (Shoemaker , 2008)
- A patient's medication experience may shape the patient's attitudes, preferences about drug therapy, and drug taking behavior.
- Be attentive to patient’s general attitude to medications, preferences, concerns, understanding, and cultural and ethical beliefs.
- Often this information is gathered indirectly in the patient interview.

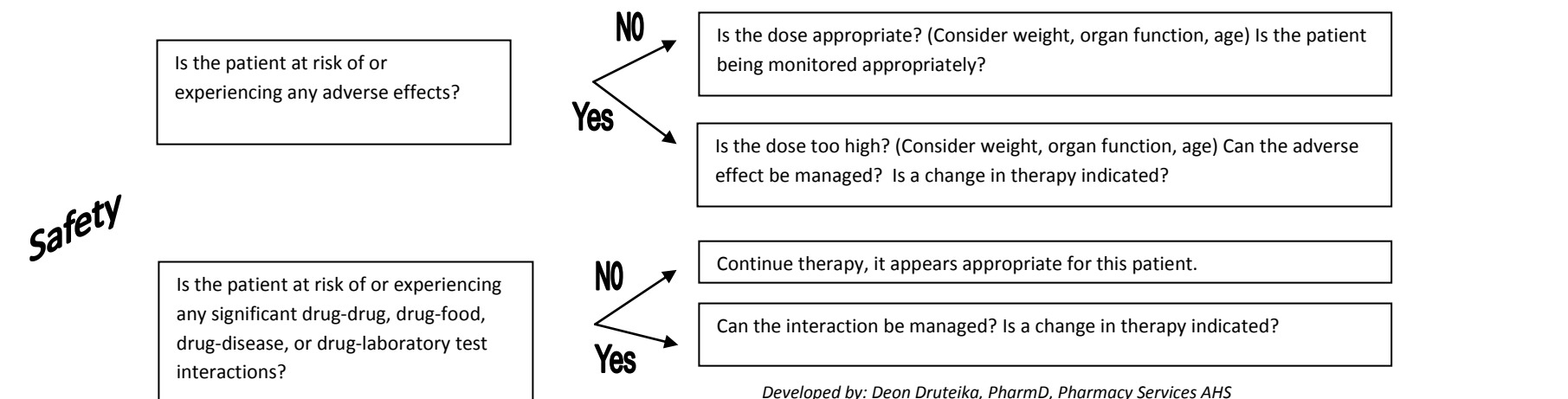
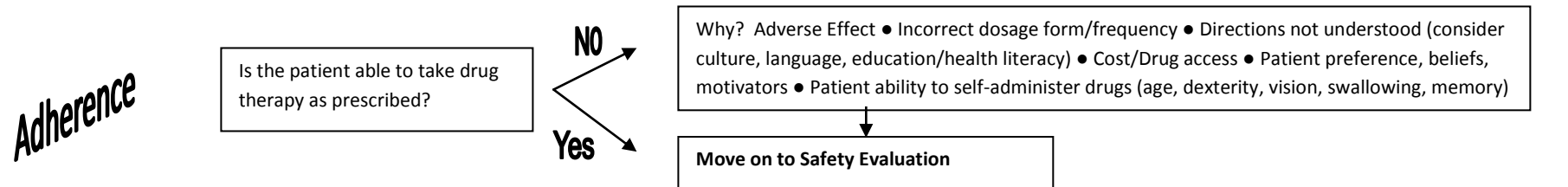
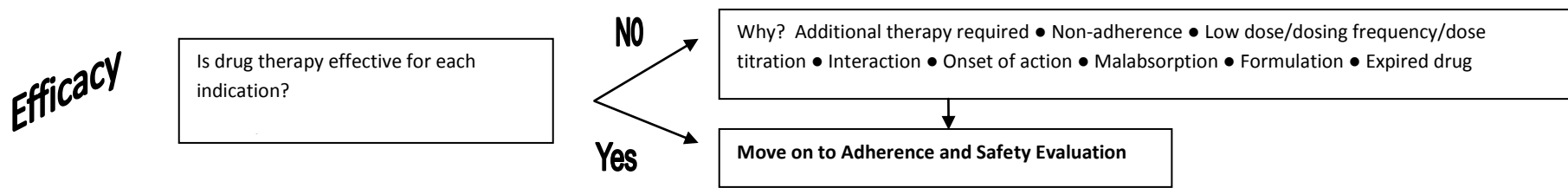
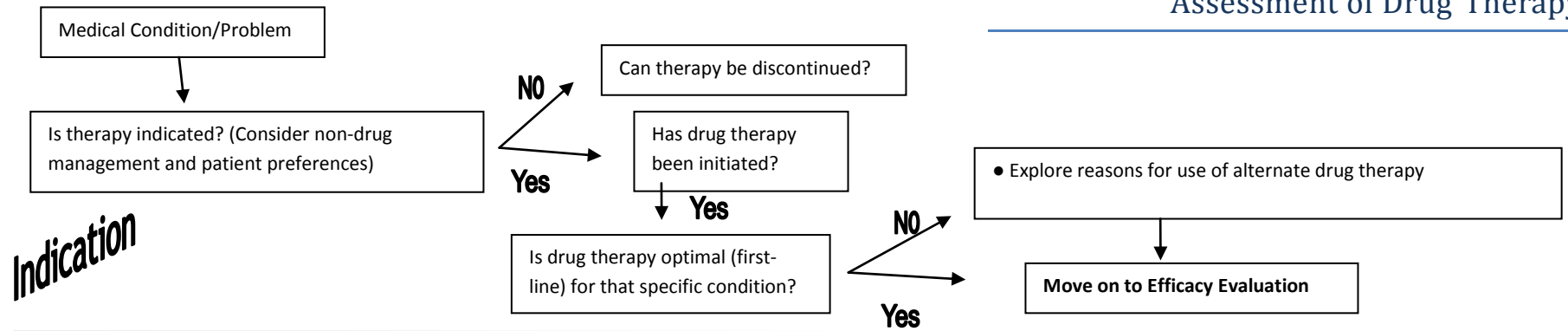
## Medication Adherence

- How is the medication prescribed vs. how does patient actually take the medication? (consider times, frequency, food; verify refill frequency)
- Describe daily routine (open-ended, non-judgemental) and how medication is taken/where it is stored?
- How often in a week does patient miss a dose of medication?
- What is the system used to manage/remember medication (i.e. supports, reminders, calendars, certain cues/times of day, blister packs, dosettes)
- Reasons for nonadherence/ potential solutions? (i.e. patient preference/beliefs, adverse effects, cost, drug formulation, dosing schedule, health literacy, memory, technique, functional ability)

## Medication Management

- Community Pharmacy, Medication Payment Plan
- Concerns with cost of medication?
- Prescribing physicians/ other health care workers involved in patient’s care
- Confidentiality (i.e. who knows about medical conditions and therapies?)
- Medication sharing (i.e. does the patient share or borrow medications from others?)
- How is the following done?
  - Ordering medication refills
  - Pick-up/delivery
  - Organization (i.e. dosette)
  - Administration (i.e. ability to self-medicate, given by caregiver)
  - Monitoring (i.e. hypertension, blood glucose, laboratory work)
  - Storage (i.e. where/how are they stored?)
  - Use/functional ability (i.e. dexterity (opening vials), vision, swallowing, memory)
  - Technique (i.e. dosette filling, blister pack uses, inhalers, injections, eye drops, etc.)

# Assessment of Drug Therapy



Developed by: Deon Druteika, PharmD, Pharmacy Services AHS

Adapted by: Patient Care Working Group, Faculty of Pharmacy, UofA 2011

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# Process to Assess Drug Therapy

## 1. Gather Information:

- Before starting to work through the process of assessing drug therapy it is important to:
  - Observe the patient's presentation (i.e. physical appearance, emotional state)
  - Gather relevant patient information
- Create a Patient Database
  - Data can be obtained from various sources including the patient, medical record, family members (with permission), other healthcare workers (pharmacist, nurse, physician, etc.), Netcare (laboratory findings)
  - Critical components of the database include a Medical History and Medication History
    - Medical History
      - Review medical record and interview the patient
    - Medication History
      - Review medical record, Netcare/PIN, interview the patient/caregivers, contact community/hospital pharmacy as appropriate

## 2. Assess Drug Therapy:

- **Keep in mind types of Drug-Related Problems (DRPs) when assessing drug therapy.**

Assessment	Type of DRP
Indication	Unnecessary Drug
	Additional Drug Therapy Required
Efficacy	Ineffective Drug- incorrect drug or drug product
	Dose too Low (correct drug, wrong dose)
Safety	Adverse Drug Reaction
	Dose too High (toxicity)
	Drug Interaction
Adherence	Non-adherence (not taking enough drug)
	Over-adherence (taking too much drug)
No DRPs identified	Drug therapy is appropriate for a specific patient

**Evaluate the following parameters (Indication, Efficacy, Adherence, and Safety).**

**INDICATION**

Review	Inquire
<ul style="list-style-type: none"> <li>• Medical History                             <ul style="list-style-type: none"> <li>○ Obtain complete list of medical conditions/problems (consider patient symptoms, diseases, laboratory data, physical examination findings, other investigations)</li> <li>○ Consider patient demographics (i.e. age, gender, ethnicity, height, weight) and organ function (i.e. hepatic, renal function)</li> <li>○ Consider need for prophylactic/ preventative therapies (including immunizations) based on medical history</li> <li>○ Consider possibility of the medical problem being caused by a drug adverse effect? (review Safety assessment below)</li> </ul> </li> <li>• Medication History                             <ul style="list-style-type: none"> <li>○ Consider contraindications to therapy, drug allergies, adverse effects when initially assessing for appropriateness</li> </ul> </li> <li>• Patient preferences and goals of therapy                             <ul style="list-style-type: none"> <li>○ Does the patient even want drug therapy?</li> <li>○ Are there non-drug measures that can be considered?</li> </ul> </li> </ul>	<p><b>Is drug therapy indicated?</b>  <b>NO:</b> If drug therapy is not indicated, can it be discontinued?   <b>YES:</b> If drug therapy is indicated, has it been initiated? If drug therapy is indicated, but has not been initiated, why?  <ul style="list-style-type: none"> <li>○ Consider patient factors such as preference, beliefs, lifestyle; unintentional omission; deferred therapy; competing priorities; cost, etc.)</li> </ul> </p> <p><b>Is drug therapy optimal (is it considered the best/first-line therapy for a given condition)?</b>  <b>NO:</b> Explore reasons for use of alternate drug therapy (i.e. optimal therapy is contraindicated, patient preference/needs, drug efficacy, drug safety, adherence and cost)  <ul style="list-style-type: none"> <li>○ Consider switching to optimal therapy if appropriate</li> </ul> </p> <p><b>YES: Move on to efficacy evaluation</b></p>

**EFFICACY**

Review	Inquire
<ul style="list-style-type: none"> <li>• Goals of therapy and timeframes to achieve these goals for each medical problem</li> <li>• Efficacy Monitoring Parameters for drug therapy                             <ul style="list-style-type: none"> <li>○ Consider drug efficacy, subjective/objective parameters; timeframe anticipated to achieve the desired outcome.</li> </ul> </li> </ul>	<p><b>Is drug therapy effective for each indication?</b>  <b>NO:</b> Consider additional therapies, non-adherence, low dose/dosing frequency/titration, interaction, onset of action, malabsorption, formulation, expired drug</p> <p><b>YES: Move on to Adherence and Safety Evaluation</b></p>

**ADHERENCE**

Review	Inquire
<ul style="list-style-type: none"> <li>• Medication History/Refill History</li> <li>• Medical History</li> <li>• Patient factors</li> </ul>	<p><b>Is the patient able to take drug therapy as prescribed?</b>  <b>NO:</b> Consider adverse effects, incorrect dosage form/frequency, directions not understood, cost/drug access, patient preference, beliefs, motivators, ability to self-administer drugs (i.e. age, dexterity, vision, swallowing, memory)  <ul style="list-style-type: none"> <li>• Can the medication taking be enhanced?                             <ul style="list-style-type: none"> <li>○ Consider medication packaging, caretaker support, drug substitution, motivational interviewing, scheduling, and addressing patient specific barriers</li> </ul> </li> </ul> </p> <p><b>YES: Move to Safety Evaluation</b></p>

## SAFETY

Review	Inquire
<ul style="list-style-type: none"> <li>• Safety Monitoring Parameters for drug therapy</li> <li>• Signs &amp; symptoms experienced by the patient</li> <li>• Medication History               <ul style="list-style-type: none"> <li>○ Review past and current medication history</li> <li>○ Review allergy history and past adverse effects to medications</li> </ul> </li> <li>• Medical History               <ul style="list-style-type: none"> <li>○ Consider possibility of the medical problem and/or laboratory data abnormality being caused by drug therapy (review likelihood of drug vs. disease- related causes)</li> </ul> </li> <li>• Patient factors (diseases, when drugs are taken relative to meals, spacing medications, etc.)</li> <li>• Drug interactions (drug-drug, drug-disease, drug-food, drug-laboratory)</li> </ul>	<p><b>ADVERSE EFFECTS</b></p> <p><b>Is the patient at risk of or experiencing a medical problem/adverse effect that could be caused by drug therapy?</b></p> <ul style="list-style-type: none"> <li>○ Consider safety monitoring parameters</li> <li>○ Consider causality, onset, timeframe, dose, and type of reaction [i.e. dose-related, idiosyncratic, hypersensitivity]</li> </ul> <p><b>NO:</b> Ensure that the dose is appropriate to prevent future adverse effects (consider weight, organ function, age). Ensure the patient is being monitored appropriately.</p> <p><b>YES:</b></p> <ul style="list-style-type: none"> <li>• Is the drug dose too high?           <ul style="list-style-type: none"> <li>○ Consider weight, organ function, age, drug kinetics/therapeutic index, duration of therapy</li> </ul> </li> <li>• Can the adverse effect be managed?           <ul style="list-style-type: none"> <li>○ Consider dose decrease, patient education, timeframe, need for additional drug therapy, nonpharmacologic intervention</li> <li>○ If the drug is discontinued, is there another appropriate therapy instead?</li> </ul> </li> </ul> <p><b>DRUG INTERACTIONS</b></p> <p><b>Is the patient at risk of or experiencing any significant drug interactions?</b></p> <ul style="list-style-type: none"> <li>○ Consider drug-drug, drug-food, drug-disease, drug-laboratory test value interactions</li> </ul> <p><b>NO:</b> Continue therapy; it appears appropriate for this patient</p> <p><b>YES:</b> Can the drug interaction be managed?</p> <ul style="list-style-type: none"> <li>○ Consider onset/offset, dosage adjustment, spacing apart, food effect, drug substitution, increased monitoring, therapeutic drug monitoring (TDM)</li> <li>○ If the drug is discontinued, is there another appropriate therapy instead?</li> </ul>

MEDICAL CONDITIONS AND/OR DRPs	GOALS OF THERAPY	ALTERNATIVES	RECOMMENDATIONS/ PLAN	MONITORING PARAMETERS	FOLLOW-UP
<p>List and prioritize each medical condition first, followed by any DRPs identified for a given condition. Although some medical conditions may not have a DRP, a care plan is still necessary for ongoing patient monitoring.</p> <p><b>DRP Categories:</b> unnecessary drug • additional drug required • ineffective drug • dose too low • adverse drug reaction/interaction • dose too high • nonadherence</p>	<p>For each medical condition and/or DRP state desired goals of therapy/timeframe.</p> <p><b>Goals:</b> cure, prevent, slow/stop progression, reduce/eliminate symptoms, normalize a lab value.</p> <p><i>Consider realistic goals determined through patient discussion. Goals of therapy are measurable or observable parameters that are used to evaluate the efficacy and safety of therapy.</i></p>	<p>Compare relevant drug and non-drug therapies that will produce desired goals. List the <u>pros</u> and <u>cons</u> of each therapy.</p> <p><i>Consider:</i>                      Indication                      Efficacy                      Adherence                      Safety                      Cost/coverage</p>	<p>In collaboration with the patient and other health care providers, select the best alternative and implement the plan. Provide a rationale for the chosen plan.</p> <p><i>Consider:</i>  <u>Drugs:</u> correct drug, formulation, route, dose, frequency, schedule, duration, medication management.  <u>Non-drug:</u> non-drug measures, education, patient referral.</p>	<p>Determine the parameters for monitoring <u>efficacy</u> and <u>safety</u> for each therapy.</p> <p><i>Consider:</i>                      Clinical &amp; laboratory parameters                      The degree of change                      The time frame</p>	<p>Determine <u>who, how and when</u> follow-up will occur.</p>

Adapted with permission from the Division of Pharmacy Practice, Leslie Dan Faculty of Pharmacy, University of Toronto, 2011.

## Initial Considerations:

- Reason for patient assessment/consultation
  - Comprehensive assessment
  - Consult letter
  - Medication history/reconciliation
  - Allergy assessment
  - Therapeutic drug monitoring
  - Patient follow-up
  - Patient education
  - Interventions
- Practice setting (i.e. community, ambulatory, hospital)
- Timeframe (i.e. urgency, quick chart note, detailed assessment)
- Documentation Systems (i.e. patient profile computer entry, free-hand note in a chart, type-written consult note)

## General Considerations:

- Scope
  - Keep notes focused on the problem/purpose of the note
  - Keep documentation notes within the scope of your practice
  - Avoid making unrealistic suggestions- tailor the note to your patient
- Writing
  - legible, clear, concise, logical, objective, professional
  - black ink in charts
  - Errors- cross out errors with a single line and initial
  - Avoid rewriting, deleting, or removing any part of the record
  - Avoid leaving blank spaces/lines when possible
  - Clearly indicate if documentation extends to another page
- Communication- diplomatic, appropriate tone
  - Appropriate terms: may benefit from, may improve with, may no longer require, suggest, recommend, consider, patient would prefer, patient unlikely to adhere to, patient stated
  - Avoid these terms: wrong, unnecessary, must, should, inappropriate/ not appropriate, patient does not want
  - Avoid being judgmental, criticizing or blaming others for errors in documentation
  - Focus on solutions, not problems
  - If relaying quotes stated by patient, ensure to indicate this clearly with quotation marks
- Include significant and relevant information only

- Abbreviations- use common or approved abbreviations only
  - Spell out drug names, directions (i.e. spell out IU, U, QD, qd)
  - Zeros: do not include a zero after a decimal point; always put a zero before a decimal point
  - Avoid other dangerous abbreviations
  - <http://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf>
- Generics vs. Brand Names
  - Generic names are preferred whenever possible; consider setting, intent, and recipient of documentation
  - Do not capitalize in the middle of a sentence
  - Use of Brand names only for longer combination products (i.e. triamterene/hydrochlorothiazide- Dyazide®) or to clarify a specific product/dosage form (i.e. Cardizem CD® vs. Tiazac®)
  - If a brand name is used, follow it by ®
- Document in a timely manner (proximate to encounter)

## Documentation Styles:

- Need to be flexible about different types of documentation styles depending on purpose of documentation and practice site
- Unstructured and semi-structured notes- may be appropriate for a clarification, routine follow-up, patient care activities (i.e. education), an intervention (i.e. IV to PO conversion, dosage adjustment for renal/hepatic dysfunction, use of a non-formulary drug, a drug interaction or adverse effect, a contraindication, therapeutic duplication)
- Pre-printed forms (i.e. medication reconciliation, consultation note, clinic visit sheet, history intake form)
- Systematic documentation
  - DAP (data, assessment, plan)
  - SOAP (subjective, objective, assessment, plan)
  - FARM (findings, assessment, recommendations, monitoring)
  - DRP (drug-related problem, recommendation, plan)
  - DDAP (drug-related problem, data, assessment, plan)

## Patient Care Note Components:

- Essential:
  - Date of encounter and purpose of note (i.e. Pharmacist Note RE lipid therapy)
  - Time written
  - Pharmacist identifier at end of note (i.e. name, signature, contact number)



- Other potential components:
  - Depending on type of note, other components in documentation will vary
  - Avoid irrelevant repetition of information already documented in the patient record. Ensure to include only the relevant and necessary information required to support your recommendations
  - See specific examples (i.e. DAP note, full assessment note, consult letter, etc.)

## DAP Note:

- Before documentation, refer to the pharmacy care plan worksheet you have made for your patient. Decide what is necessary and relevant to document. Not all components of a detailed care plan are necessary to document in the patient’s medical record.
- Multiple problems
  - Ensure to prioritize problems and list primary issue first
  - Organize notes well
  - Multiple problems: those with inter-related themes may be merged in one DAP segment; avoid repetition of the same data for multiple problems. Avoid lengthy notes.

<b>D- DATA</b> (or description of problem)	<ul style="list-style-type: none"> <li>• Patient concerns/goals/preferences</li> <li>• Relevant subjective and objective data about the patient</li> <li>• Includes pertinent orders, labs, vitals, patient concerns or statements, etc.</li> </ul>
<b>A- ASSESSMENT</b>	<ul style="list-style-type: none"> <li>• Assessment of the problem or working hypothesis (professional interpretation)</li> <li>• Supporting rationale</li> <li>• Identification of therapeutic goals/targets/desired outcomes</li> <li>• Avoid introducing new data here</li> </ul>
<b>P-PLAN</b>	<ul style="list-style-type: none"> <li>• Clearly number items in plan in appropriate order (i.e. priority or temporal sequence)</li> <li>• Recommendations (drug and non-drug)</li> <li>• Include drug regimen/product, dose, dosage form, route, duration</li> <li>• Necessary patient education or referrals</li> <li>• Monitoring plan and follow-up (tailor to practice site)</li> </ul>

## Comprehensive Initial Assessment Note:

- Depending on the type of assessment/consultation and practice setting, a comprehensive initial assessment may be conducted. In this case, a different format other than a DAP format is recommended.
- Components of an initial assessment stem from the information you have gathered to create a patient database (i.e. medical and medication history). The following components may be included in the assessment:
  - Date of encounter and title of note (i.e. Pharmacist Note); Time written (depending on setting)
  - Patient identifier (i.e. name, DOB, PHN)
  - Purpose for assessment/consultation
  - Relevant components of the patient database that you have created via patient interview and information gathering
    - refer to outlines for taking medical and medication histories
  - Drug-related problems or issues identified
  - Pharmacist assessment
  - Plans to resolve any problems/issues , including collaboration with other health care providers
  - Monitoring plan and follow-up
  - Pharmacist identifier (i.e. name, signature, contact number)

### Patient Care Process:

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