Requirements and Marking Scheme for Comprehensive Pharmacy Care Plans

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Requirements of the Comprehensive Pharmacy Care Plan (PCP)	Checklist Questions for Marking
1. Patient database includes complete patient description (using standardized format, included at end of this document (abbreviated); full version in Manual Appendix). ▪ Must include a list of all current medications (Rx, non-Rx), doses, duration and indication (should attempt to determine indication if not already known/documented) ▪ Patient beliefs/concerns need to be included as well as patient goals for health and wellness.	DATA ☐ Is data presented in organized fashion? ☐ Is proper grammar/spelling used? ☐ Is data presented complete/comprehensive? ☐ Patient goals specified (if appropriate)
2. ASSESSMENT of DRPs (based on patient database) and therapeutic alternatives ▪ Identifies key issue/DRP(s) (clearly stated, prioritized), and integrates patient's concerns/goals a. Evidence of process for assessment using 4 prime areas for therapies for each medical condition: indication, effectiveness, safety, and patient's willingness to manage therapy b. Rationale: student is concise in identifying why this is a DRP and only includes the pertinent data relevant to the DRP(s) being addressed (point form OK) c. Alternatives: Identifies at least 2 viable alternatives when appropriate, and provides reasoning and rational decision making for inclusion or exclusion of these options ▪ Desired therapeutic outcome/goal of intervention/recommendation incorporating patient goals	ASSESSMENT of DRPs and therapeutic options ☐ Are all DRPs identified (based on 4 prime areas)? ☐If no, note which are missing ☐ Are DRPs prioritized appropriately? ☐ Is rationale provided for DRPs? ☐ Is an assessment of each DRP provided (factors considered to influence/determine a plan)? ☐ Are alternatives (with rationale for each) provided? ☐ Therapeutic goal/outcome(s) stated? ☐ Patient goal incorporated (if appropriate)
3. Therapeutic Plan/Recommendations ▪ Provides rationale for treatment ▪ Incorporates PK dosing, renal dosage adjustment and patient values/preferences/goals/priorities [ie: once daily versus BID], ADR profile of drug options, medication administration abilities] into therapeutic plan for specific patient if relevant ▪ Action taken: should be appropriate to resolve DRPs (integration of knowledge, patient values)	PLAN ☐ Plan/recommendations are outlined including: ☐ dosing considerations ☐ patient preferences ACTIONS TAKEN ☐ Appropriate/acceptable action has been taken
4. Monitoring Plan ▪ States the relevant monitoring parameters, including appropriate frequency, acceptable endpoints, duration of monitoring for both efficacy/toxicity, and who is responsible for monitoring	☐ Monitoring plan present and includes: ☐ parameters (☐ safety and ☐ efficacy) ☐ frequency ☐ duration (if appropriate) ☐ which healthcare provider will follow-up
5. Follow Up ▪ Provides evidence that f/u has been provided and assesses progress toward the desired outcomes.	☐ Follow-up plan present ☐ includes outcome (if possible) ☐ Student role in care described
6. Documentation ▪ Attaches all appropriate documentation and note to physician/community PhC where applicable.	☐ Evidence of documentation noted OR actual documentation included (as Appendix to plan)
Each comprehensive pharmacy care plan is a maximum of five letter-sized pages (single-spaced) typed in a minimum of size 10 font.	

Marking Scheme

The intent is to not provide a mark, but rather whether or not the plan is "Complete", "Needs Improvement" or "Failure". Care plans that are exceptional or achieve expectations do not need to be redone. If care plan needs improvement or is considered a failure, then additional care plans, or modification of the existing care plan(s), should be submitted.

Exceptional	*Overall the student displays clinical competency and in depth complex problem solving ability and the quality of work submitted is consistently high. The student maintains exceptional standards of professional excellence in written work.* Elements included are: • Well-organized care plan with clear delineation of Data, Assessment and Plan • Uses correct grammar, punctuation, spelling and formatting conventions in the preparation of care plan. • Data gathered is appropriate and complete; no missing data • Uses supporting evidence (laboratory data, physical signs and symptoms, test results) to support assessment of patient • All DRPs are identified, prioritized and addressed in the plan in priority sequence • Therapeutic knowledge is comprehensive • Therapeutic alternatives are discussed and rationale for choice is provided • Plan implemented is appropriate (both therapeutic and monitoring) • Follow-up is complete and appropriately conducted • Evidence of communication/documentation with physician or other healthcare professionals

Achieves Expectations	*Overall the student displays clinical competency and complex problem solving ability and the quality of work submitted achieves expectations.* ▪ Organized care plan with clear delineation of Data, Assessment and Plan ▪ Uses correct grammar, punctuation, spelling and formatting conventions in the preparation of care plan. ▪ Data gathered is appropriate but may be incomplete; some missing data ▪ Uses supporting evidence (laboratory data, physical signs and symptoms, test results) to support assessment of patient, but this may be inconsistent ▪ All major DRPs are identified, prioritized and addressed in the plan in priority sequence; some minor DRPs may be missed (low clinical significance) ▪ Therapeutic knowledge is mostly comprehensive ▪ Able to provide therapeutic alternatives but not always patient specific. ▪ Plan implemented is appropriate (both therapeutic and monitoring) ▪ Follow-up is done, but may have some aspects incomplete or inappropriately conducted ▪ Evidence of communication/documentation with physician or other healthcare professionals.
Needs Improvement	*Overall the student displays below average clinical competency and complex problem solving ability and the quality of work submitted needs improvement.* ▪ Basic understanding of pharmacotherapy in the assessment or rationale. ▪ Incomplete workup and identifies only some of the DRPs. No major DRPs missed, only minor DRPs omitted. ▪ Needs to broaden therapeutic knowledge base. ▪ Of the therapeutic alternatives evaluated, requires more in depth evaluation of therapies. ▪ Fails to use correct grammar, punctuation, spelling and formatting conventions in the preparation of written assignments. ▪ Follow up not done or not conducted appropriately ▪ No evidence of communication or documentation of plan
Failed Assignment	*Overall the student displays unacceptable clinical competency and problem solving ability and the quality of work submitted is unacceptable.* ▪ Omits patient details that could impact on therapy decision-making. ▪ Major DRPS missed in work up of patient ▪ Understanding of pharmacotherapy is weak or not evident. o Indication for medications is erroneous or not clear o Dosing information for a medication is not provided o Current dosing information for a medication is harmful or suboptimal and is not addressed by the student ▪ Obvious gaps in therapeutic knowledge base ▪ Unable to provide rationale for therapeutic plan. ▪ Misinterpretation of patient specific information. ▪ Disorganized pharmacy care plan. ▪ Unable to interpret uncomplicated laboratory data. ▪ Significantly harms patient or puts patient at unnecessary risk ▪ Action taken to resolve the DRP is inappropriate e.g. discontinuation or reduction of prescribed medication without consultation with physician

*Adapted from UBC Faculty of Pharmacy, SPEP team, Kassam,R; Kim-Sing A; and Kwong M.

COMPREHENSIVE CARE PLAN FORMAT

DATA

CHIEF COMPLAINT or REASON FOR REFERRAL/CONSULT/ASSESSMENT/ADMISSION

Examples:

Community Setting:

- Patient has no particular complaint if this is chronic disease management, but they have active and ongoing monitoring needs to maximize the safe use of medication – this includes considering the patient's goals/priorities in regards to managing their health.
- Patient presents with an acute problem and requests help/advice
- Patient has some ongoing chronic issues being managed, and presents with an acute problem
- Second opinion on advice already provided

Hospital Setting:

- Reason for admission (if completing initial assessment)
- Consult for specific assessment questions - may be the current active issue, or the one the student has been asked to assess (for example: TDM, renal dose adjustment or therapeutic suggestion)

Ambulatory or Outpatient Clinic

- Summarizes the reason for referral

History of Present Illness (HPI)

This is where the background to the situation described in the section above is provided. It brings context to the reader about important details that lead to the current assessment. Remember that patients can have a long medical history, and only pertinent details to the current assessment need to be mentioned here. Typically, basic demographic information is included here such as age, gender, height, weight, and BMI (if last 3 items are relevant).

Past Medical History (PMH)

Family History (FH)

Social History (SH)

Review of Systems (ROS)

An example is presented below; note this example includes facets that the pharmacist could collect, but also facets that were taken from the medical ROS.

System	Findings
CNS	(-) headache, (-) enlarged thyroid, fundoscope not available, (-) vision changes
CVS	(-) palpitations, (-) chest pain, Normal S_1/S_2, (-) murmurs, (-) carotid bruits,
Resp	(+) SOB, ↑RR, (+) cough occasional (chronic), ↓ A/E throughout, faint crackles
Abdo	Normal bowel sounds, (-) abd/renal bruits, abd very distended (obese) – cannot examine liver/spleen; soft, non-tender
General	(+) pitting edema bilateral to knees, (-) sweating, (-) N/V, poor sleeping, psoriatic skin changes on trunk, legs and arms

PHYSICAL EXAM (if relevant to the patient):

For most assessments, this will include a visual inspection of the patient, and possibly vitals (BP, HR).

Example: General appearance: 54 year old obese male generally looking well.
VS: BP: 158/102 mmHg (average of 3, R arm, seated, large cuff) HR 88 beats/min

MEDICATION HISTORY

Example Format: (this is just one example – student may see others and prefer a different style of table, but name of drug, directions and indication should be included.

Drug Name	Directions	Indication	Adherence (Y/N)	Notes/Comments
Always state drug names	This is how	Important to		Examples: MUST INCLUDE

generically. Also include Brand name if it clarifies dose form (example: Cardizem CD versus Tiazac)	patient is taking drug which may or may reflect how it was prescribed. Include timing of dosages.	identify if the medication is required, and if dosing is appropriate		how often prn meds are used? Does the patient use the drug differently than prescribed?

ALLERGIES
This section should also include intolerances. Allergies and intolerances should be described and documented.

DIAGNOSTICS/INVESTIGATIONS
Labs
If Netcare access is available, include lab values deemed to be important to the current assessment. Do not include actual print outs of laboratory parameters from Wellnet or equivalent. It is not necessary to write down every lab value just because it is available. Ensure that only labs that are important to the assessment are mentioned. Indicate a timeframe for when the labs were drawn to demonstrate relevance.
Cultures
When appropriate, include any cultures and sensitivities that will impact treatment decisions.
Imaging
When appropriate, provide any other imaging/investigations that impact the case.

ASSESSMENT of DRPs and Therapeutic Alternatives
DRUG-RELATED PROBLEMS (DRP) or PATIENT-RELATED PROBLEM
Prioritizing DRPs is extremely important, and the student needs to orient the reader to their priorities based on the data collected and assessment conducted. Often, especially in the community setting, the patient's goals/questions will help prioritize what needs to be dealt with first.
TIP: DRPs are identified and substantiated by conducting an assessment of the 4 prime areas: indication, effectiveness, safety, and patient's willingness to manage the drug therapy relevant to their medical condition(s).

As a reminder, the 8 categories of DRPs are (categorized using the 4 prime areas of consideration for drug therapy):
Indication
1. Unnecessary drug therapy
2. Needs additional Drug Therapy

Effectiveness
3. Ineffective Drug
4. Dosage too low

Safety
5. Adverse Drug Reaction (includes drug interactions)
6. Dosage too high

Compliance
7. Non-adherence/compliance.

List DRPs with the most important being #1. ***Every care plan must include prioritization if more than one DRP.*** Ensure your DRP states a problem/concern (that is realistic), the undesirable event or risk of event, the drug, and the relationship between the two. If the DRP involves no drug therapy, this will be the concern for the undesirable event or risk of event.

As part of the assessment, DATA not previously mentioned cannot be mentioned here.

EVALUATION of DRP and THERAPEUTIC ALTERNATIVES
For each drug related problem, evaluate the following:

- Why is this a drug related problem?
- What are all of the alternatives for resolving the drug related problem? If there are no alternatives, state this.
- Provide evidence/support and a rational decision-making process for accepting or declining potential therapeutic alternatives
- Determine the best alternative for the patient
- What goals has the patient set as part of this care plan? It is important for patient to be involved in decision-making and the chosen plan.

RECOMMENDATIONS and/or PLAN

This is where the plan of action is discussed. It is usually point-form. Be specific with:

- What is the student's recommendation for an intervention based on their assessment above? ((ie: started or stopped medication, recommended a referral, provided instructions/education or outlined how the student is going to obtain information needed to construct a plan)? If the plan includes the addition or deletion of a medication, rationale for the selection of that particular agent (or its deletion) MUST be mentioned. This is outlined in your assessment section.)

– What is being monitored, by whom, when, and for how long

- This should be divided into efficacy and toxicity. Both sections should include both objective and subjective markers. Compliance should also be evaluated here

FOLLOW-UP

- How is the patient being followed up by the student and/or other healthcare providers? (i.e. vitals, pain scale, patient report, etc)
- What actually happened to the patient based on the recommendations?

DOCUMENTATION

The care provided needs to be documented. Ideally, a copy of the actual documentation developed for a patient can be submitted. If this is not possible to provide electronically (as an Appendix), then include what items were documented as part of the care plan submission.

STUDENT ROLE

This is where the student outlines their role in the patient encounter. What did the student do? Were their recommendations accepted? This enables the student to reflect on the contributions they made to the patient and healthcare team.