INTRODUCTION TO NOTE DOCUMENTATION

Pharmaceutical Care Practice

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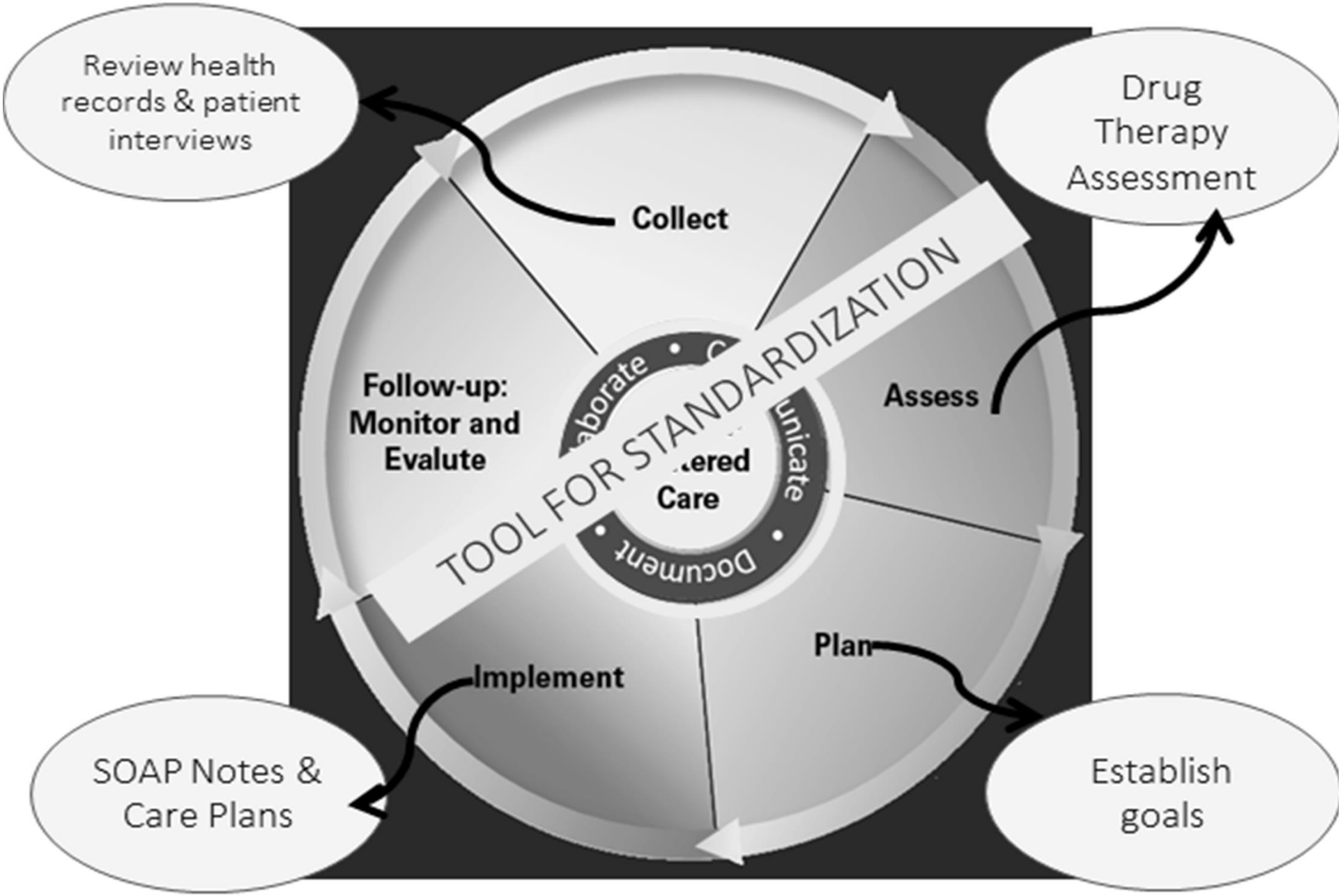
Learning Objectives

- Explain the importance of note documentation within healthcare practice
- Understand the potential outcomes and consequences of good note documentation and poor note documentation
- Discuss the major components of a SOAP note and care plan
- Be able to design an effective care plan & SOAP note for patient case scenarios


Review health records & patient interviews
Drug Therapy Assessment
Collect
TOOL FOR STANDARDIZATION
Follow-up: Monitor and Evalute
Assess
Care
Plan
Implement
SOAP Notes & Care Plans
Establish goals

IF IT WASN'T DOCUMENTED…
IT NEVER HAPPENED.

Why is documentation in healthcare important?

- It is apart of **standardized healthcare practice**
- Provides a **clear & concise idea** on what is going on with the patient
- It ensures that **workflow** in practice is appropriate
- Required for **timely payments** from insurance companies
- Ensures **“continuity of care”**

What is continuity of care?

- Many patients see more than one healthcare professional throughout their life
  - I.e. primary care provider (PCP), pharmacist, specialist, physical therapist, dentist, ophthalmologist and more
- Continuity of care ensures that each professional shares appropriate information with the PCP
- Sharing is crucial so the PCP understands the plans/actions that are occurring with the patient
- Proper note documentation is ***essential*** for continuity of care

Challenges to Note Documentation

- Time consuming
- Knowing what to include and exclude
- Effectively communicating information to others
- Identifying what insurances are looking for
- Learning different electronic health records
- Having availability/access to notes/records
- Requesting access to other specialists' notes
  - May require patient's signature for release of records

What should be included in note documentation?

- Date and time
- Title for the note
- Printed name and contact information
- Signature and credentials

<u>If note documentation is done on paper:</u>

- Write legibly
- Use blue/black ink
- Cross out mistakes with a single line
- Use appropriate grammar and spelling

Other Important Factors In Documentation

- Avoid ISMP Error-Prone Abbreviations
  - Leads to mistakes & is apart of The Joint Commission standards
- Avoid long and wordy statements
  - Should be clear, and straight-forward
- Avoid commanding language
  - The physician should stop Lisinopril vs. recommend the physician to stop Lisinopril
- Avoid accusatory language
  - The patient is non-adherent because he is slow vs. the patient displays signs of non-adherence

Documentation Must Be Clear!

- Remember that physicians will read YOUR notes
- Physicians want information that is clear & straight-forward
- They DO NOT want to read notes that are too long & superfluous
- They DO NOT want to have to call you for clarification
- They DO want to understand your exact thoughts/ideas & implementations

How will you be documenting notes?

- One way you will document is by writing **care plans**

- Another way you will document is by writing **SOAP Notes**

CARE PLANS

Care Plan Format

Prioritized Problem List (1, 2, or 3)	Problem	SMART Goals of Therapy	Specific Recommendations & Counseling	Monitoring Parameters for Safety & Efficacy, Follow-Up

Care Plan Components

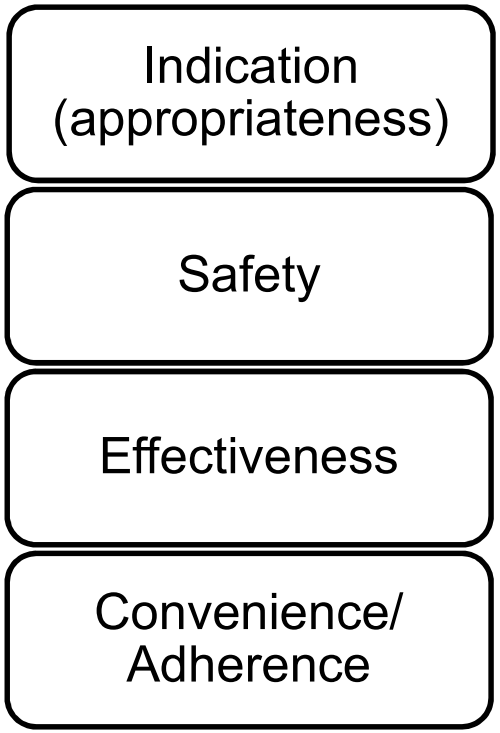
1. Prioritized problem list
2. SMART goals of therapy
3. Therapeutic recommendations
    - Treatment and/or prevention
    - Non-pharmacological
    - Pharmacological
4. Monitoring
    - Safety
    - Effectiveness
    - Follow-up

Prioritized Problem List

- Patients often times have more than 1 problem going on
- Healthcare professionals have to identify which problems need to be treated *immediately* and *what can wait*
- You will learn how to prioritize a patient's problems and list problems from most important to least important
- Problems will usually be prioritized as:
  - Primary (or #1) as most important problem
  - Secondary (#2) are problems to be addressed next
  - Tertiary (#3) are problems that can be addressed later

Problem Identification – I-S-E-C

- **Indication**
  1. Unnecessary Drug Therapy
  2. Needs additional Drug Therapy
- **Safety**
  3. Adverse Drug Reaction
  4. Dosage too High
- **Effectiveness**
  5. More effective drug available
  6. Dosage too Low
- **Convenience/Adherence**
  7. Nonadherence
  8. Monitoring (for safety, efficacy, or adherence)



Care Plan Components

1. Prioritized problem list
2. SMART goals of therapy
3. Therapeutic recommendations
    - Treatment and prevention
    - Non-pharmacological
    - Pharmacological
4. Monitoring
    - Safety
    - Effectiveness
    - Follow-up

Therapeutic Goals

- A care plan should include therapeutic goals for a patient to reach
- Types of therapeutic goals may include:
  - Cure a condition
  - Slow or halt disease progression
  - Reduce or eliminate signs and/or symptoms
  - Prevent disease
  - Normalize lab values
- When writing goals, they should be in SMART format
- Each problem in a care plan should have at least 3 SMART goals written

S-M-A-R-T Format

Care Plan Components

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    - Non-pharmacological
    - Pharmacological
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    - Safety
    - Effectiveness
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Therapeutic Recommendations

Initiate New Therapy (pharm or non-pharm)	Substitute with Therapeutic Alternative	Discontinue Drug
Continue Drug with Monitoring	Encourage Medication Adherence	Modify Medication Dose
	Refer to Physician (exclusion to self-care)	

Therapeutic Recommendations

- Be complete and specific so that any healthcare provider can follow your directions
- Medication therapy should include:
  - Drug – dose – route – frequency – (duration if applicable)
  - Special instructions or counseling points for patient
- Anticipate alternative recommendations
  - Many disease states will have multiple medication options to choose from
  - You may need to compare pros and cons of each therapeutic option

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Monitoring & Follow-Up

- You should include monitoring parameters to assess the ***effectiveness AND safety of therapy***
- Monitoring parameters need to be in SMART format as well
- Need to also provide a specific follow-up
  - **When should the patient follow-up to see if your plan worked?**
- The follow-up should discuss:
  - **Who** is going to follow-up with the patient?
  - **When** are they going to follow up?
  - **When** to seek treatment sooner if they are not getting better?

SOAP NOTES

SOAP Notes

- Universal means for consistent and effective documentation
- Provides evidence for current or potential medical and drug-therapy problems
- Presents a plan for managing or preventing the identified problems
- **Inpatient**: found in the chart
- **Outpatient**: found in the ambulatory EMR or community pharmacy MTM

The Beginning

- Date and Time
  - Write the note on the next blank page
  - Write it in order—patient medical record should read like a story
  - Protects you legally
- Title
  - Tells what your are going to cover in the note
  - Identify pharmacy note

Subjective Information

Objective Information

Assessment

Plan

S vs. O

Subjective	Objective
Cannot measure	Can measure or observe
Generally obtained through patient interview	Generally obtained through observation and direct testing
May be inaccurate or incomplete	Reproducible

Subjective Findings

- Patient demographics
- Chief complaint
- History of present illness
- Past medical history
- Past surgical history
- Family history
- Social history
- Drug allergies
- Current medications
- Vaccination history

In a SOAP note, generally only data pertinent to the problems should be listed

Note: *A patient's current medication list may be either subjective OR objective, depending on the source of this information!*

Objective Findings

- Vital signs
- Calculations
- Physical exam
- Laboratory values
- Microbiology tests
- Test results
- Current Medications

Note well: Sometimes medication list may fall under “objective” if the medication history was NOT obtained by the patient

- In a SOAP note, only findings/labs pertinent to the problem should be mentioned .

Subjective vs. Objective

- Patient complains of dry cough
- Patient has pain in left leg
- Patient rates pain score of 8 on scale 1-10
- BP is 124/85 mmHg
- LDL is 192 mg/dL
- Blood Culture reveals gram-negative bacteria
- Patient states taking lisinopril

Assessment

- Use your information from S & O to create your assessment
- Like in a care plan, you must identify drug-related problems using **I-S-E-C**
- Prioritize each problem if there is more than 1 problem noted
  - Primary problem – most important
  - Secondary problems – next problems to address
  - Tertiary problems – problems that can wait
- Be sure to characterize the problem and specify the type of action that is needed to resolve the problem
  - E.g. New onset diabetes requiring additional prescription therapy

Characterization

Action that is needed

Assessment

- After identifying, characterizing, and prioritizing the problems, each problem needs an ***evaluation and rationale***

- This is more of a discussion of why you are choosing one drug over another

- Discuss why you eliminated certain choices as an option and why you choose other options instead

Plan

- The “plan” section of a SOAP note includes what you would normally put in a care plan

- Create a plan for each drug-related problem you identified

- **The plan for each problem should include:**
  - Pharmacological and non-pharmacological recommendations
  - At least three SMART goals for each problem
  - SMART monitoring parameters for safety and efficacy
  - A statement about follow-up

A Proper Finish

- Sign and print your name and degree
- Include a contact number.

Sample Case: Mr. Lee Calm

- HPI: Mr. Calm comes to your pharmacy today for an OTC medication for a cough. He believes he caught the common cold from a coworker. He also decides to check his BP on the machine

- CC: I keep coughing up mucus! It's been bothering me every night and I have been sleeping poorly these past few nights!

- PMH: Hypertension, hyperlipidemia, diabetes, cough

- SH: Drinks 1-2 beers each night

Sample Case: Mr. Lee Calm

- Allergies: NKDA
- Vitals:
  - 165/93 mmHg (goal is <130/80); HR 78 bpm; Ht: 62 in; Wt: 220 lbs
- Vaccinations:
  - All childhood & adult vaccines are up-to-date
  - Received flu vaccine on 12/12/2018
- Current Medications (from pharmacy profile):
  - Metformin 1000 mg po BID
  - Amlodipine 10 mg po daily
  - Atorvastatin 40 mg po daily
  - Aspirin 81 mg po daily

What are his current problems?

- **Cough** – this is his main complaint so we can label it as a *primary problem*

- **High blood pressure** – this is uncontrolled and should be addressed today so we can label as a *secondary problem*

Create a care plan for each problem

- **<u>Remember to include:</u>**
  - At least three SMART goals for each problem
  - Any pharmacological and non-pharmacological recommendations along with counseling points
  - Monitoring parameters for SAFETY and EFFICACY
  - A follow-up for who and when to follow-up

Priority (1,2,3)	Problem	SMART Goal	Therapeutic Recommendations (Pharm & Non-Pharm)	Monitoring for Effectiveness, Safety, & Follow-Up
1	New Onset Cough	Eliminate cough within 1 week Eliminate chest congestion within 1 week Improve quality of sleep by reducing number of coughing spells at night to 0 by next week	**Pharm**: • Recommend guaifenesin ER 600 mg po BID x 10 days **Non-pharm**: • Gargle with warm saltwater each day and night. • Utilize humidifier throughout the day to improve congestion • Educate on reducing risk of spreading cold – including good hand hygiene and cover mouth with arm when coughing	**Effectiveness**: Assess for resolution of cough in 1 week **Safety**: Monitor daily for side effects of dizziness, drowsiness, headache and nausea daily during time of treatment **Follow-Up**: Return to see pharmacist in 1 week to assess symptom improvement

Priority (1,2,3)	Problem	SMART Goal	Therapeutic Recommendations (Pharm & Non-Pharm)	Monitoring for Effectiveness, Safety, & Follow-Up
2	Uncontrolled blood pressure	Reduce BP < 130/80 mmhg within 1 month Prevent potential CV events for lifetime (i.e. stroke, MI, CAD) Prevent target-organ damage such as kidney failure & heart failure for lifetime	**Pharm**: Recommend for PCP to start patient on lisinopril 5 mg po daily and continue amlodipine 10 mg po daily **Non-pharm**: • Begin 30-minute exercises 3-5 times a week • Increase diet of 5 cups of fruits/vegetables daily • Minimize sodium intake to 1.5 g/day • Reduce beer consumption to only 1 per day for next week then to only 1-2 on weekends	**Effectiveness**: Check BP once daily in the morning during treatment **Safety**: Monitor for side effects including cough, hypotension, and angioedema daily during treatment duration **Follow-Up**: Visit PCP in 1 month to reassess current BP regimen

For SOAP Note Writing…

- List off all subjective information pertinent to the case in the “S” section
- List off all objective information pertinent to the case in the “O” section
- Identify the problems and prioritize them then provide a characterization and rationale/evaluation for each problem for the “A” section
- Create a plan in the “P” section like you would in a care plan
  - Include 3 SMART goals, monitoring parameters, and follow-up

SOAP Note Example

- **S**:
  - **HPI:** Mr. Calm presenting with wet cough causing trouble with sleep and believes he caught the cold from someone at work. Also takes his BP today and it is elevated.
  - **PMH:** HTN, diabetes, hyperlipidemia, wet cough
  - **Allergies:** NKDA

SOAP Note Example

- **O:**
  - BP 165/93 mmHg (goal is <130/80); HR 78 bpm; Ht: 62 in; Wt: 220 lbs
  - Current Medications:
    - Metformin 1000 mg po BID
    - Amlodipine 10 mg po daily
    - Atorvastatin 40 mg po daily
    - Aspirin 81 mg po daily

SOAP Note Example

- A:
  - Priority #1: **New Onset Cough Requiring additional OTC therapy**
    - Patient has a wet cough with mucus thus an expectorant (i.e. guaifenesin) is preferred over traditional cough suppressants (i.e. dextromethorphan or benzonatate) to help expel mucus

Problem characterization

Rationale!!

  - Priority #2: **Uncontrolled Hypertension Requiring Additional Therapy**
    - Patient needs an additional agent as amlodipine 10 mg po daily is at the maximum dose and cannot be increased
    - Addition of an ACE-inhibitor (i.e. lisinopril) would be the most preferred as it will also will provide renal protection since the patient currently has diabetes and is at risk of kidney disease

SOAP Note Example

P:

- **Priority #1. New-Onset Cough Requiring Additional OTC Therapy**
  - Pharm:
    - Recommend gauifenesin ER 600 mg po BID x 10 days
  - Non-Pharm:
    - Also recommend gargling with saltwater in the morning and evening
    - Continue utilizing a humidifier daily to help minimize chest congestion
    - Be sure to use proper hand hygiene and cover mouth with arm while coughing
  - SMART GOALS:
    - Goal is to eliminate cough within 1 week after starting therapy
    - Eliminate any congestion within 1 week
    - Improve quality of sleep by reducing nighttime coughing spells to 0 by next week
  - Monitoring Parameters (for efficacy & safety):
    - Patient and pharmacist to monitor for any cough in 1 week for assessment of efficacy
    - Monitor for side effects related to medication such as dizziness, drowsiness, and nausea daily during treatment
  - Follow-up in 1 week with PCP to reassess cough

SOAP Note Example

P:

- **Priority #2. Uncontrolled Hypertension requiring additional Rx Therapy**
  - Pharm:
    - Recommend PCP to start lisinopril 5 mg po daily
  - Non-Pharm:
    - Recommend increasing exercising to 30 minutes per day, 3-5 days a week
    - Recommend increasing number of vegetables/fruits (at least 5 cups/day)
    - Also recommend minimizing sodium intake to no more than 1.5 g per day
    - Minimize beer consumption to 1 beer per day for 1 week then down to 1-2 on weekends
  - SMART GOALS:
  - Goal is to have BP <130/80 mmHg in 3 months
  - Prevent CV events for lifetime (i.e. heart attack, stroke)
  - Prevent target-organ complications for lifetime (i.e. kidney failure, heart failure)
  - Monitoring Parameters (efficacy & safety):
    - Monitor BP daily and record readings for PCP to review in 1 month
    - Monitor for side effects including dry cough, dizziness, hypotension, angioedema daily during the course of treatment
  - Follow-up in 1 month with PCP

Care Plan Summary

- Identify the drug & medical related problems
- Prioritize each problem
- Provide SMART Goals (at least 3 for each problem)
- Provide BOTH pharmacological & non-pharmacological treatment
- SMART Monitoring parameters for efficacy & safety
- Follow-Up (with who and when?)

SOAP Note Summary

- **Subjective:**
  - Include information from patient (CC, PMH, HPI, FH, SH, PSH, Drug Allergies & medications if explained by patient)

- **Objective:**
  - Include ***pertinent*** labs, findings, vitals & medications (if found on chart)

- **Assessment:**
  - Prioritize the problems and include a characterization with the action required
  - Provide a rationale of selecting and eliminating different therapeutic options

- **Plan:**
  - Include both pharmacological & non-pharmacological recommendations
  - Include SMART goals (at least 3)
  - Include monitoring parameters for BOTH safety & efficacy
  - Include follow-up

Summary

Even if you aren't writing a SOAP Note or a Care Plan in every day practice, you still need to learn to THINK in this format.

This is what will make you a GREAT pharmacist.