Documentation of Pharmacist Interventions

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If there is no documentation, then it didn't happen! This philosophy is the standard in all health care settings as physicians, nurses, respiratory therapists, physical therapists, social workers, and other health care providers generate and maintain detailed notes regarding the patient's situation and their efforts to achieve the best possible outcomes for the patient. Documentation chronologically outlines the care the patient received and serves as a form of communication among health care providers, so that each practitioner involved knows what evaluation has occurred, what the plan for the patient's treatment is, and who will provide it. Furthermore, third-party payers require reasonable documentation from practitioners that assures that the services provided are consistent with the insurance coverage. General principles for documentation include:

- A complete and legible record.
- Documentation for each encounter with a rationale for the encounter, physical findings, prior test results, assessment, clinical impression (or diagnosis) and plan for care.
- Identified health risk factors.
- The patient's progress, response to and changes in treatment, and revision of the original diagnosis/assessment.

Much of this documentation is derived from a systematic patient care process of evaluation that is standardized within each discipline. For example, physicians are taught to perform a history and

Pharmacotherapy Casebook Instructor

Terry L. Schwinghammer, Julia M. Koehler, Jill S. Borchert, Douglas Slain, Sharon K. Park

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