Patient Assessment and Documentation

According to the SCPP/NAPRA Standards of Practice for Pharmacists and Pharmacy Technicians in Canada, an assessment (review) of each prescription or non-prescription medication that a patient is taking **shall be done with each patient encounter** to ensure there are no drug related problems associated with the medication (e.g. drug interaction, contraindication, dose too low, dose too high, inappropriate therapy, drug needed, drug not needed).

This assessment is to be done regardless of the scope of practice being performed. In order to fully perform the above assessments, there is a requirement to collect and interpret relevant patient and medication information. Once this information has been collected and interpreted, if a medication related problem exists it is to be resolved.

The following information should be collected, documented and used to properly assess appropriateness of medication and identify potential drug related problems.

1. **Demographic Information**

   Name, address, phone number, gender, date of birth, weight, height, occupation or unusual work situation (e.g., shift work, physically demanding), Health Service Number (HSN), Drug Plan category (e.g. Senior's Drug Plan, palliative care, Non-Insured Health Benefits (NIHB) program)

2. **Current Physician List**

   Including specialists and nurse practitioners

3. **Allergies, Intolerances and Adverse Reactions**

   Description of incident and whether they are willing to accept the drug again

4. **Medication Experiences and Expectations**

   General attitude toward medications, expectations, any concerns about their medications, any other issues (e.g., ethical, cultural, financial)

5. **Social Drug Use**

   Do they smoke and how much, how many glasses of alcohol/week, caffeine use/day, recreational drug use

Current and Relevant Past Medical History

6. **Current Medications**

   Including prescription, non-prescription, and herbal products

7. **Past Medications**

   Why and when they stopped taking

8. **Review of Systems**

   To ensure nothing has been missed (may use a tick box format)

9. **Relevant Test Results or Lab Work**

   If available

Periodic checks (at least once yearly) should be done to confirm the all the above information is still correct and complete.

New Prescriptions

Ensure:

- ☐ there are no significant drug interactions or contraindications
- ☐ medication is most appropriate for patient based on patient characteristics and other conditions and medications
- ☐ dose and instructions for use are correct
- ☐ patient understands the indication for which they have been prescribed the medication
- ☐ monitoring is identified and will be done to ensure patient is reaching the therapeutic goal for which the medication was prescribed
- ☐ patient education is provided in order that the patient sufficiently understands why, when, how, and how often to take the medication

Refill Prescriptions

Current and Relevant Past Medical History

Ensure:

- ☐ there still are no significant drug interactions or contraindications
- ☐ there are no adverse effects occurring
- ☐ medication is still required
- ☐ dose and instructions are correct
- ☐ patient is receiving appropriate monitoring for medication and disease
- ☐ patient's adherence is assessed and any compliance issues are addressed
- ☐ patient education is provided in order that the patient sufficiently understands why, when, how, and how often to take the medication

Non-Prescription/Herbal Products

Ensure:

- ☐ there are no significant drug interactions or contraindications
- ☐ medication is appropriate taking into account patient factors, signs and symptoms, and other conditions and medications
- ☐ dose and instructions for use of the medication is clear
- ☐ recommended self-care measures are evidence based
- ☐ patient education is provided in order that the patient sufficiently understands why, when, how, and how often to take the medication

Patient Record

To ensure consistency of care and a foundation for good evidence-based decisions, pharmacists should ensure the following information is documented in a retrievable and accessible patient record:

- ☐ Patient relevant information collected as per recommendation above.
- ☐ Interactions with patient that reveal medication related problems to be resolved, actions taken to resolve, and results of actions taken
- ☐ Issues around adherence and actions taken to resolve
- ☐ Monitoring to be done and results of the monitoring
- ☐ Interactions with physicians and other health care providers that deal with the patient's care
- ☐ Interventions and recommendations made to physicians and other health care providers and the results of the interventions or recommendations
- ☐ Requests for non-prescriptions/herbal medications by the patient, condition patient is treating and recommendations made for treatment
- ☐ Any information/education given to the patient that is in addition to the accepted standard of care

Community Pharmacy Safe Medication Checklist

Initial _____

Prescription Entry and Documentation

- ☐ Name and address
- ☐ Health Card Number
- ☐ Patient age and weight
- ☐ Allergies
- ☐ Past/Current medical conditions
- ☐ OTC medications
- ☐ Other prescription medications (PIP, MedRec)
- ☐ Herbal medications
- ☐ Recent lab values
- ☐ Condition medication is prescribed for is appropriate
- ☐ Dose is appropriate for patient
- ☐ Logged prescriptions
  - Pharmacist is able to refer to original prescription when filling a logged prescription
- ☐ Social issues
  - smoker/non-smoker
  - alcohol use
- ☐ **High Alert Medication/High Risk Patient**

Initial _____

Patient Education

- ☐ Open container to show patient the medication's appearance
- ☐ Name, dose and use of medication
- ☐ Directions and duration of use
- ☐ Benefits and expected outcome of medication
- ☐ How drug works
- ☐ Side effects, contraindications and drug interactions and how to handle or minimize if possible
- ☐ Further tests and follow up if required
- ☐ Storage requirements of medication
- ☐ Notified patient whether refills exist on prescription
- ☐ If brand has changed, patient is aware there has been a brand change since last fill of prescription and the reasoning
- ☐ Patient able to teach back what they have learned
- ☐ Interaction with patient is documented
- ☐ Lifestyle changes

Initial _____

Monitoring – to be done regularly at refills

- ☐ **Compliance**
  - Is the patient having trouble remembering to take medication as prescribed?
  - Is the patient having any other problems with taking medication?
- ☐ **Efficacy**
  - Does the patient notice any improvement or worsening of condition since starting the medication?
  - Are there any test/lab results that will confirm/deny efficacy of medication?
- ☐ **Tolerability**
  - Is the patient experiencing any side effects, adverse reactions or signs of toxicity since starting the medication?
- ☐ **Medication error or near miss discussed, investigated and documented.**

Initial _____

Dispensing

- ☐ How much has been dispensed?
- ☐ Expiry date check
- ☐ Label check against original prescription:
  - Patient
  - Doctor
  - Date
  - DIN number
  - Drug name
  - Dose
  - Directions for use
  - Quantity
  - Refills
  - Auxiliary labels
- ☐ Product Check
  - Medication
  - Strength
  - Route of Administration
- ☐ Independent double check performed
- ☐ Measuring device provided, if required
- ☐ Open container to show patient the medication's appearance

Resources

1. COMPASS program Safety Resources
2. Institute for Safe Medication Practices (ISMP) Canada website https://ismpcanada.ca
3. ISMP Safety Alert "Santa Checks His List Twice. Shouldn't We?"
4. Flynn E, Barker K, et al. Dispensing errors and counseling quality in 100 pharmacies. *J Am Pharm Association* 2009; 49: 171-180: https://www.ncbi.nlm.nih.gov/pubmed/19289343.