Preceptor Development: Patient Care Process

Documentation of Patient Care

Outline

- **Setting the stage for precepting documentation**
- **Elements of documentation**
  - Format
  - DAP note
  - Content
- **Feedback and evaluation of your student**
- **Overview of the preceptor role**
- **My practice – an example**

Setting the Stage

1. **Identify and evaluate how you document in your practice**
   - Review your practice setting with your student
   - What are the main reasons for documentation in your practice?
   - Where do you document?
2. **Get to know your student; specifically, their comfort and experience with documentation.**
   - How much and what format(s) of documentation have been learned and practiced?

Setting the Stage

3. **Share your approach with your student.**
   - What format do you use for documenting?
     - Pre-printed forms?
     - Consultation/free-form note?
   - How often do you document?
   - When do you document?

Elements of Documentation: Format

Essential:

- Date of encounter and time written
- Purpose of note (i.e. Why did you see the patient? Example: Pharmacist Note RE: warfarin education)
- Content: Data, Assessment and Plan
- Pharmacist identifier at end of note (i.e. name, signature, contact number)

PRECEPTING TIP:

Help your student focus on only including relevant and necessary information required to support their recommendations.

Elements of Documentation: DAP Note

D- DATA (or description of problem)	• Patient concerns/goals/preferences • Relevant subjective and objective data about the patient • Includes orders, labs, vitals, patient concerns or statements, etc.
A- ASSESSMENT	• Assessment of the problem or working hypothesis (professional interpretation) • Supporting rationale • Identification of therapeutic goals/targets/desired outcomes • Avoid introducing new data here
P-PLAN	• Clearly number items in plan in appropriate order (i.e. priority or temporal sequence) • Recommendations (drug and non-drug) • Include drug regimen/product, dose, dosage form, route, duration • Necessary patient education or referrals • Monitoring plan and follow-up (tailor to practice site)

Elements of Documentation: Content

Guide your student about the audience and the scope of the documentation

Audience:

- Who is the audience?
- What will they need to know?
- What is their probable attitude about this topic?

Scope

- Keep note focused
- Keep in mind the level of detail required

Feedback and Evaluation

Provide *feedback* and *evaluate* your student on the following criteria:

- ***Appropriateness/scope* of information**
  - Is too much/too little information included?
  - Is the note focused?
- ***Quality* of content**
  - Are the assessment and plan acceptable?
  - Are they clearly outlined and conveyed appropriately?

Feedback and Evaluation

- ***Communication – Clear, Diplomatic, and Timely***
  - Is the note legible, clear, concise and logical?
  - Is the note written in a professional manner without being judgmental or criticizing of others?
  - Was it created in a timely fashion?

PRECEPTING TIP:

Have your student write a draft documentation note first so that you can provide feedback and incorporate edits before making it "official".

Note: If student is unable to appropriately document patient care despite feedback and sufficient practice, please contact the course coordinator.

Overview of the Preceptor Role

Early in the clinical placement

- Discuss with your student your expectations regarding documentation of patient care activities
- Review examples of pharmacist documentation in your practice setting
- Review draft documentation notes with your student to identify strengths and areas for improvement, and allow time for editing

Later in the clinical placement

- Promote more independent documentation of patient care as appropriate

My practice

- **Ambulatory HIV Clinic**
  - Specialized clinic located within the outpatient medicine clinics at the University of Alberta Hospital
  - Patients seen by interdisciplinary team
  - Paper-based medical record
    - health care professionals document in progress notes section of medical records
    - Template (consult letter) developed for more complicated consults

My practice – precepting students

- During orientation, explain:
  - What, when, why and how to document
- Share examples of pharmacist documentation in chart
  - Patient assessment (clinic visits) – adherence, medication history, medication management
  - Consultation note- drug resistance, medication intolerances, cardiovascular risk assessment
  - Patient education
  - Patient Follow-up note
  - Other interventions
- Draft notes – provide feedback and edit prior to including in chart