

Abstract Submission

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Presentation Title: Pharmacists' documentation in patients' hospital medical records: issues and educational implications

Poster

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Abstract

This study aimed to identify potential barriers to pharmacists writing in hospital medical records and explore their training needs. The study was set in a London teaching hospital with 40 clinical pharmacists using a questionnaire and focus group design.

39 pharmacists answered the questionnaire and 32 of those attended focus groups.

Questionnaire analysis revealed that 29 (74%) pharmacists did not write in medical records. Most preferred temporary notes. Most agreed on the importance of documenting input in the medical record. Opinion was divided on how prescribers viewed pharmacists writing in the medical record. Most pharmacists were not concerned that writing in medical records would affect the doctor-pharmacist or patient-doctor relationship. Most agreed that medical record availability and time were not an issue. Most knew when, how and which issues to write in medical records. However, most also wanted to receive more training.

Focus group analysis revealed that pharmacists feared litigation and criticism from doctors when writing in medical records. Written communication was also influenced by pharmacists' perceptions of the significance and appropriateness of clinical issues, their acceptance by doctors and ownership of the medical record. Although other non-medical healthcare practitioners routinely documented in the medical record, pharmacists perceived that these practitioners' areas of clinical expertise were different to those of other healthcare professionals. Such clinical expertise was therefore more difficult to challenge by others. Some pharmacists felt their skills were inter-changeable with those of other practitioners and that their written contributions were therefore more vulnerable to challenge. Pharmacists stated that they did not correct incorrect medication histories they found in the medical record. Oral communication was the preferred method.

This study revealed that pharmacists' attitudes and beliefs discouraged them from writing in the medical record. Medical record writing was often used as self-protection. Pharmacists need to overcome their fear of criticism and litigation to write in medical records. Other non-medical healthcare practitioners regularly write in medical records. Ideally, medical record documentation should be taught to pharmacists at undergraduate level, to prevent the development of disabling attitudes and beliefs. A postgraduate training programme must acknowledge and defuse learnt attitudes and beliefs that impede effective documentation. Involving practitioners such as doctors, occupational therapists and dieticians in training programmes may alleviate pharmacists' fears. A Trust or departmental policy and formal training may offer self-protection, enabling pharmacists to write confidently in medical records. However, regardless of training initiatives, effective pharmacist medical record documentation will not evolve unless traditional structures are changed. While reflective practice is often advocated to be the starting point of this evolution, in relation to writing in patient's health records, we first need to resolve the compelling issues of pharmacists' attitudes and beliefs. Only once there is greater acceptance of this role will reflective practice be useful.