

Sample Pharmacy
GOOD DOCUMENTATION PRACTICES
P-104.2

1.0 Definition and Purpose

To define the requirements of good documentation practices that produce concise, legible and easily retrievable compounding and patient records. These practices will include patient chart or compounding record entries and storage and disposition of patient care records.

2.0 Applicable Documents

2.1 *Signature Log; F-104.a*

3.0 Policy:

- 3.1 All documentation practices must clearly and legibly reflect compounding processes and patient care interventions. These interventions may include prescription compounding records, physician, patient or caregiver communications. All interventions must be recorded at the time of occurrence in order to preserve the integrity and content of the event.
- 3.2 All documentation must be completed in such a manner as to allow others to easily understand and re-trace activities or actions if necessary.
- 3.3 All documentation must be filed and stored in such manner to ensure that they are readily retrievable.

4.0 Definitions

"Original documentation" is defined as documentation that is the result of an original observation, action or intervention.

5.0 Procedure

- 5.1 All original prescription information or documentation will remain on file to meet all state and/or federal requirements.
- 5.2 Only authorized employees of the company may access information in the patient medical record.
- 5.3 Employees are only permitted access to patient care information relative to performing their respective job function.
- 5.4 Only pharmacists and authorized technicians of the department are to have access to the pharmacy computer system. Access will be password restricted, and the pharmacy manager will issue appropriate security levels.
- 5.5 All documentation will be made in ink (blue or black is acceptable). The use of pencils or writing instruments with erasable medium is prohibited.
- 5.6 Documentation should be completed at the time of occurrence, action, observation, interaction or intervention or documented in such a manner to denote the actual time, date and outcome as soon as possible.
- 5.7 All documentation must be legible.
- 5.8 All documentation must be signed and dated at the time of occurrence, observation, interaction or intervention. Signatures may be either distinctive initials or bear the full name of the employee.
- 5.9 If documentation cannot occur at the time of the original occurrence, the intervention will be recorded and followed with the following statement: "Performed on (Month/Day/Year) by (Initials or Signature) but (unable or failed) to document". This entry must be signed and dated.

**Sample Pharmacy
GOOD DOCUMENTATION PRACTICES
P-104.2**

- 5.10 A signature log will be maintained in the pharmacy to cross reference signatures and/or initials to staff members. All employees will sign the *Signature Log (F-104.a)* at the time of hire and if their signature changes (i.e. change in name or credentials).
- 5.11 Only authorized personnel will be allowed to record observations, actions, occurrences or interventions in patient clinical care charts or records.
- 5.12 Times must be recorded to indicate the time of day of the intervention or occurrence. 2400 hour clock or military time is the preferred method.
- 5.13 Consecutive entries that are the same or similar, may be recorded using ditto marks or arrows after the first entry
- 5.14 Erroneous documentation entries **MUST NEVER** be covered with "white-out", paper correction fluid, erased or rendered illegible.
- 5.15 When a correction is required, the erroneous entry will be crossed out with a single line. This single line will be dated and initialed.
- 5.16 If a patient care record, prescription, compounding, environmental monitoring or other document has to be corrected and replaced by a new one, the original **MUST NOT** be discarded.
 - 5.16.1 The original will be crossed out with a single line and the word "VOID" will be written on it and attached to the new document.
 - 5.16.2 The date and initials of the person voiding the document will be written under the word "VOID".
 - 5.16.3 All documents to be voided must be approved by either the pharmacy manager or designee.
- 5.17 If there should ever be any doubt as to the correct way to document an action, occurrence, or intervention, the individual will contact the pharmacy manager at the earliest opportunity for clarification.
- 5.18 All defined document spaces that are not used must have a "N/A" or a single line placed on or through that space, block or section, with a N/A in close proximity to the line.

6.0 Confidentiality

- 6.1 All information concerning care (compounding records, prescription information, patient history, and communications with the patient or members of the healthcare team) must be treated confidentially.
- 6.2 Access to records is permitted only to authorized individuals who require access to properly perform job duties.

7.0 Falsification of Documentation

- 7.1 Falsification of any documentation will not be tolerated. Any confirmed incidents of document falsification will be fully investigated and may require the pharmacy manager to prepare a written statement assessing the potential impact that the falsification incident had on patient care and/or product integrity. Falsification of documentation may result in disciplinary action, which may include termination.
- 7.2 An inspection, action, interaction, intervention or conversation may not be documented to have occurred when, in fact, it did not.
- 7.3 The documentation of a task, action, interaction or intervention must not be done before it is actually performed.

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P-104.2**

- 7.4 The recorded date of a task, action, interaction or intervention on any form, paper, or patient record must be the actual date the entry occurred and recorded. Backdating of entries is not permitted.
- 7.5 Rewriting of documents and discarding the original is not permitted. Rewriting of a document can only occur after receiving approval from the Pharmacy Manager or designee.
- 7.6 An employee must not document that another employee or individual performed a check, task, action, interaction or intervention, unless it is clearly documented in a third-person narrative format.
- 7.7 An employee must not sign a document for a check, task, action, interaction or intervention that was performed by another employee.

8.0 Storage:

- 8.1 All compounding documents, patient care records and other official pharmacy documents must be retained according to local, state or federal laws.
- 8.2 Archived documents must be readily retrievable and stored in an area that provides adequate protection from fire, theft, environmental deterioration, damage, or unauthorized access.
- 8.3 All documents, papers or patient care records will be stored in cartons indicating a "Discard Date" based on current local, state or federal law.

9.0 Disposition:

- 9.1 All papers, documents or patient care records will be destroyed according to the discard date and by a means to insure complete destruction.
- 9.2 If an outside vendor performs the destruction of papers, documents or patient care records, proof of confidentiality and destruction should be obtained and kept on file.