

## **Subject: Pharmacist Documentation – Initial Assessment and Plan of Care**

### **Introduction**

The practice standards of NHIA represent a consensus of professional judgment, expert opinion, and documented evidence. They provide guidance and direction to NHIA members and other audiences who affect the home infusion industry, and the patients served. Their use may help to comply with federal and state laws and regulations, meet accreditation requirements, and improve patient care. They are written to establish reasonable goals, to be progressive and challenging, yet attainable as best practices in applicable home or alternate site settings. They should not be viewed as NHIA requirements. The use of NHIA's practice standards by members and other practitioners should be assessed and adapted based on independent judgment.

### **Purpose**

Comprehensive and accurate documentation is fundamental to ensuring continuity of care and optimizing patient outcomes. Pharmacists, as integral members of the healthcare team, are responsible for maintaining detailed patient records that encompass medical history, prescribed medications, allergies, clinical findings, and treatment plans. These records facilitate personalized care, serve as a critical reference for multidisciplinary teams, and support medication safety by enabling the monitoring of dosages, adverse effects, therapeutic adjustments, and adherence.

As pharmacists assume increasingly prominent roles in diverse care settings and interdisciplinary models of care, the necessity for standardized documentation practices becomes paramount. Consistent, well-structured documentation enhances collaboration among healthcare professionals by ensuring that all members of the care team have access to accurate, up-to-date information regarding the patient's condition and treatment course. Precise and comprehensive documentation is essential for regulatory compliance, legal accountability, and the maintenance of patient confidentiality, while also serving as a reliable record for audits.

Despite the expanding scope of pharmacy practice, there remains a shortage of literature or evidence addressing best practices for pharmacist documentation. This gap is particularly evident in the home infusion setting, where standardized documentation practices have not been well established. Given the increasing reliance on electronic health records, optimizing their functionality and prioritizing the clarity and quality of pharmacist documentation to support seamless communication and patient care transitions is imperative.

This practice standard has been developed to address these challenges by establishing clear guidelines for home infusion pharmacist documentation. It aims to promote consistency, accuracy, and effectiveness in clinical documentation practices, thereby enhancing patient safety, regulatory compliance, and the overall quality of pharmaceutical care.

Organizations should have specific standard operating procedures (SOP) for determining the individual documentation style and format using applicable laws, regulations, and accreditation standards. SOPs should be individualized based on clinical judgment, the patients served, and the medications administered.

## **Practice Standard Development Procedure**

A need for standardized guidance was identified in an area of practice where clear direction is essential to promoting quality and consistency. The topic of best practices for home infusion pharmacist documentation emerged as a priority due to increasing demand among practitioners for authoritative guidance. Sufficient professional experience existed to support the development of a formal standard, and the topic was highly relevant to a significant portion of NHIA's membership.

To develop this practice standard, the NHIA Quality and Standards Committee—comprising experienced home infusion professionals—conducted a comprehensive review of available evidence. Committee members, including clinical and research experts, collaborated to examine industry trends and data sources such as membership insights, community feedback, best practices, industry research, published literature, and existing practice guidelines.

Based on this review, an initial draft of the practice standard was developed and refined through committee consensus. Following internal revisions, a formal draft was presented for public comment. At the conclusion of the comment period, the committee reviewed the feedback, considered proposed revisions, and made final recommendations before approving the standard.

## **Target Audience**

The target audience includes clinicians, regulatory agencies, reimbursement professionals, and industry stakeholders.

## **Practice Standard for Pharmacist Documentation – Initial Assessment and Plan of Care**

1. Plan of care development and review
  - a. Determine goals for infusion medication treatment
  - b. Review patient medical records for barriers to care and education
    - i. Pregnancy and lactation status
    - ii. Caregiver support, home environment considerations (e.g. medication storage)
    - iii. Language barriers, cultural preferences
  - c. Review allergy history and first dose information
    - i. Need for ancillary prescriptions (e.g. anaphylaxis kit)
  - d. Review and verification of drug orders for indication/diagnosis
    - i. Method of administration
    - ii. Compounding considerations
    - iii. Baseline and ongoing monitoring/lab results and orders
    - iv. Confirm prescriber following the patient for infusion orders
2. Assess vascular access device information and care
3. Reconcile medication profile (e.g. drug, dose, indication, interactions, duplication)
4. Recommendations and interventions
5. Document date/time/pharmacist who performed the assessment

**Comments/Contact:** NHIA welcomes feedback and suggestions for content to incorporate into future revisions and editions. Contact: [standards@nhia.org](mailto:standards@nhia.org)

*DISCLAIMER: The National Home Infusion Association (NHIA) produces educational resources to aid good clinical practice that reflects the input of its members and experienced clinicians in the field. The information offered in NHIA resources is intended as a guide for information purposes only and does not replace or remove clinical judgment or the professional care and duty necessary for each specific situation. While great effort has been made to assure all information is complete and accurate as of the time this resource was issued, given the continuously evolving health care environment and the particular circumstances of individual cases, no assurance can be given that the information is entirely complete or accurate in every conceivable respect (and, as such, NHIA and its board members, committee/work group members, officers and employees disclaim all liability for the accuracy or completeness of this resource, and disclaim all warranties, express or implied to its incorrect use).*

PROPOSED