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INTEGRATING ON-SITE PHARMACISTS INTO RESIDENTIAL AGED CARE FACILITIES

ON-SITE PHARMACIST'S **CLINICAL NOTES**

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The University of Canberra acknowledges the Ngunnawal people, traditional custodians of the lands where Bruce Campus is situated. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of Canberra and the region. We also acknowledge all other First Nations Peoples on whose lands we gather.

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www.canberra.edu.au/research/institutes/health-research-institute/pharmacists-in-residential-aged-care-facilities

CONTENTS

USING THE ON-SITE PHARMACIST'S **CLINICAL NOTES**

This file contains forms and templates to assist you to manage your workflow and appropriate record-keeping while performing your role as an on-site pharmacist in Residential Aged Care Facilities (RACFs). Use it in conjunction with the On-site Pharmacist's Toolkit:

CLINICAL AUDIT FORM

This form can be used for a clinical audit of charts to identify residents with certain medications of concern in a systematic way in order to prioritise medication reviews.

See **page 3**

MEDICATION REVIEW FORM

When you assess a resident's medicines, such as when they enter the facility or return from hospital, please use this to document the assessment recommendations and outcomes. After you have made recommendations to the GP or prescriber, follow up and check whether your recommendations have been accepted, then 'close off' the review. If the GP or prescriber has not accepted your recommendations, follow up with them within 1 to 3 months.

See **page 5**

GP AND PRESCRIBER COMMUNICATION NOTES

Use this form to communicate with a GP or prescriber, noting that you might need to contact some GPs or prescribers that do not regularly attend the facility via fax, phone or in writing. We suggest you contact the GP or prescriber and ask how they would prefer you communicate with them.

See **page 7**

ON-SITE PHARMACIST'S WEEKLY ACTIVITIES SUMMARY

This form is for keeping track of day-to-day activities and follow up notes — feel free to use these forms as a recording tool.

See **page 9**

VACCINATION CONSENT FORM

Use this form to record vaccinations and obtain consent as outlined by the Pharmaceutical Society of Australia and Pharmacy Guild of Australia guidelines to meet the legal requirement of pharmacist-led vaccination. Please follow facility guidelines for uploading the records into Australian Immunisation Register and storing vaccination consent forms.

See **page 11**

KEEP ALL RECORDS OF RESIDENT INFORMATION OUT OF REACH TO ENSURE CONFIDENTIALITY, SUCH AS AT THE NURSE STATION FOR EASY DAY-TO-DAY ACCESS.

FORM 1:

CLINICAL AUDIT

FACILITY

ON-SITE PHARMACIST: DATE:

CLINICAL AUDIT TOPIC:*

NUMBER OF RESIDENTS INCLUDED IN AUDIT: NUMBER OF RESIDENTS IDENTIFIED FOR FOLLOW UP:

RESIDENT NAME	ACTION PLAN	FOLLOW UP TIMELINE	OUTCOME

FORM 1:

CLINICAL AUDIT (CONTINUED)

RESIDENT NAME	ACTION PLAN	FOLLOW UP TIMELINE	OUTCOME

* SUGGESTED AUDIT TOPICS: PIMS, HIGH DOSE PPIS, ANTIPSYCHOTICS, BENZODIAZEPINES, NSAIDS, TCAS, REGULAR FALLS, LONG TERM ANTIBIOTICS

FORM 2:

MEDICATION REVIEW

DATE OF REVIEW:

RESIDENT'S DETAILS

RESIDENT'S NAME:				DOB:	
DATE OF ADMISSION:		ROOM:		GENDER:	
HEIGHT:		WEIGHT:		BMI:	CrCl:
ALLERGIES:					
DATE DISCUSSED WITH GP:					

POTENTIAL DRP	ASSESSMENT	ON-SITE PHARMACIST RECOMMENDATIONS	GP/PRESCRIBER RESPONSE
			☐ AGREED-IMPLEMENT ☐ OTHER-SPECIFY
			☐ AGREED-IMPLEMENT ☐ OTHER-SPECIFY
			☐ AGREED-IMPLEMENT ☐ OTHER-SPECIFY

FORM 2:

MEDICATION REVIEW (CONTINUED)

POTENTIAL DRP	ASSESSMENT	ON-SITE PHARMACIST RECOMMENDATIONS	GP/PRESCRIBER RESPONSE
			☐ AGREED-IMPLEMENT ☐ OTHER-SPECIFY
			☐ AGREED-IMPLEMENT ☐ OTHER-SPECIFY

ADDITIONAL NOTES:

FORM 3:

GP AND PRESCRIBER COMMUNICATION NOTES

ATTENTION:

FROM (ON-SITE PHARMACIST'S DETAILS)

PHARMACIST'S NAME:

FACILITY NAME:

EMAIL:

MOBILE:

PHONE:

DATE:

TIME:

RESIDENT'S DETAILS

RESIDENT'S NAME:

GENDER:

DOB:

ROOM:

NOTE: PLEASE RETURN THE FILLED FORM TO

EMAIL:

FAX:

PHONE:

ISSUE(S):

PROPOSED RECOMMENDATION (S)

FORM 3:

GP AND PRESCRIBER COMMUNICATION NOTES (CONTINUED)

GP/PRESCRIBER RESPONSE

FORM 4:

ON-SITE PHARMACIST'S WEEKLY ACTIVITIES SUMMARY

NAME OF FACILITY:		WEEK STARTING:	
ACTIVITY:		FOLLOW UP:	

CLINICAL AUDITS

MEDICATION REVIEWS

VACCINATIONS

MEDICATION ROUND OPTIMISATION

PHARMACISTS IN RESIDENTIAL AGED CARE FACILITIES (PiRACF)

FORM 4:

ON-SITE PHARMACIST'S WEEKLY ACTIVITIES SUMMARY (CONTINUED)

CONTRIBUTION TO POLICIES AND PROCEDURES
EDUCATION
ADMIN AND OTHER

FORM 5:

VACCINATION CONSENT

Pharmaceutical Society of Australia

Pre-vaccination screening and consent tool for pharmacist immunisation services

CONSUMER DETAILS		Date:
Name of person to be vaccinated:		
Date of birth:	Age today:	Gender: ☐ Male ☐ Female Other:
Identifies as Aboriginal and/or Torres Strait Islander (TSI): ☐ No ☐ Yes, Aboriginal ☐ Yes, TSI ☐ Yes, both Aboriginal and TSI		
Address:		Phone:
Allergies:		Medicare No:
Name of person completing this form (if different from above):		
Relationship to person to be vaccinated (if completed by someone else):		
NOMINATED PRIMARY HEALTH CARE PROVIDER (if known)		
Name:		
Address:		Phone:
Email:		
VACCINATION(S)		
I or the person to be vaccinated (if applicable), expects to be vaccinated with the following vaccine(s) today *(list all)*:		

Please indicate if you or the person to be vaccinated *(if applicable)*:	Yes	No
Is unwell today (e.g fever). If yes, please specify:	☐	☐
Has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy) If yes, please specify:	☐	☐
Has had anaphylaxis or any severe reaction following any vaccine. If yes, please specify:	☐	☐
Has ever fainted after having an injection:	☐	☐
Has a severe allergy to anything. If yes, please specify:	☐	☐
Has had a vaccine in the past month. If yes, please specify:	☐	☐
Has had an injection of immunoglobulin, or received any blood products or a whole-blood transfusion within the past year	☐	☐
Is pregnant	☐	☐

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PHARMACISTS IN RESIDENTIAL AGED CARE FACILITIES (PiRACF)

FORM 5:
VACCINATION CONSENT (CONTINUED)

Please indicate if you or the person to be vaccinated *(if applicable)*:	Yes	No
Is planning a pregnancy or anticipating parenthood	☐	☐
Is a parent, grandparent or carer of a newborn	☐	☐
Has a history of Guillain-Barré syndrome (a rare disorder of the nervous system)	☐	☐
Has a chronic illness (e.g diabetes, heart or lung disease). If yes, please specify:	☐	☐
Has a severe illness. If yes, please specify:	☐	☐
Has a bleeding disorder or is taking medications that prevent blood clots	☐	☐
Does not have a functioning spleen	☐	☐
Lives with someone who has a disease that lowers the immunity (e.g leukaemia, cancer, HIV/AIDS) or takes treatment that lowers immunity (e.g. oral steroids, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)	☐	☐
Is planning overseas travel	☐	☐
Has occupational or lifestyle factor(s) where vaccination may be needed. If yes, please specify:	☐	☐

CONSENT/AUTHORITY

I,..... (Print full name) declare that:

- I have been provided with, read, and understood the information given about immunisation including the risks and benefits, and I have been given the opportunity to ask questions.
- The information completed by me on this form is true and correct to the best of my knowledge.
- I am legally authorised to provide consent on behalf of the person being vaccinated.
- I request to have each vaccine or for the person to be vaccinated to have each vaccine (if applicable) and understand that it is completely voluntary.
- I consent to the immuniser collecting my personal information and that of the person to be vaccinated (if applicable) for the purpose of creating and maintaining a vaccination statement and providing a copy of the vaccination statement, including any such personal information contained in the statement, to the Australian Immunisation Register (AIR) and the nominated primary health care provider.
- I am aware that the immuniser will collect, hold and use my personal information and that of the person to be vaccinated (if applicable) in accordance with relevant privacy laws and its privacy policy, and that I can contact the immuniser at any time for a copy of its privacy policy. I may also contact the immuniser with any concerns I may have about the use of or access to my personal information that it holds.
- I agree to remain within the vicinity of the vaccination service for 15 minutes or for the person to be vaccinated to remain within the vicinity of the vaccination service for 15 minutes (if applicable).
- I have been informed of, and agree to pay, the fees or charges associated with this service.
- I consent to emergency care if required and give permission for the immuniser or pharmacy staff to access medical care on my behalf or on behalf of the person to be vaccinated (if applicable). I understand that I am responsible for any costs associated with any emergency care.

Signature of person consenting: .....

Date: .....

Name of person consenting: .....

.....

Relationship to person to be vaccinated (if applicable):
Parent ☐ Legal guardian ☐

Authorised immuniser:
Physical location (e.g. location of pharmacy or vaccination premises where vaccine is administered):
Pharmacy Stamp (if applicable):

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NOTES

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