Appendix Item 4: Form for Documenting Medication Discrepancies

MRN: _____ Age: _____ Admission Date/Time: _____ Comparison Date/Time: _____

Admit Service: _____ Admit Location/Unit: _____ Admitting Provider: _____ Discharging Provider (if different): _____

☐ Control Patient ☐ No Home Meds

☐ Intervention Patient ☐ Number of GS Meds: ____

Patient Understanding of Medications:
☐ High ☐Medium ☐Low

Intervention Level (if Intense/Standard bundle instituted)
☐ Intense ☐ Standard

Med Rec Provider(s)
☐Dedicated History-taker ☐Pharmacist reconciler/counselor ☐ Other:

Describe intervention received by patient. Check all that apply:

☐ BPMH in ED by dedicated MARQUIS-trained clinician Type of clinician_____
☐ BPMH outside ED by dedicated MARQUIS-trained clinician Type of clinician_____
☐ D/C med rec by dedicated MARQUIS-trained clinician Type of clinician_____
☐ Patient counseling by dedicated MARQUIS-trained clinician Type of clinician_____
☐ Other intensive intervention reserved for high-risk patients Please describe_____
☐ Other intervention Please describe_____

GS Medication	Confidence	PAML Comparison	Admit Comparison	Discharge Comparison	Pharmacist Comments
Name **DRF** **Drug Class** ☐ PRN ☐ OTC **Comments** **For Additional Med** **Name**	**High** **Medium** **Low**	**Comparison/Difference (select all that apply)** Same Omission Dose Route Frequency Substitution Additional med Formulation Duplication Duration Other **Details** **Questions for provider** **Provider Response**	**Comparison/Difference (select all that apply)** Same Omission Dose Route Frequency Substitution Additional med Formulation Duplication Duration Other **Details** **Reason** Reconciliation Error History Error Intentional Documented **Questions for provider** **Provider Response**	**Comparison/Difference (select all that apply)** Same Omission Dose Route Frequency Substitution Additional med Formulation Duplication Duration Other **Details** **Reason** Reconciliation Error History Error Patient Expired Intentional Documented **Questions for provider** **Provider Response**	**Need to notify team** ☐ Before admission orders ☐ After admission orders but before dc orders ☐ After discharge orders ☐ Does not need to be notified **Recommended action:** _____ **Action taken by team,** if any: _____ **Comments:** _____ **In your opinion, is this discrepancy clinically relevant?** ☐ Yes ☐ No

All Sources Used: ☐Patient ☐Patient's Family/Caregiver ☐ Pill Bottles ☐ Pt's Own Med List ☐Outpatient Provider(s) ☐Outpatient EMR ☐Past DC Summary ☐Transfer Records ☐ Pharmacy(s) ☐Pharmacy Database ☐Other - Details:

General Comments:

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Confidence: (How confident are you that the "Gold Standard" list is correct):
High: Pt (or person who administers pts meds) and at least 2 corroborating sources agree
Med: Pt (or person who administers pts meds) and at least/perhaps 1 corroborating source
Low: Anything not High or Med

Start w/ easily accessible sources. If patients use a list or pill bottles and seem completely reliable (and the data are not that dissimilar from the other sources, and/or differences can be explained), then other sources are not needed. If patients are not sure or are relying on memory only, or cannot clearly "clean up" the other sources of medication information, then it's time to rely on additional sources: community pharmacies, outpatient physician offices, having the family bring in the pill

Patient understanding of medications:
High: understands indications, dose, strength, and frequency of most medications
Med: Inconsistent or incomplete understanding of indications, dose, strength, and frequency of medications; not high or low
Low: at most, can identify medications by name or indication but not both, has little understanding of dose (e.g., "I take the blue blood pressure pill once a day")

Documenting Adherence in Gold Standard list:

- If completely non-adherent (on purpose or b/c didn't know to take medication), then leave off list and note it in general comments
- If sporadically non-adherent, give general assessment of adherence in comments
- If systematically non-adherent (e.g., always takes medicine once a day instead of 3 times a day), then note actual frequency taken in dose/route/freq and make note of difference from prescribed frequency in comments
- If patient denies knowledge of a medication that is on another list (i.e., doesn't know why not taking it), keep track of these in comments

PAML Comparison:

1. (If have an electronic place to document PAML separate from admission note): What if the PAML has not been documented: return again > 24 hours after admission. If it still has not been documented, then use the list from the admission note if available. If still not available, then treat PAML as blank.
2. For transfers from within the hospital or from another acute care hospital, the PAML is what the patient was taking before the initial hospitalization. For admissions from a nursing home, the PAML is what the patient was taking at the nursing home (which may be in the transfer orders).
3. If meds are completely different from GS gold standard med hx, then contact provider and find out what sources they are using and document in comments in main form. This is to make sure they didn't have a better source of info than you.
4. If the frequency is missing, how is that coded: as a change in dose/route/frequency, note "missing" in the details section.
5. If the PAML includes a medication that you did not include in the gold standard hx because the patient was completely non-adherent with it (or didn't know s/he was supposed to take it), then mark it as an additional PAML med, error in PAML, and explain in the comments.
6. If the only reference to preadmission meds is in the admission note history of present illness (e.g., "patient responded well to risperdal," without dates), does that count as a PAML med? No.

Admission Comparison

1. What are considered admission orders: all orders written from the time of admission until 8 am the following morning or until 8 hours after the time of admission, whichever comes first
2. Should admission medications that are later discontinued still be counted: yes.
3. For PRN meds, if the frequency is a range (e.g., q4-6h) and the medication is prescribed within that range (e.g., q6h), is that a change in frequency: No.
4. To save time, you can leave out the following **additional** admission orders:
    a. Those that are clearly related to the chief complaint (e.g., levofloxacin for pneumonia when that is the admitting diagnosis)
    b. Those that are clearly documented (e.g., lovenox for DVT prophylaxis)
    c. Those that are standard prn orders at your hospital (e.g., Tylenol prn if that is in the standard order set at your hospital)

SIMON SAYS:

- Sedatives
- Inhalers (includes nebs)
- Muscle relaxants
- OTCs – may leave off for this study if PRN unless pain medications (meds (i.e. "What do you take for pain when you have pain?")
- Nitroglycerin
- Stomach acid meds
- Aspirin
- eYe drops (glaucoma) – may leave off artificial tear eye drops for this study
- Stool (colace/senna etc) – may leave off if PRN

Can exclude PRNs (things that would not need to go to adjudication):
Except – we ARE including PRN: inhalers, nitroglycerin, opiates, muscle relaxants, sedatives, analgesics (include Tylenol and NSAIDs)