Pharmacist Training FAQ's

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PATIENT SELECTION AND IMPLEMENTATION

Q: Could a Friday patient be considered a "weekend patient"? Is a patient admitted on Friday at 2:00pm considered a "weekend patient"?
A: As a general guideline, patients admitted **after 5:00pm** on a Friday should be considered a "weekend patient."

Q: How exclusive should sites be when selecting services/units to include in the data collection?
It is okay if there are patients not getting any interventions at the beginning of the intervention period?
A: You should collect data from all units/services that have potential to get the intervention during the time-course of the study. That way, you will see the effects of broader implementation over time, even if at the beginning a particular service is not getting the intervention at all.

Q: Should we implement the intervention by service, team, or by unit?
A: For the intervention, you will choose where to intervene based on how it makes the most sense clinically to implement your intervention. For example, if pharmacists will be the major players in the intervention, and they are assigned by unit, then implementing by unit may make the most sense, but if they are assigned by medical team, then you might implement by team.

Q: Should we exclude observation patients?
A: If the medication reconciliation process is very different from a traditional admission, you may exclude these patients. If they are excluded they should be excluded for the life of the study so we are consistent throughout the study.

Q: What determines whether a patient received the intense vs. standard bundle?
A: If you have determined a policy to identify high-risk patients and institute a more intensive version of the intervention in those patients, and if the patient in question would fit into that category, then document it as intense bundle.

Q: What is the definition of a control patient?
A: A Control Patient is a patient during baseline data collection phase OR a patient who has been assigned to a floor or service line (area) that is NOT applying any elements of the MARQUIS2 intervention components.

Q: What is the definition of an "intervention patient"?
A: An intervention patient is someone assigned to a service/unit implementing at least one component of the MARQUIS2 toolkit after the intervention period has started.

Q: What are the definitions of the "intervention providers"?

A: An Intervention provider is the individual who has performed at least one component of the med rec bundle (e.g., the BPMH, Discharge Medication Counseling, etc.).
- Pharmacist = a pharmacist trained in taking an in-depth BPMH, identifying and correcting medication discrepancies, and/or providing in-depth discharge medication counseling
-Other trained staff = other staff (nurse, educator, pharmacy tech) who have been trained in taking a BPMH or providing Discharge Medication Counseling

PHARMACY

Q: If the gold standard med history finds a patient on a combination drug (ie diovan hct) and the patient is ordered for diovan only (no hctz) on admission and discharge - how do we mark that on the comparison form?
A: We would call this an "Other" discrepancy and note exactly what the difference is in the details section. You can also mark "dose" or any other field that applies to the particular comparison.

Q: Do I need to document an additional medication (i.e., not part of the gold standard) if it is for the primary diagnosis and it has been added intentionally?
A: No. You do not need to document an additional medication IF the medication is clearly for the primary diagnosis AND it has been intentionally added.

Q: Is there a time window after admission when a medication is considered part of the admission orders?
A: Yes. Follow the "Rule of 8's": Medication(s) should only be considered part of the admission orders up to 8 hours after admission OR 8:00am the morning after admission, whichever comes FIRST.

Q: Can I call a pt discharged and do the comparison if the pt has been discharged to an on-site rehab area?
   "We have an onsite 'rehab' facility. When a patient is discharged to this onsite rehab area, should I classify them as discharged and go ahead with the comparisons? The MD following the patient writes DC summary, DC med list is sent as if normal discharge, etc., and patient discharged from computer system (however, shows up as admission on same date as discharge – to new 'facility'). This is the SAME process if patient transferred hospital to hospital (Ortho to Main or vice versa). Patient gets a new chart too. When I had the patient that transferred hospital to hospital, I had to hunt down both charts.
   For transfers from our Ortho hospital to our Main hospital, which are both onsite but separate locations (connected by skywalk), I have been counting them as still admitted because it's the same level of care (hospital to hospital), whereas the rehab facility is not quite the same.
A: You would classify the patient discharged to the onsite rehab area as discharged from the hospital (as long as there is no chance they could be randomized again as an admission on general medicine or surgery). The logic behind this is that you would classify the patient as discharged from your hospital if they went to another rehab facility.

Q: Can you explain "Reconciliation Error" versus "History Error"?
A: A History error is when the difference in your comparison is generated from the PAML not being correct. For example, if the PAML listed lasix 20mg bid, but the pt really takes 40mg bid, and the pt is ordered for lasix 20mg bid, then the reason the admission order is likely wrong is b/c the PAML is wrong and thus a History error. The team did not have a correct PAML so '*did not know*' what pt was really taking, leading to differences in orders.
   A Failure to Reconcile is when the PAML is correct ('*they knew*' at one point what the pt was actually taking) but did not order patient for what 'they knew'. An example would be: Team states to continue patient's home asa 325mg daily, but orders for 81 mg daily. If there is no documented reason for change, one could consider this a "failure to reconcile". Sometimes this happens if there is a default dose in the computer (e.g., 81mg daily is the "default" dose). The MD when asked would say they had meant to order what the pt was on at home. (Basically '*knew*' what they were on, wanted to order same thing, but didn't.)
   This kind of error is ***more likely to happen at discharge*** than at admission (because it's several days later and discharge orders might be written by a different person than who took the history or wrote the admission orders). For example, a patient is taking ASA 325 mg at home, the team records it in the

history, holds it on admission for a clinical reason, but forgets to restart it at discharge even though they should have restarted it. If the PAML is correct but the orders are wrong, sometimes it may be unclear whether it's a failure to reconcile or whether the change was intentional (for clinical reasons that are not documented in the chart). That's when it might be necessary to contact the team and ask.

Q: Can you give some examples of "intentional documented" versus "intentional not documented" discrepancies?
"How would you best define an 'intentional documented' discrepancy? I believe on a few occasions I've listed intentional 'documented' when I was thinking the handwritten order (i.e. new prescription) was enough documentation, but didn't know if I specifically had to find it in the H& P or discharge summary.
For example, a physician started a nicotine patch on a patient with a smoking history. There was no documentation that that was why it was started, but I assumed it was 'intentional documented' since the pt had a smoking history. How would you classify this one?
A: This would be intentional, not documented. If there is no written wording in admission or progress notes or discharge summary that mentions a nicotine patch, then it is not documented.

"If an admission order set is used, then the physician just checks a box for certain items (such as aspirin, protonix, SL NTG). They are not necessarily documented in the H& P, but since the physician checked the box I assume it is 'intentional documented'. Since there really isn't any 'documentation' why these were started other than the checked boxes, is my 'intentional documented' incorrect?"
A: This would be an example of "intentional not documented". In general if there is no other source other than the order itself mentioning whether to start a medication, then it is "not documented".

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 in a note (e.g., enoxaparin for DVT prophylaxis); and
   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).
   If Protonix, asa, or SL NTG falls into that category, you would not need to enter them. However, if they were discrepancies, say Protonix is a formulary interchange, it would be "intentional not documented".

Q: What is considered a "clinically relevant" discrepancy where I need to contact the team to determine if it was intentional or not if it is not documented in the medical record (i.e., intentional and not documented vs. a reconciliation error)?
A.   While this is a matter for clinical judgment, consider the following partial list of examples:
   • Omission or $\geq$ 50% decrease in daily dose of a scheduled medication indicated for a documented chronic clinical condition
   • Addition or $\geq$ 50% increase in the daily dose of a medication with common side effects (>5%) or alteration of a major physiological parameter (such as blood pressure, heart rate, glucose)
   • Discrepancy in a medication with a narrow therapeutic window (e.g., anticoagulants, insulin, oral hypoglycemics, antiepileptics, opioids, IV vancomycin)
   • Discrepancy in route, formulation, or frequency that will result in a major alteration in pharmacokinetic effects (e.g., metoprolol tartrate 100 mg PO daily instead of metoprolol succinate)

Q: Can you give some guidance on using the pharmacist comment box and when to check the "need to notify team after discharge orders are written" box?
"There are a few occasions where there were discrepancies but I did not notify prescriber. One example was valsartan ordered as 160/20. The correct drug/formulation is valsartan/hctz 160/25. I have used clinical judgment in these cases to not call the provider, since in all cases so far the patient has already been discharged for usually at least several days by the time I review it. The pharmacist

comments box is mainly to help document when I need to call a provider BEFORE the discharge, but want to make sure I'm using it correctly."

A: This is a good question. I think the valsartan/hctz 160/20 option is unusual since to my knowledge it doesn't come in that formulation, and HCTZ wouldn't be able to be prescribed at 20mg. There could be a problem in getting that prescription filled, which in a worst-case scenario may delay therapy or there could be a change in therapy if the pharmacy filling the prescription called to get clarification on the order and the order was changed. It would be worth contacting the patient or the pharmacy to see what was filled and make sure this error didn't result in the pt not getting the medication at all (easier than asking MD days later).

For the pharmacist comments box, you would still mark the box of "need to notify team after discharge orders are written", even if pt has already been discharged.

Q: Should I document sources used for all medications and/or each medication?

"For sources used, I have been documenting the sources used individually for *each* medication. In other words, if they have some of their med bottles I circle med bottle for only those medications. From the data entry, it looks like you only need ANY source used for any medication. So for clarification, are sources used a general statement rather than specific to any individual drug?"

A: In REDCap, the place we have for sources of medication is on the first page and is for *all* medications rather than each medication. If you have more specific source information for each medication, in the "General Comments section" for that medication, you could state for example, "I did have the pill bottles for xyz, and not abc." Then at the top, list all the sources used for the medication list as a whole.

Q: What if I am required to review admission orders before discharge orders are written?

A: At one of the MARQUIS sites the pharmacists are already reviewing PAML and admit orders early in the patient's admission process. If they see a discrepancy, they have to intervene (i.e., track down the admitting provider) to correct the issue. You would then document when you intervened, what action was taken, and provide details in comments.

Q: Can you give an "Error in frequency" example?

"If a patient takes something PO BID PRN but it is listed in the PAML as PO BID (but not PRN) is this an example of an error in frequency?"

A: Yes, this would be considered an error in frequency.

Q: Is it considered documented or undocumented when a gold standard medication is intentionally changed and the reason is not stated, but the pharmacist, using clinical judgment, knows why it was altered?

A: The medication is considered undocumented if the reason is not explicitly stated (but it would be considered intentional.)

Q: Residents take initial medication histories before putting in admission orders. Later, these histories may be corrected by an "intervention pharmacist." When comparing the study pharmacist "gold standard" medication history to the PAML, which list should be used? The resident's or the intervention pharmacist's?

A: The principle here is to know the cause of discrepancies in admission orders. Admission orders are defined as those written within 8 hours of admission or by 8am, whichever comes first. So, the PAML to be used for evaluation is the most recent version done prior to admission orders. This could be either the resident's version or the inpatient pharmacist version depending on when the pharmacist arrives. Then if the admission orders have discrepancies, you'll know if it's due to errors in the history.

Q: Can patients be seen by the study pharmacist before the intervention pharmacist? Can the intervention pharmacist ask for information obtained by the study pharmacist?

A: The study pharmacist (SP) should see patients and take a gold standard med history after the intervention pharmacist (IP) so as to not interfere with the process. If the SP takes the GS history first, do NOT share what you learned with the IP. If the IP asks you for help, observe the following rules:

-If you have already evaluated the PAML and the admission orders (which is likely), your contact with the IP may still influence the discharge orders (by correcting the PAML before the discharge

orders are written). If the discharge orders are about to be written (i.e., the patient's discharge is imminent) and access to the pharmacy list or other information is now impossible (e.g., the pharmacy is closed), then tell the IP to do the best they can with what they have or can get on their own. After the discharge orders are written and you evaluate them, you can give the IP your information (see below about correcting errors).
-If the discharge is not imminent, it is safe to assume that if you didn't provide a pharmacy list to the IP now, they would be able to get it on their own prior to discharge. In this case, go ahead and provide the list to the IP.
-If you obtained a pharmacy list or other information by direct contact (i.e., there is no paper trail), then the IP is going to have to repeat this process on their own (because they may do it differently than you).
-Needless to say, a pharmacist can't be the SP and IP on the same patient!

Q: What if the study pharmacist sees the patient after the intervention pharmacist? Am I allowed to get the information obtained by the intervention pharmacist?
A: Assuming that you have obtained all necessary information under all circumstances to take a gold standard med history and there is a paper trail (i.e. prescription history from a community pharmacy) obtained by the IP, you can ask for it to avoid bothering the pharmacy a second time. However, if you need additional information (i.e. about a specific med), you may need to contact the pharmacy directly. If the IP obtained the info by direct contact and there is no paper trail, you will need to contact the pharmacy on your own.

Q: What if I encounter a medication discrepancy with potential for patient harm that needs to be corrected? When should I contact the team? Which member of the team should I contact?
A: It depends on the potential severity and urgency of the discrepancy. If the potential severity and urgency are high (e.g., omission of dilantin orders), regardless of whether the IP has yet to be involved in the case, you should contact the team immediately to have the orders corrected. If the potential severity and urgency are low (e.g., omission of omeprazole orders), you should wait 24 hours to see if the orders would be corrected by normal processes (e.g., the IP taking a better history and contacting the team). If, after 24 hours, the issue has not been corrected, then contact the team. If it's not clear whether the IP has been involved yet, you should not contact the IP to ask if they have been involved – this would tell the IP they are being watched for this particular patient and may change their behavior. Just wait the 24 hours if you can based on the potential severity/urgency of the error.
        When alerting the team about an error, you can contact the IP if there is one. This way, the team only has to interact with one pharmacist and acknowledges the IP as their pharmacist. If there is no IP, then contact the "responding clinician" (usually an intern at a teaching hospital).
        If the patient has been discharged, then contact the attending physician. If you cannot reach them, then contact the physician leader of your QI team (or as determined by your QI team's policies).

Q: How do I complete the discharge comparison if my patient expires?
A: Under the discharge comparison, choose "Other," and enter "patient expired" under Reason.

Q: How do I input comparisons for a patient who comes in with no home medications?
A: If there are additional medication discrepancies, then just enter those. If there are no discrepancies at all, then enter the patient information, zero for the number of GS meds, and do not enter any medication information.

Q: What categories of medications can be excluded from the gold standard history?
A:
        a.) PRNs except: inhalers, nitroglycerin, opiates, muscle relaxants, sedatives, analgesics (include Tylenol, and NSAIDs)
        b.) Topical lotions/creams
        c.) Saline nasal spray and artificial tear eye drops
        d.) Herbals, supplements (if not clinically relevant)
        e.)Vitamins (if not clinically relevant - can include Vit D)

Q: How long should we consider a patient no longer taking a medication when collecting the gold standard?
A: If a patient is not taking a prescribed medication for greater than 30 days, they should be considered no longer taking this medication. Therefore, if the team writes down that the patient is taking it, call it an additional medication.

Q: If the team thinks a patient is taking a medication ("added med"), but the patient is not, and the care team holds the medication on admission or discharge orders, how should I list this medication?
A: This medication should be listed as "same/no discrepancy" because the gold standard is nothing. In other words, it is the same as nothing; there is no discrepancy.

Q: How do you determine patient understanding of medications?
A: -High: understands indications, dose, strength, and frequency of most medications
-Medium: inconsistent or incomplete understanding of indication, 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")

MISCELLANEOUS

Q: Who is the admitting provider?
        "Who would be considered the 'admitting provider': the resident who writes the note, the attending, the person who writes the order, the ultimate person responsible for the orders?"
A: Admitting Provider – this is the person you would ask questions of if you had a question on the admission orders (vs. PAML), usually the intern or resident who sees the patient and writes admission orders first.

Q: What is the "true" admission time?
        "Admission for a patient was at ~9pm but orders were written at 8:30am next morning. The intention was that the 8:30am orders be 'admission' orders. What is considered the 'true' admission time (i.e., should we use time in computer, or time patient leaves ED or arrives to floor, etc.)?"
A: If you have the time the patient arrives on the floor (in some hospitals, it may be the nursing admission assessment note) you may use this as the admission time. The point of this rule is to specify when admission orders end if there are several sessions of them. If nothing has been written before 8 am or 8 hours after admission, then just go with the first ordering session after that time (but nothing after that).

Q: Can we use the registration time for the admission time?
        "REDCap requires that we enter an admission time, as well as date. I initially was using the patient 'registration' time as the admission time since it was much easier to determine, but now I'm trying to look at the location census and determine the actual time the patient is documented as transferring to a floor location. Otherwise, it is impossible to determine a true 'admit' time. Is this appropriate?
A: Use the *registration time*. First, it's easier to find. And second, once the patient is "officially" admitted, even if they are not on the floor, the clock starts ticking for a physician to write admission orders.