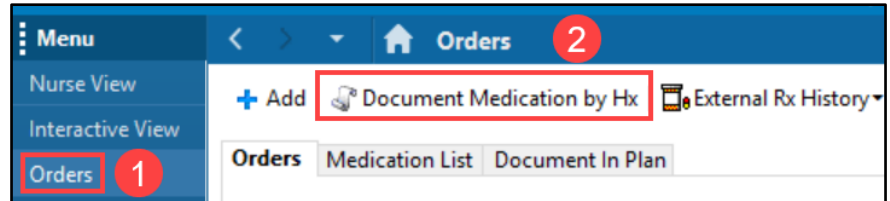


Documenting Home Medications After Admission for Nurses

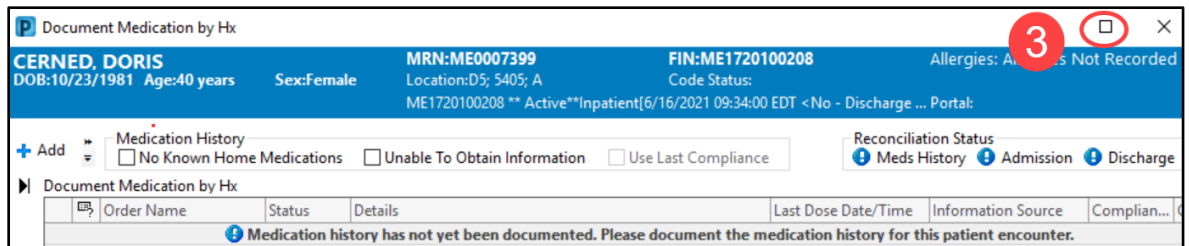
Cerner PowerChart EDUCATION

Documenting Home Medications After Admission

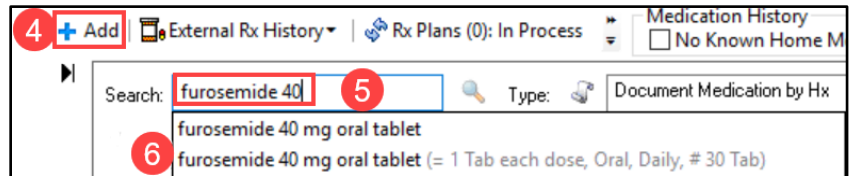
- Under the dark blue Menu, select Orders.
- Select the Document Medication by Hx tab.



- Maximize the screen to view all charting options.



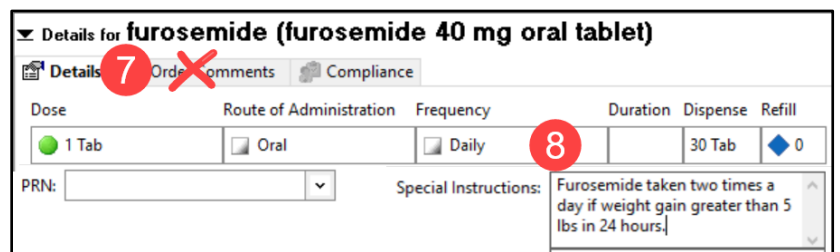
- Click **Add**.
- Enter medication and dosage in search window.



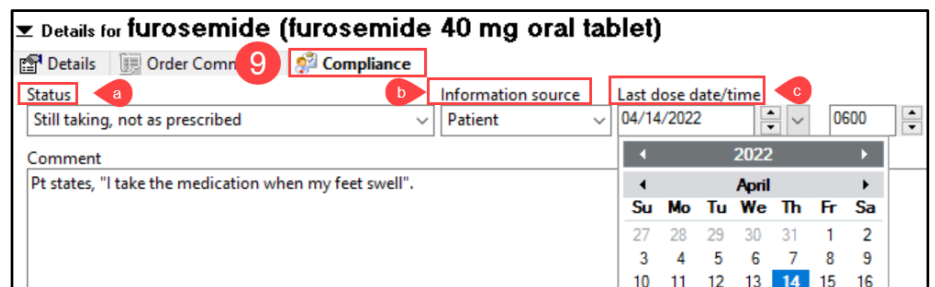
- Select dose, route, and frequency information.

Remember to enter the medication and dose as the patient states. Examples: Furosemide vs. Lasix and 1/2 of a 20 mg tablet vs 10 mg tablet

- Do not use **Order Comments** as the provider is unable to view information here when completing the reconciliation process.
- Use **Special Instructions** if needed to add a comment.



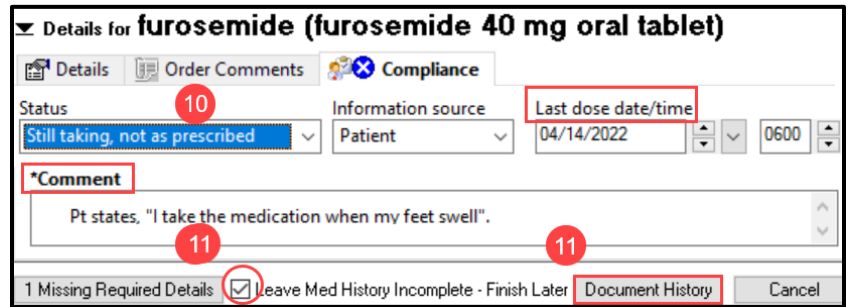
- Select the **Compliance** tab and enter:
 - Status
 - Information Source
 - Last dose date/time.



Documenting Home Medications After Admission for Nurses

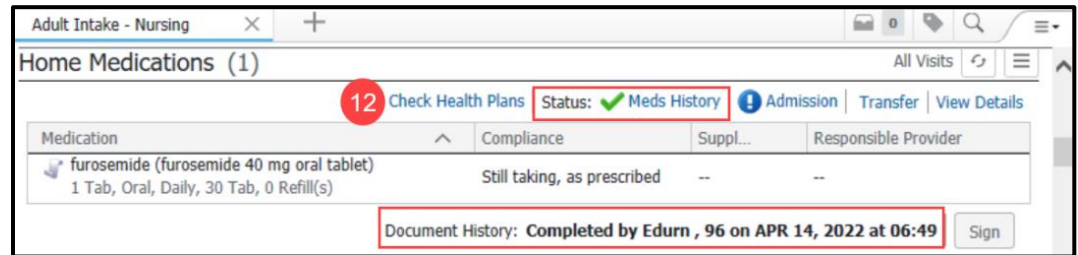
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10. When a medication status is **still taking, not as prescribed**, a **Comment** is required to indicate how the patient is taking the medication. Record the last date and time the medication was taken.



11. When all home medications have been entered, **remove** the check mark next to Leave Med History Incomplete, and select **Document History**.

12. The **green checkmark** indicates Meds History status is complete. The date, time, and completing staff member's name displays.

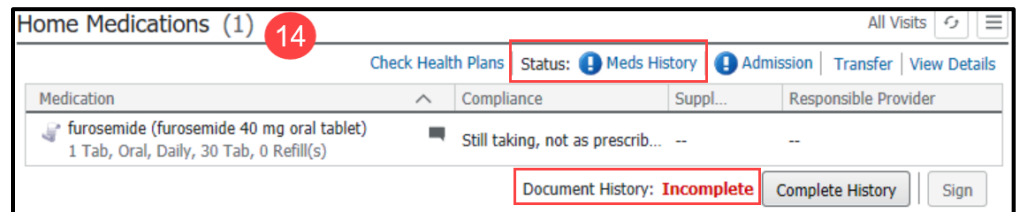


13. If **unable** to complete medication entry, **do not remove the check mark**.

Select **Document History** which will save all the information added.



14. Meds History will display a blue exclamation point, and Document History is **Incomplete**.



15. When able to complete Home Medication documentation, select **Complete History**. Follow steps 5 through 13.

