Documenting Home Medications upon Admission for Nurses

Cerner PowerChart **EDUCATION**

Documenting Home Medications upon Admission

1. Select Nurse View on the dark blue Menu.

2. Select Adult or Pediatric Intake – Nursing.

3. Select Home Medications.

4. Click Complete History.
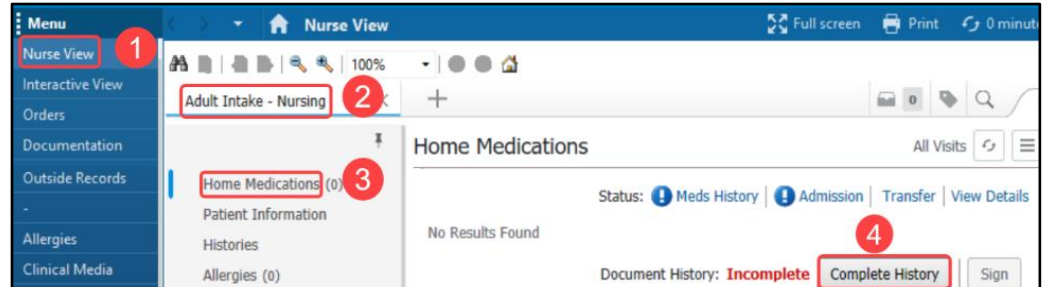
Note: See separate education for instructions regarding the medication topics below.
- Reviewing medications previously entered
- Medications that are Not Found/Not Known/NonFormulary

Adding Medications: Enter the medication name and dose as the patient states to prevent reconciliation discrepancies.

1. Select Add.

2. Enter the medication and dose in the search window.

3. Select the dose, route, and frequency.
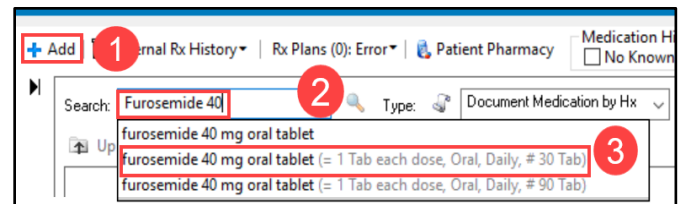
NOTE: The order sentence selected can be modified if something does not match. Disregard the tablet #; this is for providers ordering prescriptions.
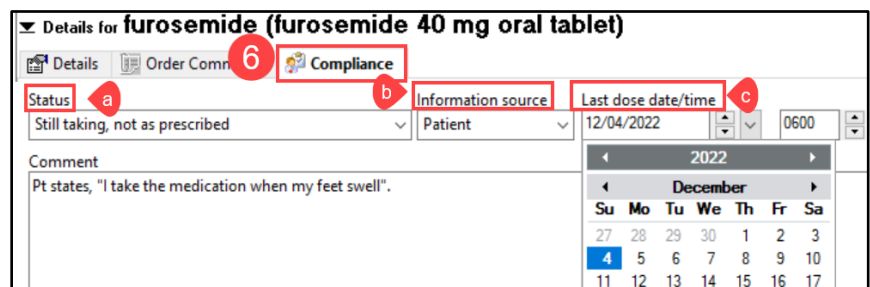
Do not use the Order Comments tab as the Provider is unable to view information without hovering here when completing the reconciliation process.

4. Complete order Details:
   a. Dose.

   b. Route of Administration.

   c. Frequency.
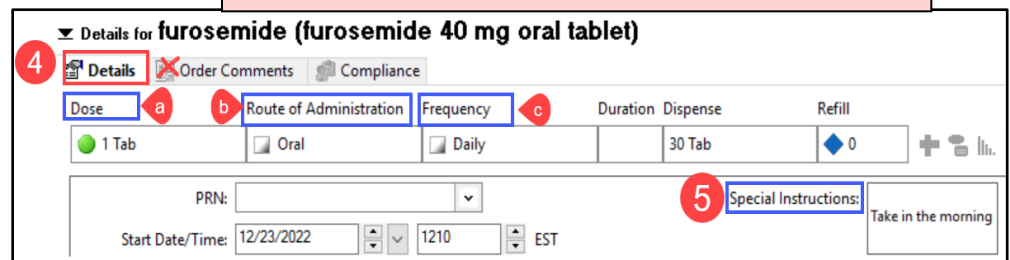
5. Enter Special Instructions if needed to add a comment.

6. Select the **Compliance** tab and enter:
   a. Status.

   b. Information Source.

   c. Last dose date/time.

7. When a medication status is Still taking, not as prescribed, a Comment is required to document how the patient is taking the medication.

8. When all home medications have been entered:
   a. Remove the check mark from the Leave Med History Incomplete box.

   b. Select Document History.

9. The green checkmark indicates Meds History status is complete.
   The date, time, and completing clinician name displays.

10. If unable to finish medication entry, do not remove the check mark. Select Document History to save all information added.

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

12. When able to finish Home Medication documentation, select Complete History.