

Cerner PowerChart | FirstNet Education

Accurate medication history at admission to hospitals leads to preventable adverse drug events, which in turn decreases mortality, morbidity, and health care costs.

Use at Least Two of the Following Sources

Source #1: Patient/Family

- Patient Interview
- Family members or caregivers
- Home medication list
- Actual Medication Bottles

Source #2: Elsewhere

- Recent hospital discharge summary
- Prescription information: External Rx History
- Notes or lists from providers: H&P
- Transfer orders from other facilities: SNF or AFC facilities medication documentation forms

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Tips for Obtaining an Accurate Home Medication List

- Ask about current medications the patient is taking.
- Ask about Over-the-Counter medications (vitamins, herbals, supplements).
- Ask the patient if they are taking their medications as prescribed. Ask open-ended questions, such as, "How do you take this medication?"
- Ask, "Which eye drops, inhalers, patches, and/or creams or ointments are you using?"

Terminology Guidelines

Indicates a prescription

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Indicates a documented Home Medication

Modify	Make changes to medication dose/route/frequency			
Suspend	Do not use, requires a provider's order			
Complete	Use when patient is no longer taking the medication			
Cancel/DC	Do not use, requires a provider's order			
Delete/Void	Use only when entered in error			
Add/Modify Compliance	Add/change how patient is taking medication and last dose taken			

Do NOT complete a patient's prescription unless the patient is no longer taking the prescription, or the dose/route/frequency has changed.

*If a patient's prescription dose/route/frequency has changed, do the following:

- 1. Right click on prescription and select complete.
- 2. Enter the correct medication dose/route/frequency as a home medication.





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Documenting Home Medications Upon Admission

- 1. Under the dark blue Menu, select: Nurse View.
- 2. Select: Adult or Pediatric Intake Nursing.
- 3. Select: Home Medications.
- 4. Select: Complete History.

Menu	< 🔿 🔻 🔒 Nurse View		🔀 Full screen 🛛 🖶 Print 🛭 🍫 2 minute
Nurse View	A 🗎 📥 🛋 🔍 100%		
Interactive View	Adult Intake - Nursing	Pediatric Intake - Nursing X	
Orders + Add		readere intarte intering	
Documentation	Ŧ	Home Medications (0)	All Visits 🥱 🚍
Results Review	* Admission PowerForms (0)		
MAR Summary	Patient Information		
Outside Records	Histories		Status O Made Uistan O Admission Transfer View Dataile
-	Allergies (0)		Status. Transfer View Details
Allergies + Add	Home Medications (0)	No Results Found	
Clinical Media	Immunizations		Document History: Incomplete Complete History

- 5. Select Add.
- 6. Enter medication and dosage in search window.
- 7. Select dose, route, and frequency information.

5	🕂 Add 🔄 External Rx History 🕶 🖑 Rx Plans (0): In Process 🛃 Patient Pharmacy									
	Þ	Search:	Furosemide 40 6 Type: 🦨 Document Medication by Hx 🗸							
	furosemide 40 mg oral tablet									
			furosemide 40 mg oral tablet (= 1 Tableach dose, Oral, Daily, # 30 Tab)							

Examples: Furosemide vs. Lasix and 1/2 of a 20 mg tablet vs 10 mg tablet	

- 8. Add **Order Comments** as necessary.
- 9. Add **Special Instructions** as necessary.

Note: Text added to Order Comments and/or Special Instructions is visible to the provider within Medication Reconciliation workflows.

😭 Det 8 📴 Order Cor	iments and Compliance									
Dose	Route of Administration	Frequency	Duration	Dispense	Refill					
🥚 1 Tab	🔄 Oral	🔲 Daily		30 Tab	• 0					
9 PRN:		~								
Special Instructions:	ake 2 times a day for weigh greater than 5 lbs in 24 hour	nt gain rs.								



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10. Select Compliance tab. Enter Status, Information Source, and Last dose date/time.

▪ Details for furosemide (furosemide 40 mg oral tablet)									
🖀 Details 🗓 Order Comments 🔊 Compliance 10									
Status Information source Last dose date/time									
Still taking, as prescribed V Patient V	07/08	8/2021	1			08	300	▲ ▼	
Comment	•			2021			١.		
	•			July			•		
	Su	Мо	Tu	We	Th	Fr	Sa		
	27	28	29	30	1	2	3		
	4	5	6	7	8	9	10		
	11	12	13	14	15	16	17		

11. When a medication status is **still taking not as prescribed**, all fields are required including a **Comment**. Record the last date and time the medication was taken.

y Details for furosemide (furosemide 40 mg oral tablet) The table of table	
Status Information source Last dose date/time Still taking, not as prescribed 11 Patient V Patient O7/01/2021 V D800 EDT	
Pt states, "I take the medication when my feet swell".	^
1 Missing Required Details 12 C Leave Med History Incomplete - Finish Later	Document History Cancel

12. When all home medications have been entered, **remove** the check mark, and select Document History. If unable to complete medication entry, do not remove the check mark, select Document History **only** which will save all information added.

Documentin	Beneficiations After Admission
Documentin	

- 1. Under the dark blue Menu, select Orders.
- 2. Select the Document Medication by Hx tab
- 3. Enlarge the screen to view all charting options.



P	P Document Medication by Hx 3								
EDUCATION, TOM DOB:5/24/1975 Age:46 years Sex:Male				Sex:Male	MRN:ME000 Location:B3; 3022; A ME1720000020 ** Active	FIN:ME1720000020 Code Status: **Inpatient[2/25/2021 15:02:00 EST <i< th=""><th>Allergies:e No - DiPortal:</th><th>rgies Not Recor</th></i<>	Allergies:e No - DiPortal:	rgies Not Recor	
Medication History Medication History Medications Unable To Obtain Information Use Last Compliance Medis History Admission Admission Document Medication by Hx									
		\$	Order Name	Status	Details		Last Dose Date/Time	Information Sour	
	✓ Last Documer							t Documented Or	
	⊿	Ho	ne Medications						
	Grupsemide Documente = 1 Tab each dose, Oral, Daily, Fursosemide taken two times a (furosemide 40 mg or d day if weight gain greater than 5 lbs in 24 hours., # 30 Tab, R								



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Na	me of Medication Unknown or Not Found in For	mulary							
•	Enter " Med Not Found " in Search field. Select —		ſ	Search: n	ned			٩	
•	Enter the name or if the name is unknown enter a description of medication in Freetext	⊈ Details fo	Med Not	Found/I	Med Not Not Know	Found/No	t Known/N mulary (t	VonForm	ulary I pill)
	Orderable.	Dose	Route of Ad	Frequency	Duration	Dispense	Refill		a llu.
•	Enter any known information in Special Instructions.	Free	etext Orderable: t	l olue oval pill for BP					
		U							

⊿ Medications

⊿ Medications

mg oral tablet)

mg oral tablet)

Modifying Medications

If the previously documented medication dose and/or frequency has changed:

- 1. Right click on medication and select Modify.
- 2. Make appropriate changes. For example, patient now takes Lasix 20 mg daily.

Completing Medications

- 1. Complete all medications and prescriptions that the patient is no longer taking.
- 2. Right click on medication or prescription and select **Complete.**

Unable to Obtain a Med List

- Select Unable to Obtain Information only when the patient or family members are not able to provide any information on a patient's home medications.
- Medication History

furosemide (Lasix 40 Documented = 1 Tab each dose, Oral,

furosemide (Lasix 40 Documented = 1 Tab each dose, Oral,

Complete

Modify

- A task will be created to remind the RN to try to collect the information later.
- When all home medications have been entered, Uncheck Leave Med History Incomplete, select Document History.



• Do NOT remove or change any medications from a previous visit at this time.