Home Medication Documentation: Overview for Nurses

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

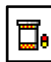
Source #2: Elsewhere

- 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

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 

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

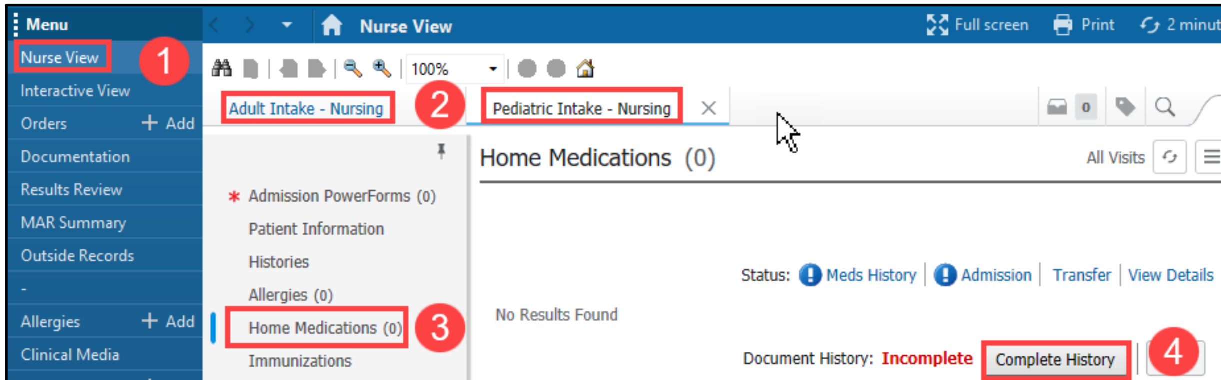
Do NOT complete a patient’s prescription unless the patient is no longer taking the prescription, or the dose/route/frequency has changed.

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

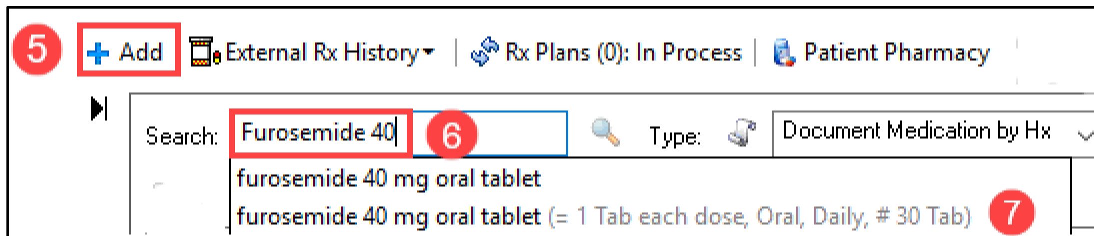
1. Right click on prescription and select complete.
2. Enter the correct medication dose/route/frequency as a home medication.

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.



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

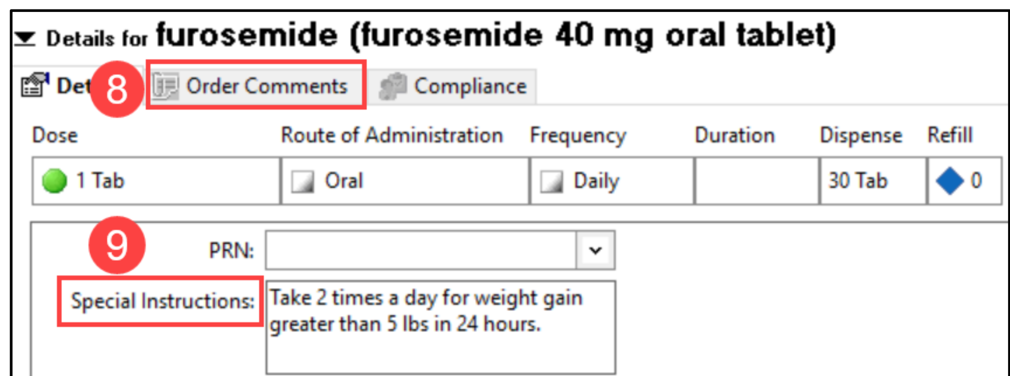


Remember to enter the medication and dose as the patient states
Examples: Furosemide vs. Lasix and 1/2 of a 20 mg tablet vs 10 mg tablet

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.



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

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.

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.

Documenting Home Medications After Admission

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.

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Name of Medication Unknown or Not Found in Formulary

- Enter "**Med Not Found**" in Search field. Select
- Enter the name or if the name is unknown enter a description of medication in **Freetext Orderable.**
- Enter any known information in **Special Instructions.**

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.
- 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.