

Medication History Documentation for Clinical Staff

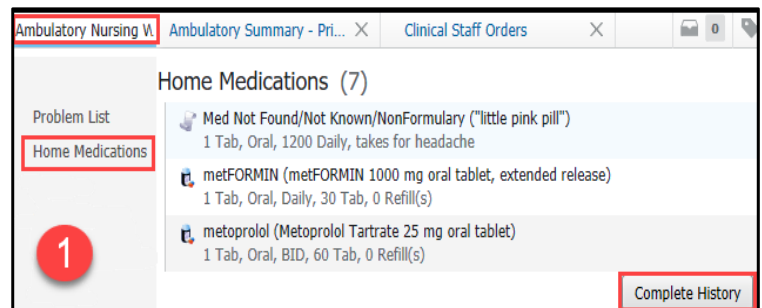
Cerner PowerChart Ambulatory EDUCATION

Accurate medication history documentation at office visits is an important part of patient care and helps avoid preventable adverse drug events, which in turn decreases mortality, morbidity, and health care costs. Medication history documentation includes reviewing existing medication compliance and adding additional home medications as needed. An accurate medication review should include using two information sources.

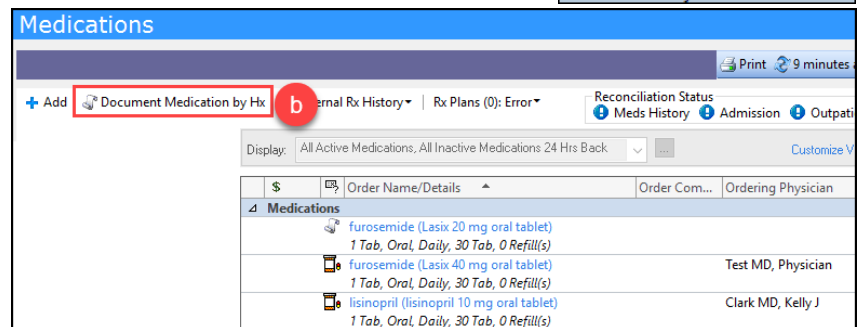
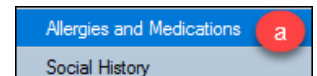
Home Medication Compliance Documentation

The intake process includes the patient's home medication review and compliance documentation and is performed at each visit within Document Medication by History.

- Access Document Medication by History from:
1. Within the Ambulatory Nursing Workflow page:
 - a. Navigate to the Home Medications component.
 - b. Click on Complete History.



2. Within the Intake form:
 - a. Select Allergies and Medications.
 - b. Click on Document Medication by Hx.

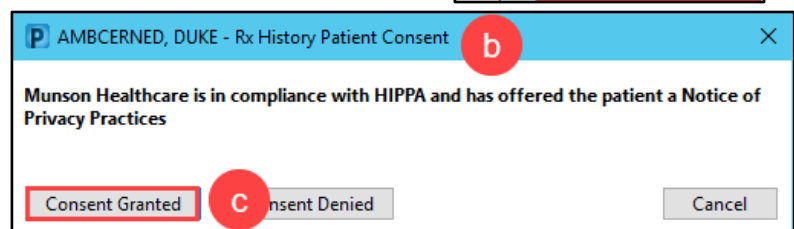
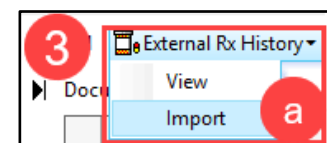


External Rx History:

Accessing the **External Rx History** is the most accurate way to view and update the current medication history and medication details.

Note: It may not be a complete list and will not include prescriptions that were paid for out of pocket, filled through the VA, or various other exceptions.

3. To access External Rx History:
 - a. Click on the External Rx History drop-down and select Import.
 - b. An Rx History Patient Consent window may display. This is obtained at patient registration but also needs to be acknowledged electronically.
 - c. Click Consent Granted.

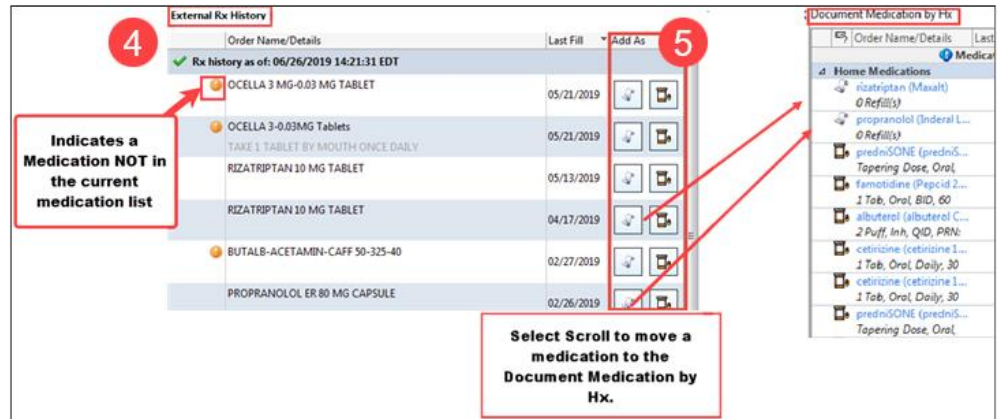


Medication History Documentation for Clinical Staff

Cerner PowerChart Ambulatory EDUCATION

4. The External Rx History window opens:

- Import will display a side-by-side comparison of the External Rx History on the left and the current medication list on the right and allows a one-click addition of the External Rx History prescriptions to the patient's current medication list.

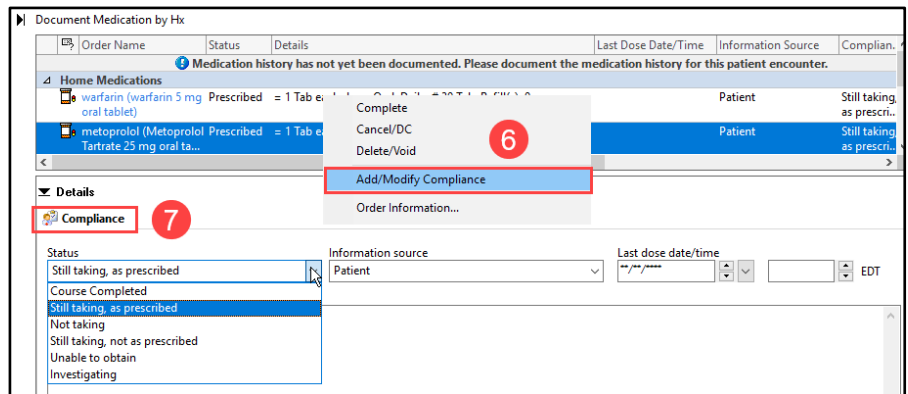


Note: It is important to add the medication with all details (doses/route/directions) to the home medication list, this will allow the medication to flow into the MAR.

5. Selecting the scroll in the Add As column will move the selected medication along with the medication details to the home medication list.

Once the medications have been added to the home medication list, the **compliance** must be completed.

6. Right click on the selected medication and select Add/Modify Compliance.
7. In the displayed **Details** pane, update the Status, Information source, last dose if applicable and add any additional comments necessary. Repeat steps 3 and 4 for each medication listed.



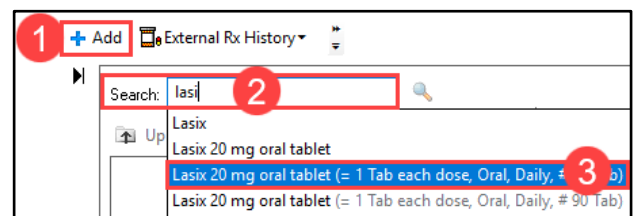
Note: A comment is required for all statuses except 'Still taking, as prescribed'. Use Last Compliance checkbox is available to use and will pull in the last compliance documented for every medication that was previously charted. Caution: If this function is used, it is still necessary to confirm compliance status for all medications.

Adding Medications to the Home Medications list

Within the Document Medication by History, additional home medications may be manually added.

1. Click on **+ Add**.
2. Type the medication in the Search field to display options.

NOTE: Do **NOT** free text the medication
3. Click the correct medication sentence with the details attached. The Details for (the selected medication) will display and may be modified as needed.



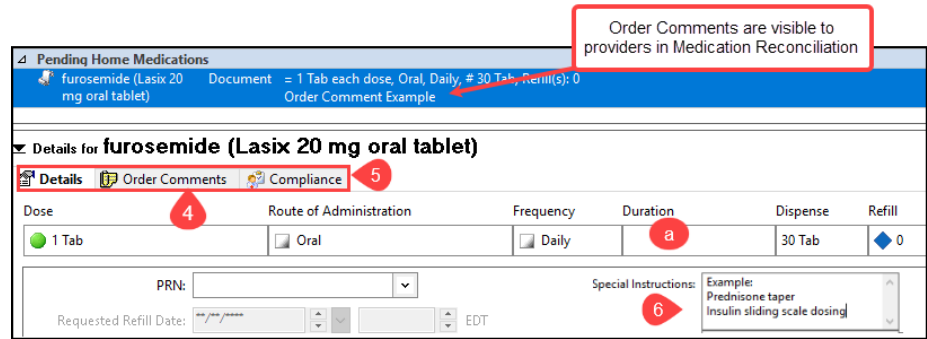
Note: Remember to enter the medication and dose as the patient states. Examples: Furosemide vs. Lasix and 1/2 of a 20 mg tablet vs 10 mg tablet.

Medication History Documentation for Clinical Staff

Cerner PowerChart Ambulatory EDUCATION

a. Medication details need to be added in the Details tab. **Enter the correct dose, route, and frequency of the medication.**

4. Add Order Comments if needed.
5. Click on the **Compliance** tab to add the Compliance Status.
6. Add **Special Instructions** as necessary.



Note: Text added to Order Comments and/or Special Instructions is visible to the provider within Medication Reconciliation workflows. Pharmacy **will not** see comments from Order Comments and may not notice Special instructions.

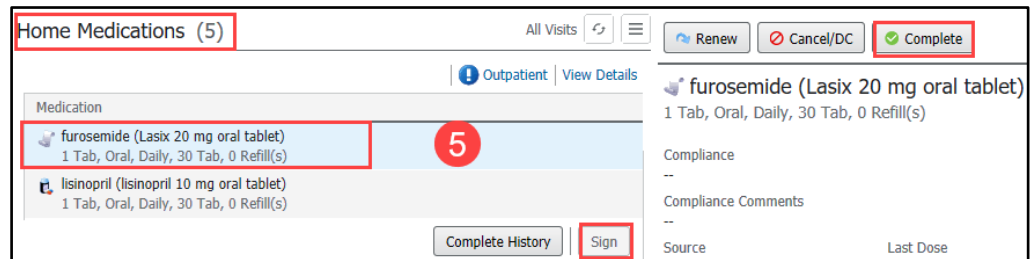
Completing Medications:

Medications may be completed if a patient has completed a medication, there is a duplicate medication, or to remove a documented historical medication from a patient’s medication list when ordering the medication as a prescription.

Note: Only complete prescribed medications if the patient has completed the medication course or have been directed to discontinue the medication by the prescribing provider.

To **complete** a medication:

5. From the Home Medications Component on the Ambulatory Workflow page: highlight the medication(s), click Complete, and Sign.



6. From the Medication List: right click on the medication and select Complete, click Orders for Signature, and Sign.

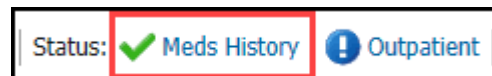
Once all medications have been reviewed and the compliance status has been completed:

7. Click the Document History button to complete the medication review.



8. Reconciliation Status will show a green check mark next to Meds History on both the Intake form and Ambulatory Nursing Workflow page. This can be found in two places:

- a. The Intake Powerform.
- b. Ambulatory Nursing Workflow.



Note: Once Document Medication by History is completed, the provider can complete the medication reconciliation process.