Overview

When a patient arrives in the ED, PreOp, SSU or is admitted to an inpatient unit, the patient’s medications must be reviewed, updated and have compliance entered. This includes documented home medications and prescriptions.
Accessing Document Medication by Hx

From the Orders tab, click the Document Medication by Hx button.

![Image of Document Medication by Hx button]

**Note:** Do not open Document Medication by Hx from the Add button, as it will not set the Med History status to Complete.

On the Document Medication by Hx window:

- **Add** - Use to add a historical medication to the patient’s medication history.
- **No Known Home Medications** - This button is only available if no historical medications are documented for previous encounters or the patient has no past encounters.
- **Unable to Obtain Information** - Use if you are unable to obtain historical medication information from the patient’s parent or guardian. This encounter will be flagged as “Unable to Obtain Information”.
- **Use Last Compliance** - When documenting medication history for the first time on an encounter, you are able to see medications that existed on previous encounters and the compliance status that was documented at the time. If the information is the same as what you would document today, you can select Use Last Compliance and the system will automatically generate a new compliance status with the new date stamp and your user ID attached.

![Image of Document Medication by Hx window with options]

Reviewing Existing Medications

Review the list of documented historical medications and prescriptions with the patient/family to ensure the medication history is correct.

Actions for reviewing existing medications include:

- **Modify** medication history
- **Document Compliance**
- **Cancel/DC** medications that are no longer valid

Modifying Historical Medications

1. Right-click on medication, and select **Modify**.

![Image of Documented Medications by Hx with Modify option]

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2 Update the appropriate order details with the new information.
   Note: Click into the field to display the detail options. If not displayed, field can be used as a free text field to type in the appropriate information.

3 Click Compliance tab to document compliance.

4 Add Status, Information source, and Last dose given.
   Note: Select the Status reason that is most appropriate. In this example Still taking, as directed is selected because the details were modified to reflect what the patient was taking.
**Documenting Compliance**

If modifications are not needed, only compliance needs to be documented.

1. Right-click on medication, and select **Add/Modify Compliance**.

2. Historical medications that are no longer being taken should be documented in the **Compliance** section as **Not taking**. Document details in the **Comment** section.

3. Document compliance as appropriate.

**Deleting a Historical Medication**

Historical medications that are completed (e.g. antibiotics) should be **Cancel/DC’ed**.

1. Right-click on the medication and select **Cancel/DC**.
Review and Document Historical Medications

2 Select the reason the patient is no longer taking the medication.

Reviewing Prescription Medications

The details of Prescription Medications cannot be modified, only Compliance can be entered.

1 Right-click on the Prescription, and select Add/Modify Compliance.

2 Update the Status, Information source, and Last Dose given, as appropriate.
Adding Historical Medications

Add a Medication from External Rx History

1. From the Orders Tab, click the External Rx History button.

2. Right-click on the Medication(s) to be documented as history, and select Convert to Documented Medication.

3. Click the Orders for Signature button at the bottom of the screen.

4. Highlight the order(s) to open the order details window.

5. If known, add Dose, Route, Frequency and/or any other order details for each med.

6. Click Sign, and Refresh the screen.

Add a Medication that is Not Displayed

1. From the Document Medication by Hx window, click the Add button.

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2 Enter the name of the historical medication in the **Find** field. Select the best matching description from the order window that matches the level of detail obtained from patient/family.

Some medications have order sentences. An order sentence is a saved set of details that is a typical order or prescription for the medication selected. If the **Order Sentences** window displays, select the appropriate **Order Sentence**. If none are applicable, click **None**, and **OK**.

3 Close the Add Order window.

4 Add your details for **Dose**, **Route of Administration** and **Frequency**.
Note: In this example, a PRN medication was added, which requires a PRN reason.

5 Once order details are added, click on the Compliance tab. Add Status, Information source and Last dose given.

Add a Medication with Missing Details
Example, a family reports patient is taking amoxicillin (1 tsp, PO, BID). The missing detail is the concentration of the amoxicillin.

1 Click the Add Button

2 Enter the name of the historical medication in the Find field.
3 Select the appropriate Order Sentence. Close the Add Order window, and enter the known details.

Note: The dose is typed in as 1 tsp because the concentration was unknown.

4 Click the Compliance tab. Select Missing medication detail(s) for Status, and complete Information source, and Last dose given. Use the Comment field to enter information about the missing detail.

Note: Missing medication detail(s) alerts the clinician and pharmacist that the information is incomplete and follow-up is needed.

Add a Medication with Unknown Name
Example, a family reports patient is taking a medication, but the medication name is unknown. The details given are “little blue pill”, by mouth, at bedtime for sleep.

1 Click the Add button.

2 Add the medication, by entering “free text med.” in the Find field. Select either entry.
3 Close the Add Order window, and enter the known details. In the Drug Name field, enter description of medication. Whether you have a little or a lot of information about a patient’s medication history, enter all information that you have.

![Image of medication details form]

Note: If entering a selection that is not in the dropdown list, you will be prompted to confirm your entry before continuing.

4 Click on Compliance tab. Select Missing medication detail(s) for Status, and complete Information source and Last dose given.

Note: Missing medication detail(s) alerts the clinician and pharmacist that the information is incomplete and follow-up is needed.

5 Use the Comment field to enter information about the missing detail.

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Add a Medication with Differing Doses Throughout the Day

Example: Depakote 200 mg in the morning, and 500 mg at HS.

1. Click Add.
2. Enter name of medication.
3. Select the appropriate dose in the order sentence for the morning dose and click OK.
4. Close the Add Order window. Add your details for Dose, Route of Administration, and Frequency for the morning dose.
5. Click on Compliance tab, add Status, Information Source, and Last Dose Given as appropriate.
6. Repeat the process for the HS dose.

There will now be two entries for this medication, one for the morning dose, one for the HS dose.

Signing Medication Documentation

Once you have reviewed, modified, updated and added compliance to the patient’s medications, click the Document History button to sign.

Once the documentation is signed, the status of the medication history is updated with a green checkmark which indicates that documentation is completed.
Reviewing Documented Medications at Discharge

Documented home medications should be reviewed at discharge.

1. **Check Disch. Meds Rec.** Once Discharge Medication Reconciliation has been completed by the clinician, review the Documented Medications.

2. **Click Document Medication by Hx from the Orders tab.** If duplicates exist, the documented home med can be discontinued. Right-click on the documented home med, and select Cancel/DC.

   **Note:** Duplicates are medications that share all the same order details (drug, dose, route, frequency).

3. **Select Duplicate Order for Discontinue Reason.**

4. **Click the Document History button** when you are finished to sign charting.

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