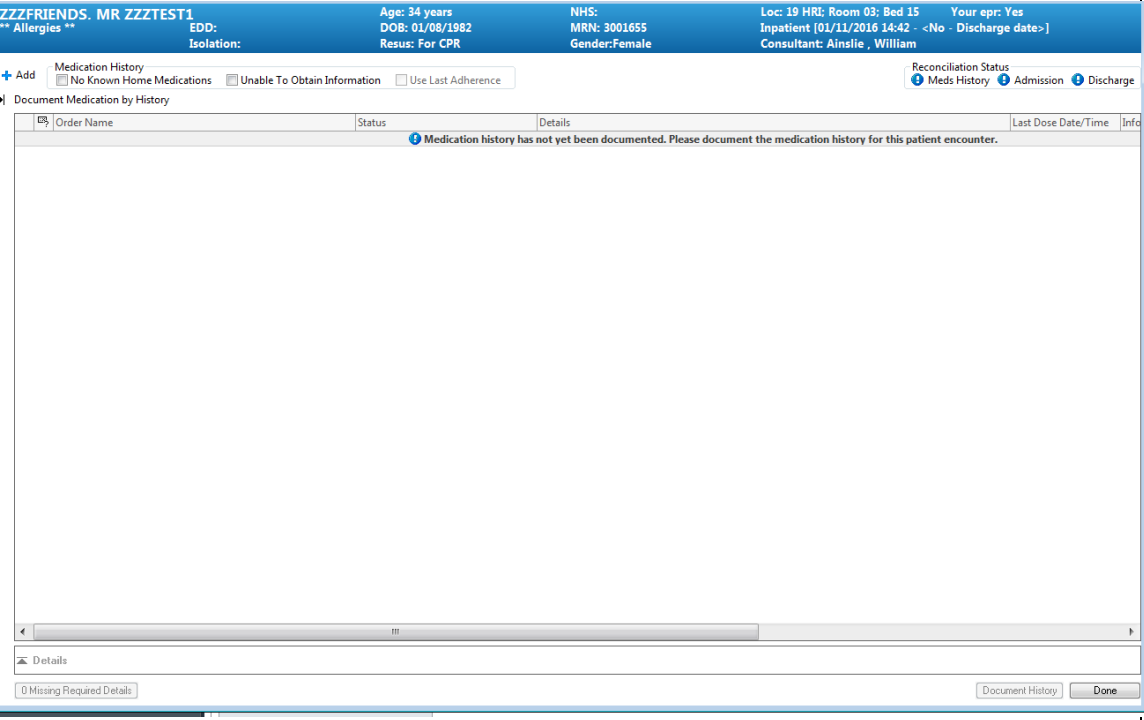


QRG – Medication History and Admission Reconciliation

No.	Action	Responsibility
DOCUMENTING MEDICATION HISTORY		
1.	<p>Using the Drs worklist or relevant patient list, identify for your area of responsibility the patients which require medication histories to be documented:</p> <p>Click on patient name to go to record. Any alerts regarding VTE, allergies or weight/height should be completed with patient details.</p>	Clinician, Nurse, Prescriber.
2.	<p>Under Requests / Care plans click on the “document medication by History” button.</p> <p> Add Document Medication by History Reconciliation ▾ Check Interactions</p>	Clinician, Nurse, Prescriber.
3.	<ul style="list-style-type: none"> • If confirmed to be taking no medication tick the “No Known Home Medication” tick box. • If unable to confirm history tick “unable to obtain information” tick box. • If admitted within 28 days and medication history has not changed since last admission tick “use last adherence” tick box. <p>NOTE -There may already be some entries in this window :</p> <ul style="list-style-type: none"> • If readmitted within 28 days • If a clinician has already documented some of the history <p>These will require checking / modifying as appropriate.</p> 	Clinician, Nurse, Prescriber.
4.	<p>If able to document medication click on the Add symbol. Search for medication and select the appropriate medication or Order Sentence from the drop down list. Continue to search until</p>	Clinician, Nurse, Prescriber.

all medication has been found. Click 'Done' to exit the Add Order screen.

ZZZFRIENDS. MR ZZZTEST1
 ** Allergies **
 EDD:
 Isolation:
 Age: 34 years
 DOB: 01/08/1982
 Resus: For CPR

Search: [] Type: [Document Medication by Hx]
 Folder: Favourites Search within: Medications

5. For each medication complete the Order entry format (OEF) with as much information as possible.
- If this medication is a recent acute prescription ensure this is documented by including when the course was started / stopped/ duration, use the special instructions box to document this.
- If the medication is a weekly/ fortnightly/ monthly etc. ensure that the next dose due is documented in the special instructions box.

Clinician,
Nurse,
Prescriber.

Document Medication by History

ZZZFRIENDS. MR ZZZTEST1
 ** Allergies **
 EDD:
 Isolation:
 Age: 34 years
 DOB: 01/08/1982
 Resus: For CPR
 NHS:
 MRN: 3001655
 Gender: Female
 Loc: 19 HRB: Room 03; Bed 15
 Inpatient [01/11/2016 14:42 - <No - Discharge date>]
 Your epr: Yes
 Consultant: Ainslie, William

Medication History
 No Known Home Medications Unable To Obtain Information Use Last Adherence

Reconciliation Status
 Meds History Admission Discharge

Order Name	Status	Details	Last Dose Date/Time	Info
Medication history has not yet been documented. Please document the medication history for this patient encounter.				
Pending Home Medications				
Simvastatin (Simvador)	Document	- START: 02/11/2016 14:50		
Glyceryl trinitrate (Glyceryl trinitrate 400micrograms/dose pu...)	Document	- START: 02/11/2016 14:49		
Beclomethasone (Qvar Easi-Breathe)	Document	DOSE: 200 microgram - ROUTE: inhalation - inhaler - TWICE a day - START: 02/11/2016 14:49		
Salbutamol (Salamol Easi-Breathe)	Document	- START: 02/11/2016 14:49		
Bisoprolol	Document	DOSE: 2.5 mg - ROUTE: oral - tablet - ONCE a day (morning) - START: 02/11/2016 14:48		
Atorvastatin	Document	DOSE: 20 mg - ROUTE: oral - tablet - ONCE a day (night) - START: 02/11/2016 14:48		
Furosemide	Document	DOSE: 40 mg - ROUTE: oral - tablet - ONCE a day (morning) - START: 02/11/2016 14:48		
Ramipril	Document	DOSE: 1.25 mg - ROUTE: oral - capsule - ONCE a day - START: 02/11/2016 14:47		

Details for Simvastatin (Simvador)

Details | Order Comments | Adherence

Dose: [] Route of Administration: [] Frequency: [] Duration: []

Drug Form: [] PRN: []

Special Instructions: [] Indication: []

Start Date / Time: 02/11/2016 1450 Patient's Own Meds: Yes No

Admission Med: Yes No Stop Date / Time: []

Days Supply: [] Dose Change Reason: N/A GP to Continue: []

Missing Required Details Leave Med History Incomplete - Finish Later

6. Use the Adherence tab to document any further information if required

Clinician,
Nurse,
Prescriber.

Details for Bisoprolol

Details | Order Comments | Adherence

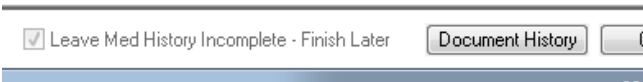







Status: Still Taking, as Prescribed
 <Not Entered>
 Still Taking, as Prescribed
 Not Taking
 Still Taking, Not as Prescribed
 Unable to Obtain
 Investigating

Information source: <Not Entered>

Last dose date/time: **/**/****

7. Once all medication documented click on the "Document History" box
 NOTE – Clinicians will not be able to untick the "Leave Med History incomplete – Finish Later", this is pharmacy only function.

Clinician,
Nurse,
Prescriber.

		
MEDICATION ADMISSION RECONCILIATION		
8.	<p>To Prescribe the medication if appropriate and to ensure the patient is reconciled go to the requests/care plans section and click on reconciliation “admission”</p> <p> Add  Document Medication by History Reconciliation ▾  Check Interactions</p>	Clinician, Nurse, Prescriber.
9.	<p>For each history item (scroll symbol  and status of documented) on the left decide if this is to be continued or stopped:</p> <p>To Continue a history medication - click on continue (green arrow ) . When continued this moves the medication to the right hand side of the window and the medication can be amended and changed as clinically appropriate.</p> <p>To stop (hold) a history medication – do nothing in the reconciliation screen (i.e. do not select the green arrow or the red square ) to indicate that the medication is currently on hold and not to be continued during admission.</p> <p>IMPORTANT: If a history medication is definitely to be stopped and not to be continued on discharge, right-click on the history medication, select cancel/DC and indicate the reason why it is to be stopped. This action cannot be undone and it will appear on the discharge summary as a stopped home medication. If there is a chance that the item is to be continued on discharge, do not cancel, but leave un-reconciled.</p> <p>To add new medication - New medication can be added at this point by clicking on the  Add button.</p>	Clinician, Nurse, Prescriber.
10.	<p>Once all medication needed has been prescribed, click on ‘Reconcile and Sign’.</p> <p>NOTE – the ‘Reconcile and Plan’ function does not provide any additional functionality and should <u>not</u> be used.</p>	Clinician, Nurse, Prescriber.
11.	<p>Go to drug chart and check the medication is prescribed as intended</p>	Clinician, Nurse, Prescriber.
RE-ADMISSION WITHIN 28 DAYS		
12.	<p>If the patient is re-admitted with 28 days the Medication History section will contain the history medication from the last encounter (status documented) and the TTO medications from the last encounter (status prescribed).</p> <p>To change the list to the current medication history this medications need to be amended with the aim of having a current list of history medications (only status documented).</p> <p>To achieve this, medications with status documented can be amended or stopped if required (right-click > Modify or right-click > cancel/DC). Medications with status prescribed need to be completed (right-click > Complete) which will remove them from the history screen.</p>	Clinician, Nurse, Prescriber.