QRG – Medication History and Admission Reconciliation		
No.	Action	Responsibility
	DOCUMENTING MEDICATION HISTORY	
1.	Using the Drs worklist or relevant patient list, identify for your area of responsibility the patients which require medication histories to be documented: Click on patient name to go to record. Any alerts regarding VTE, allergies or weight/height should be completed with patient details.	Clinician, Nurse, Prescriber.
2.	Under Requests / Care plans click on the “document medication by History” button. + Add | Document Medication by History | Reconciliation ▾ | Check Interactions	Clinician, Nurse, Prescriber.
3.	• 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. **NOTE** -There may already be some entries in this window : • If readmitted within 28 days • If a clinician has already documented some of the history These will require checking / modifying as appropriate.	Clinician, Nurse, Prescriber.
4.	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	Clinician, Nurse, Prescriber.

	all medication has been found. Click 'Done' to exit the Add Order screen.	
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.
6.	Use the Adherence tab to document any further information if required	Clinician, Nurse, Prescriber.
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.

	Leave Med History Incomplete - Finish Later · Document History	
	MEDICATION ADMISSION RECONCILIATION	
8.	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" + Add | Document Medication by History | Reconciliation ▾ | Check Interactions	Clinician, Nurse, Prescriber.
9.	For each history item (scroll symbol and status of documented) on the left decide if this is to be continued or stopped: **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. **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. **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.** **To add new medication -** New medication can be added at this point by clicking on the + Add button.	Clinician, Nurse, Prescriber.
10.	Once all medication needed has been prescribed, click on 'Reconcile and Sign'. **NOTE** – the 'Reconcile and Plan' function does not provide any additional functionality and should not be used.	Clinician, Nurse, Prescriber.
11.	Go to drug chart and check the medication is prescribed as intended	Clinician, Nurse, Prescriber.
	RE-ADMISSION WITHIN 28 DAYS	
12.	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). 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). 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.	Clinician, Nurse, Prescriber.