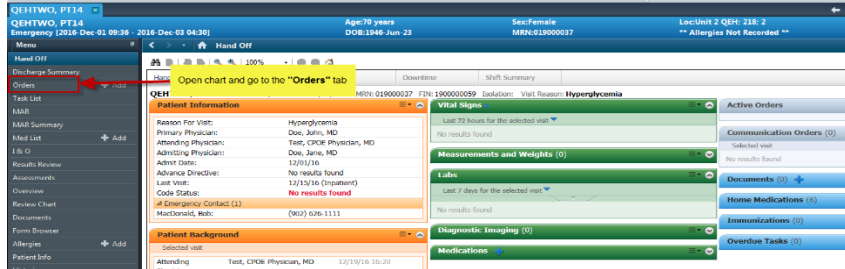


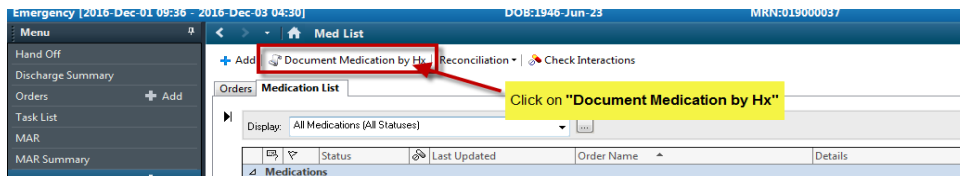
Best Possible Medication History

Documentation of Best Possible Medication History (BPMH)

1. Click on the “Orders” Tab on the Menu Bar

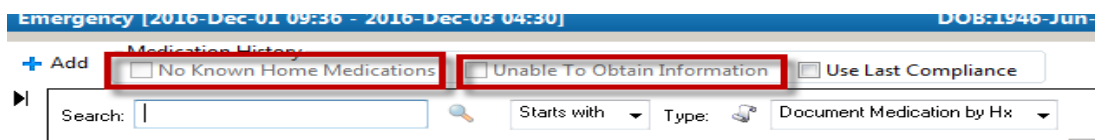


2. Click on “Document Medication by Hx” button



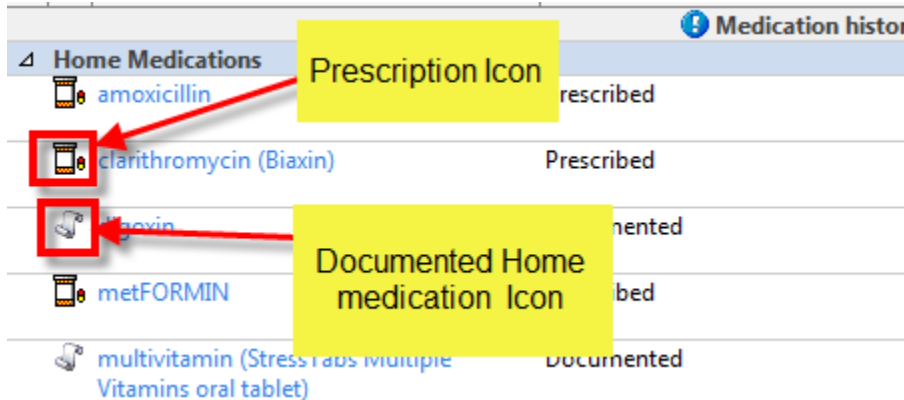
No Known Home Medications/Unable to Obtain Information

If the patient does not have any home medications or if you are unable to obtain the home medication information, you will have the option to select “No Known Home Meds” or “Unable to Obtain Information”.



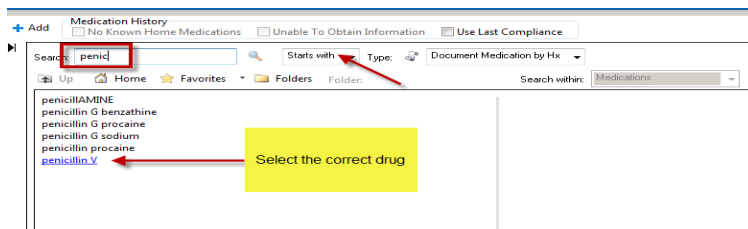
BPMH must be completed within 24 hours of admission for Inpatients.

Icons on the Documented Meds by History screen

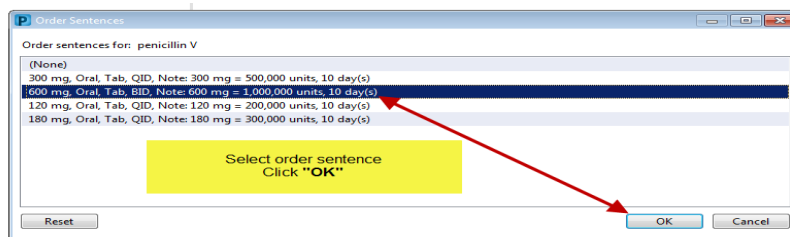


To add a new home medication:

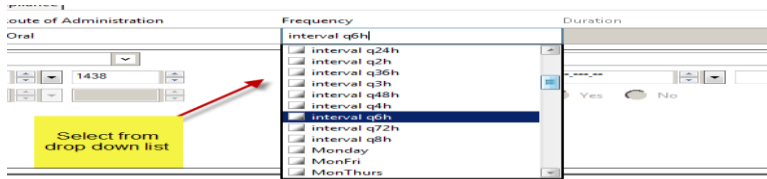
1. Click on ADD button
2. Type first few letters of the medication into the “Search” window
3. The Search should be set to “Starts With”
4. Select correct drug from the list that appears



5. Select an order sentence from the list that appears. If the details are not exactly what you are looking for, pick an order sentence that is closest to the home medication information you need. (Details may be easily changed later in the process)



6. Details window will appear
7. **IF necessary** you can correct dose or frequency information at this time
8. Click in field(s) you wish to adjust and make the required change(s)

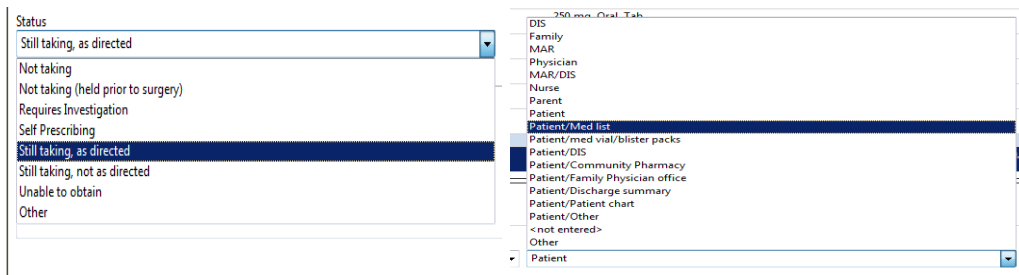


9. Click on “Compliance” tab

10. The “Status” and the “Information Source” must be completed on all medications



11. Select appropriately from the drop down menus that appear

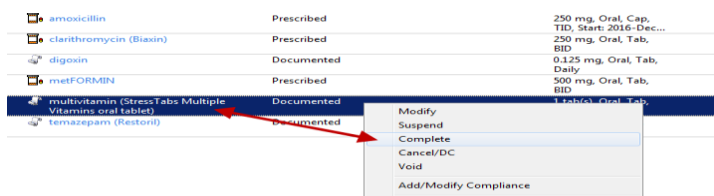


“Still taking as directed” can refer to the directions on a prescription label or the directions on a manufactures (over the counter) label

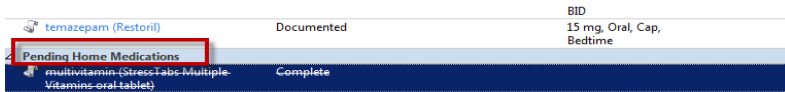
NOTE: Do not sign medications off one at a time. Stay on this screen until you have entered/ modified all home medications as needed.

To Discontinue a medication that the patient is no longer taking:

1. Select the medication you wish to remove
2. Right click and Select “Complete”



3. Medication will move to a “Pending Home Medications” list and will have a strike thru it

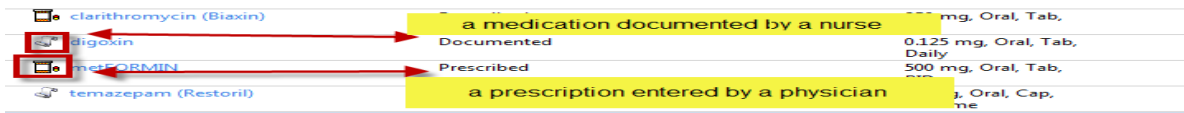


*** ICON's that appear on the Documented Home Medication Screen (BPMH)

You will notice one of two different icons next to the name of the home medication

The scroll indicating this med was documented by a nurse or pharmacy technician

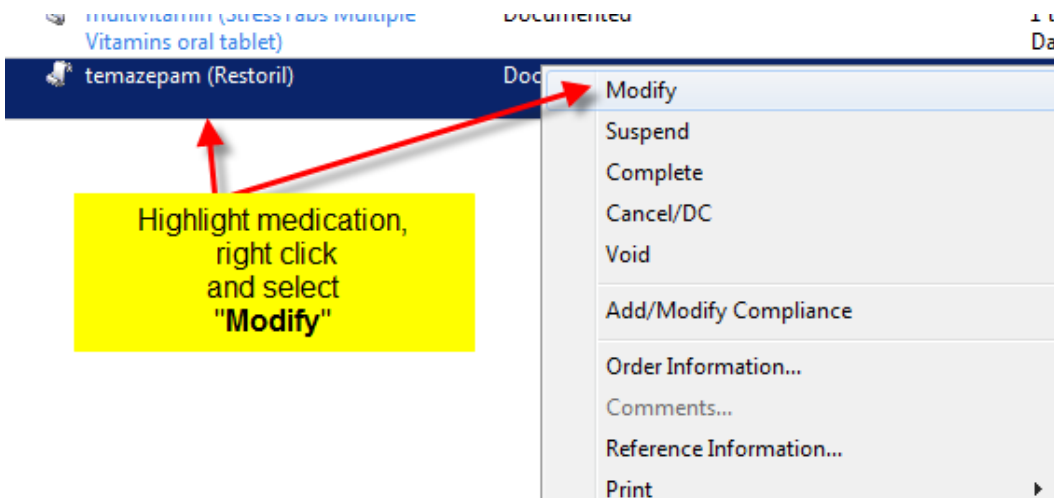
The Pill Bottle indicating the physician completed a prescription for this medication



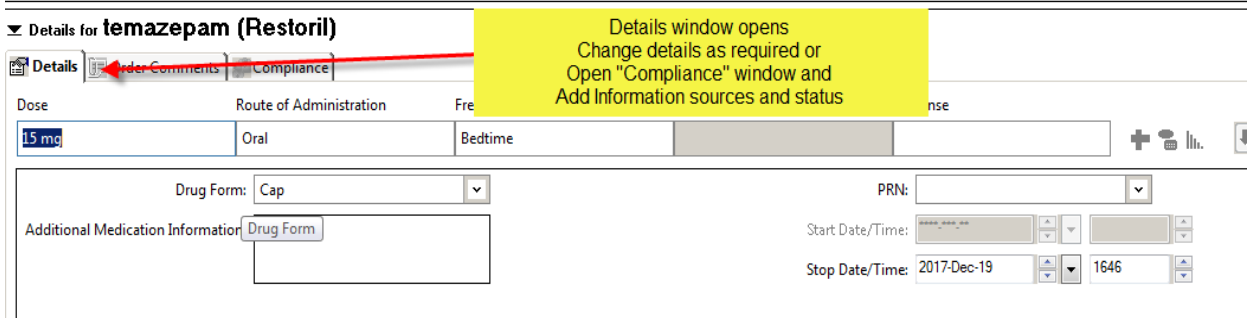
Note: a Nurse is able to modify the details of a medication documented by another nurse or a pharmacy technician. Nurses cannot modify the details of a prescription written/entered by a physician.

To Modify a Documented Home Medication

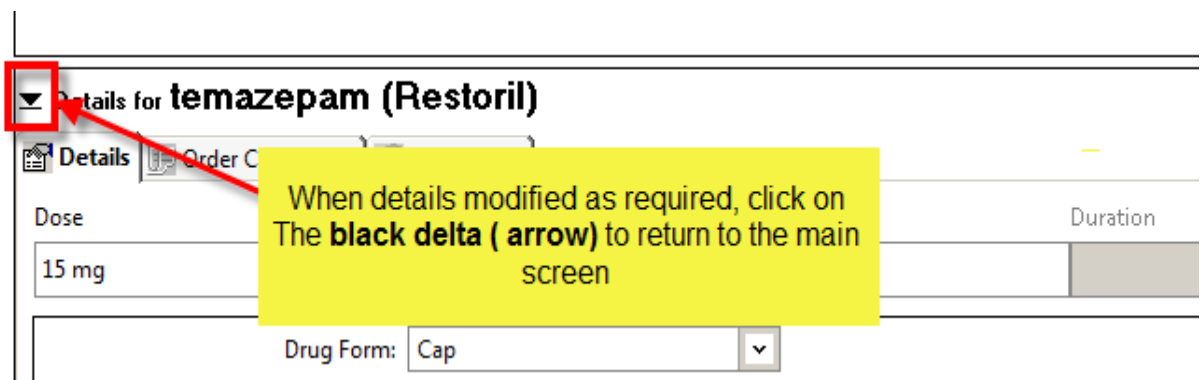
1. Right click on the medication
2. Choose Modify.



3. The Details screen will open and you can modify any detail or change the compliance as necessary

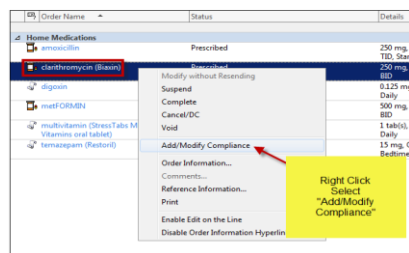


4. Click on the down arrow to return the main screen.



Dealing with Prescription Medications on the Documented Medication by History (BPMH)

1. **IF all the order details remain the same:** Complete the “Status” and “Compliance” by: Right clicking and selecting “Add/Modify Compliance”



2. **If you have additional information you wish to add:**
Click in “comment” box and add information about compliance.

▼ Details

Compliance

Status
Still taking, as directed

Comment
On day three of a three day course

Add any additional information you wish to share with other clinicians here

3. If the dose, route or frequency are different:

- Click on “Add” to enter the drug from scratch
- Follow instructions “To Add a new medication”
- When you have added the new information and compared it to the prescription for accuracy
- “Complete” the prescription as instructed in section “To Discontinue a medication patient is no longer taking”

In Review:

When completed

1. All medications should have 2 information sources and status entered
Reconciliation Status bar should display a Green Checkmark

File To Obtain Information: **BPMH not done or not signed off**

Reconciliation Status: Meds History Admission Discharge

Status: Medication history has not yet been documented. Please document the medication history for this patient encounter.

250 mg, Oral, Cap, TID, Start: 2016-Dec-... Patient/med vial/blister packs: Still taking, as directed

2. If you are entering medications and you are unable to finalize the BPMH:

- Leave the green check in the box “Leave Med History Incomplete-finish later”
- Click on “Document History”

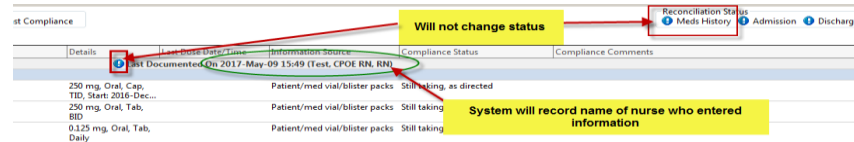
Last dose date/time: ____/____/____

If BPMH not completed

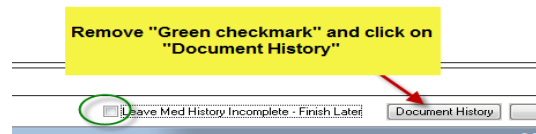
Leave Med History Incomplete - Finish Later

Document History

1. **Will** Save the information already entered
2. **Will** Record the name of the clinician who entered information, and the time the information was entered
3. **Will Not** change the Reconciliation Status

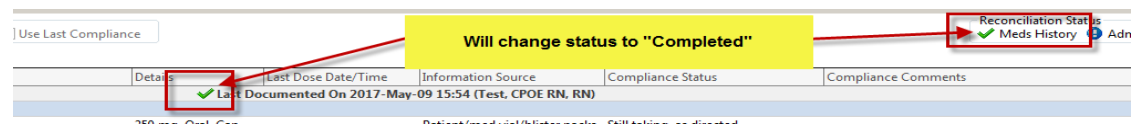


When the medication history is completed:



Removing the “Green Checkmark” will:

1. Sign the BPMH off as completed
2. Change the Reconciliation status

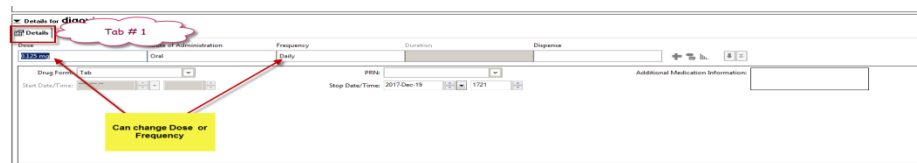


In the Order window:

There are three Tabs:

1. Details Tab

- If necessary, the Dose and Frequency may be modified in this window
- Additional Medication Information (ADI) window available to enter any additional information (for example- the dose was decreased from 0.25 mg last Tuesday at the direction of Dr. Smith)

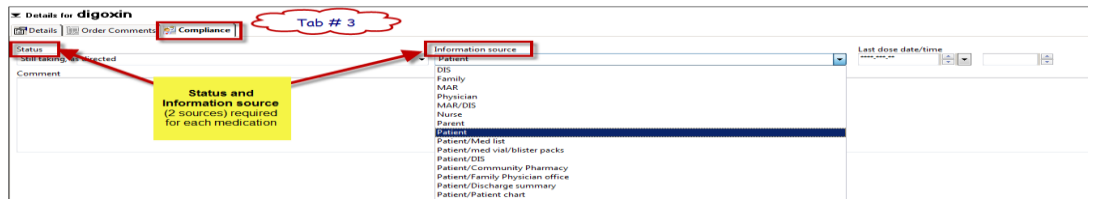


2. Order Comments Tab: **Do not use this Tab.** Information placed in this tab cannot be seen face up by the physician in the Med Reconciliation Screen.



3. Compliance Tab

- Status –Indicates if the patient is taking the medication as directed. There is a drop down menu to use for reason of non-compliance
- Information Source –two sources are required for each medication entered. Options are available in a drop down menu.



- When the “Information Source” is completed the information is visible in the medication line.
- If it is not completed then there is no information in this field.
- Information sources are a requirement for the physician medication reconciliation process

Medication history has not yet been documented. Please document the medication history for this patient encounter.

Medication	Status	Dose/Frequency	Route	Dispense
amoxicillin	Prescribed	250 mg, Oral, Cap, TID, Start: 2016-Dec-...	Patient/med vial/blister packs	Still taking, as directed
clarithromycin (Biaxin)	Prescribed	250 mg, Oral, Tab, BID	Patient/med vial/blister packs	Still taking, as directed
digoxin	Prescribed	0.125 mg, Oral, Tab, Daily	Patient/med vial/blister packs	Still taking, as directed
metFORMIN	Prescribed	500 mg, Oral, Tab, BID	Patient/med vial/blister packs	Still taking, as directed
multivitamin (Stress Tabs Multiple Vitamins oral tablet)	Documented	1 tab(s), Oral, Tab, Daily		
temazepam (Restoril)	Documented	15 mg, Oral, Cap, Bedtime		

Sourcing and Compliance done CORRECT

Sourcing and Compliance not done INCORRECT