Documenting Medication History within Cerner's PowerChart for Nurses

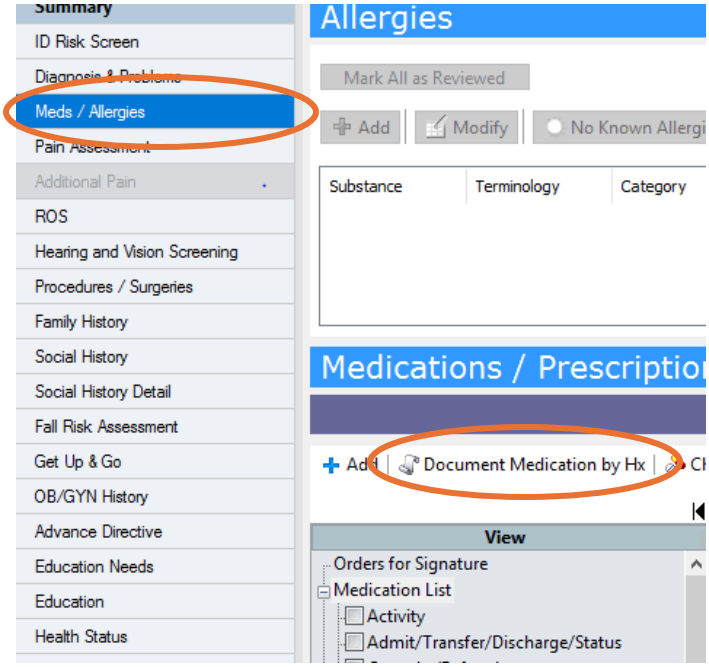
Documenting a patient's medication history in Cerner's PowerChart involves accurately entering and reviewing medication-related information to ensure precise medical records. The goal is to maintain an up-to-date and comprehensive medication list, enabling the provider to complete the medication reconciliation process. This is a nursing responsibility that needs completed for every patient visit, regardless of the type of visit.

Key Points:

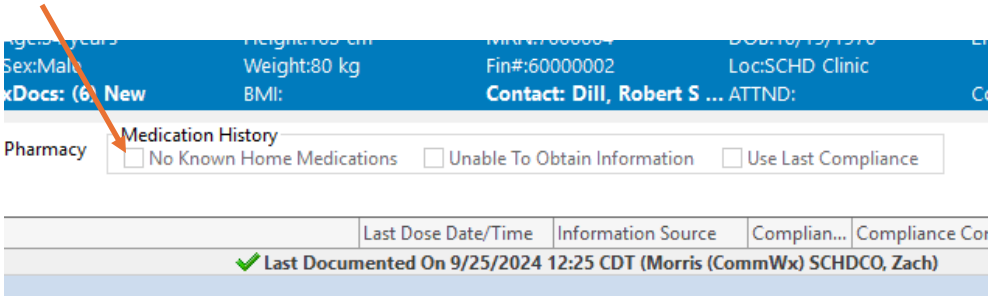
- **Conduct the Best Possible Medication History (BPMH)** to ensure the provider has the most current and accurate list for informed decision-making.
- Medications on the “Document meds by hx” screen may be outdated.
- Medication history and prescriptions may carry over from previous encounters in Cerner, potentially reflecting medications from months or years ago.
- **DO NOT** click “Document History” without verifying the information.

Steps to Document Medication History:

1. **Access the Meds/Allergies Tab:**
    - Open the patient's intake form and locate the "Meds/Allergies" tab.
    - Once open, click "Document Medication by HX."



2. **If No Medications are Being Taken:**
    - If the patient is not taking any medications at home, select the "No Known Home Medications" checkbox.



3. **Review Existing Medication History:**
    - Review the patient's current and past medication history, which may already be populated in the system. PowerChart often pulls data from previous healthcare encounters or external providers.
    - Categories to review:
        - **Current Medications:** Medications the patient is actively taking.
        - **Home Medications:** This includes prescriptions from other providers, over-the-counter medications, and herbal supplements.
4. **Document New Medication History:**
    - If the patient has new medications or updates, follow these steps:

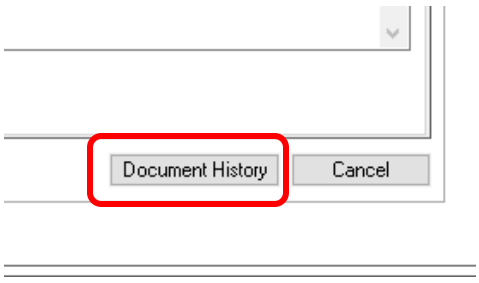
1. Click on the "Add Medication" or "Medication History" button.
2. Enter the medication details:
    - **Medication Name:** Type or select from the dropdown list.
    - **Dosage:** Specify the dosage (e.g., 50 mg, 5 mL).
    - **Route:** Indicate the method of administration (oral, IV, etc.).
    - **Frequency:** Specify how often the medication is taken (e.g., every 4 hours, daily).
    - **Start and End Dates:** Include the start and end dates (if applicable).

- **Special Instructions or Notes:** Include any relevant instructions (e.g., take with food, monitor for side effects).
- **Complete Compliance:**

0. Complete Status, Information source and Last dose
1. If patient is Not taking or is Not taking as prescribed – Add comment as to reason. (Required field)

2. Compare the medications listed in PowerChart with the patient's reported medications and make any necessary adjustments.

5. **Review and Confirm Medication History:**
   - After entering or reviewing medications, confirm that all entries are correct and up to date.
   - Double-check for any errors in dosage, frequency, or other critical details.
6. **Sign and Document:**
   - Once the medication history is complete or updated, sign off on the documentation by clicking the "Document History" button at the bottom right-hand corner.



- If completed correctly, a green checkmark will appear, confirming the entry. This allows the provider to complete the Med reconciliation.