

The Create Order and Document workflow is a process that can be used in various clinical settings, such as urgent situations. Create Order and Document does not replace the process of entering routine medications.

To ensure a medication order is entered, confirm the **7 Rights of Medication Administration: Right Patient, Right Medication, Right Dose, Right Time, Right Route, and Right Reason.**

STEP 1: Open the patient chart and confirm the patient information within the demographics banner bar.

STEP 2: At the patient's bedside, verbally/visually verify the correct patient, following hospital policies/directive.

STEP 3: Click the **Medication Administration** button within the toolbar.



STEP 4: Scan the **patient's wristband** (inpatient) or scan the **barcode** on the **NLH Labels/Wristband Sheet** (outpatient).

STEP 5: Click the **Create order and document** button.



STEP 6: Scan the medication barcode to administer.

STEP 7: Complete the details in the administration window.

- Fields **highlighted in yellow** are mandatory.

NOTE: The Dose and Volume fields will default to the mg or ml amount of the product scanned. Clinicians should update the dose administered to the patient to maintain the accuracy of the medical record.

STEP 8: Click **Sign**.

NOTE: The medication order will appear in the chart and the administration documentation will populate to the MAR once signed.

