From the Office of Health Informatics

Oracle Health (Cerner) Millennium Inpatient Medication Reconciliation

May 4, 2021

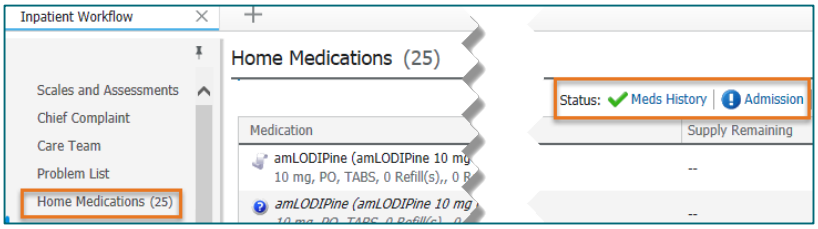
Medication Reconciliation must be completed electronically when there is a change in level of care, within 24 hours of an admission, and at discharge.

Admission Reconciliation Process

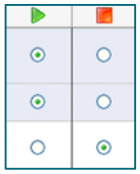
Medication Reconciliation should be completed **prior** to placing admission orders. If a completed Medication History is not available at the time of ordering, the Provider will continue placing the necessary admission orders and complete the reconciliation at a later time.

➢ Admission Process

- Navigate to the **Home Medications** component on the Workflow MPage.
  - Verify the Medication History has been reviewed and updated, as noted by the green checkmark.

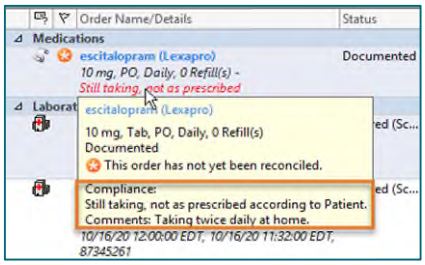


  - Select the **Admission** hyperlink to open the **Reconciliation** window.
  - The **Admission Reconciliation** window is split into two sections:
    - **Orders Prior to Reconciliation** on the left.
    - **Orders After Reconciliation** on the right.



  - The two columns between these sections contain the option to either **Continue** or **Do Not Continue** medications prior to admission.
    - **Active Orders** created prior to **Admission** or **Transfer Medication Reconciliation** will default to **Continue**.
  - After selecting the Continue option for a medication, modifications can be made by clicking the order from the **Orders After Reconciliation** section and changing the Order Details displaying in bottom portion of window.
  - The **Do Not Continue** option will <u>not</u> **Suspend** the home medication
    - These medications will be available for reconciliation on **Transfer** or **Discharge** if needed.
  - Select **Reconcile** and **Sign** button once reconciliation is complete.

NOTE: **Hovering over medications will allow Compliance Comments entered by nursing to be visible. These comments contain important information that will assist in the decision-making process.**



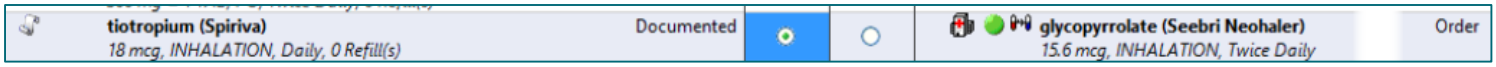
➢ **Provider Consults for Reconciliation**

- On Admission, if a Provider is not familiar with the medications/prescriptions documented in the **Medication History** by the Nurse or another Provider, they may opt to consult with the appropriate Provider regarding those particular medications/ prescriptions.
  - For example, the admitting Provider should consult with an Oncologist if unfamiliar with a patient's chemotherapy regimen before reconciling.

NOTE: **It is the Admitting Provider's responsibility to ensure that Admission Medication Reconciliation is completed.**

➢ **Auto-sub Medications**

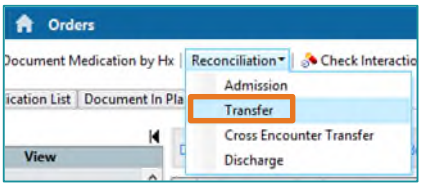
- For most medications not on hospital formulary there is a Northern Light Health approved therapeutic substitution available. When continuing a non-formulary home medication, the system will automatically substitute the approved therapeutic alternative along with its appropriate dose conversion.



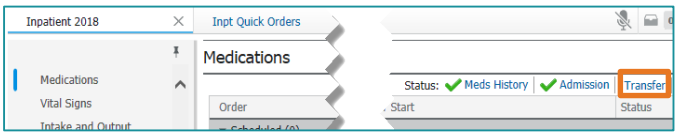
  - Free-text items can never be converted to an inpatient medication.

Transfer Reconciliation Process

- Enter the **Transfer Level of Care order** following the process for your facility.
- Open the **Transfer Reconciliation** window
  - Option 1: Select **Reconciliation** from the **Orders Toolbar** and select **Transfer** from the dropdown list
  - Option 2: Navigate to the **Medications** component on the Workflow MPage



NOTE: **Transfer reconciliation will require all active inpatient medications and home medications/ prescriptions to be addressed that were not addressed upon admission.**



- Items requiring a reconciliation action are marked with the **Unreconciled Item** icon.

- After selecting the **Continue** option for a medication, modifications can be made by selecting the order from the **Orders After Reconciliation** section and changing the order details displaying in bottom portion of window.
- If the **Do Not Continue** option is selected, the existing inpatient medication order will be discontinued.
- New medication orders can be placed by clicking + Add in upper left corner of window.
- Select the **Reconcile** and **Sign** button once reconciliation is complete. 

Discharge Process

- Navigate to the **Discharge Workflow** MPage.
- Select the **Discharge Medications** component and select the Discharge hyperlink to open the Reconciliation window.

NOTE: **The Discharging Provider must reconcile all the items within the list (Home Medication and Inpatient Medication).**

- The **Discharge Reconciliation** window includes a **Create New RX** option column.
  - Selecting **Create New RX** will start a new prescription for the selected medication order.
  - Selecting **Continue** will resume the selected medication order as it was prior to admission.
  - Selecting **Do Not Continue** will discontinue the selected medication order.

NOTE: **If the provider clicks Continue to resume a home medication upon discharge, then they need to click Do Not Continue on the inpatient version of the same medication. Providers need to exercise caution not to duplicate orders by resuming the home medication and converting the inpatient medication to a prescription at the same time.**

- Select **Continue Remaining Home Meds** to automatically reconcile the active prescriptions/ documented home medications remaining on the list.
  - Be sure to modify any prescriptions/documented home medications order details (dosage, Continue Remaining Home Meds frequency etc.) that need to be updated before selecting.
- Select **Do Not Coninue Remaining Orders** to automatically select **Do Not Continue** option for all unreconciled orders.
  - Be sure to convert any desired inpatient medications to prescriptions before selecting **Do Not Coninue Remaining Orders**.

- Select the **Reconcile** and **Sign** button once reconciliation is complete. 

Planning

Providers are able to **Plan** future Admission, Transfer or Discharge medication reconciliations. This allows for the reconciliation to then be initiated at a later date with modifications, if necessary. It is possible for one provider to plan a medication reconciliation and have a different Provider initiate it.

➢ **Open the appropriate Medication Reconciliation window.**

- Complete reconciliation process.
- Select **Reconcile** and **Plan**.

NOTE: **Active orders created prior to Admission or transfer medication reconciliation will default to Continue.**

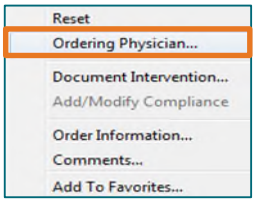
- A **Pending Indicator** will display in the **Reconciliation Status Toolbar** when there is a **Planned Reconciliation**.
  - Hover the mouse of the indicator to display additional information.
  - Orders in the pending status will not appear on the **Orders Profile** until signed.

NOTE: **A Planned Transfer Reconciliation must be Signed before the Discharge Reconciliation will be able to be completed.**

Modifying and Initiating Planned Reconciliations

➢ Modifications can be made to a **Planned Medication Reconciliation**.

- Additional orders can be added by clicking Add.
- Right-click any order on the right side of the screen, to **Modify** the **Order Details** or remove the order prior to signing.
- If modifications are made or orders are added, the reconciliation can be re-planned.
- To modify a prescription in another Provider's Planned Medication Reconciliation, the prescription details will have to be modified and the Ordering Physician updated.
  - Right-click the modified planned order and select **Ordering Physician** from menu to update.



NOTE: **The Ordering Physician is not automatically updated by the system.**

- Selecting **Reconcile** and **Sign** will complete medication reconciliation and all orders will be active.