From the Office of Health Informatics

Quick Reference Guide (QRG)
Document Home Medications

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This Quick Reference Guide (QRG) reviews the steps for documenting home medications.

Common Buttons & Icons

Patient Pharmacy	**Patient Pharmacy** toolbar icon
	**Pill Bottle** icon
	**Paper Scroll** icon

	Scratch pad dropdown arrow
	**Missing Details** icon
	**Add** icon
	**Refresh** icon

Document a Patient Preferred Pharmacy

➢ **From the Ambulatory View, Ambulatory Nursing workflow page within the patient's chart:**

STEP 1: Click **Patient Pharmacy** from the toolbar.

STEP 2: Enter any information needed to help filter results; then click **Search**.

NOTE: **If a patient has no preferred pharmacy the Preferred Pharmacy window will default to the Search tab.**

STEP 3: Right-click the appropriate pharmacy.

STEP 4: Click **Add to Patient Preferred**.

NOTE: **A patient can have up to 5 preferred pharmacies.**

STEP 5: Click the **Patient Preferred** tab to review that the pharmacy was added.

STEP 6: Hover over the pharmacy name to gather additional location and contact details.

STEP 7: Set a default preferred pharmacy by right-clicking the selected pharmacy; then click **Set as Default**. The default pharmacy will be listed in bold text.

STEP 8: Click **OK**.

Remove a Patient Preferred Pharmacy

➢ **From the Ambulatory View, Ambulatory Nursing workflow page within the patient chart:**

STEP 1: Click **Patient Pharmacy** from the toolbar.

STEP 2: Click the **Patient Preferred** tab.

STEP 3: Right-click the pharmacy to be removed.

STEP 4: Click **Remove**.

STEP 5: Click **OK**.

Document No Preferred Pharmacy

➢ **From the Ambulatory View, Ambulatory Nursing workflow page within the patient's chart:**

STEP 1: Click **Patient Pharmacy** from the toolbar.

STEP 2: Select the **No Preferred Pharmacy** check box.

NOTE: **Only prescriptions within the United States can be submitted electronically. Out of the country pharmacies will not populate in a pharmacy search, there are also pharmacies not in the system. Document No Preferred Pharmacy in these situations.**

STEP 3: Click the **Reason** dropdown arrow; click the appropriate Reason.

STEP 4: Click **OK**.

Document Home Medication

➢ **From the AMB Nursing 2018 MPage within the patient's chart:**

STEP 1: Click **Home Medications** in the Ambulatory Nursing workflow menu.

STEP 2: Click the blue **Meds History** hyperlink.

STEP 3: Review patient medication.

NOTE: **The Pill Bottle icon indicates a Northern Light Health provider prescribed medication. The Paper Scroll icon indicates that the medication was added to the list by clinical staff at a Northern Light Health location.**

STEP 4: Modify medication details using the right-click menu. Right-click the medication; then click **Modify**.

NOTE: **Multiple medications can be selected and changes made to modify the details one time for all selected medications. Click the first medication then hold down the CTRL key and select the additional medications needed.**

STEP 5: Click the fields that need modification. Preset options display. Click the option needed.

NOTE: **If what is needed is not listed, type the first two or three letters of what is needed, and a list will populate. Click the appropriate selection.**

STEP 6: Click the medication scratch pad dropdown arrow to close the scratch pad.

STEP 7: Click **Document History** once completed.

STEP 8: On the Ambulatory MPage, click the **Refresh** icon.

Modify Compliance

➢ **From the Document History window**

STEP 1: Right-click the medication.

NOTE: **Multiple medications can be selected and changes made to modify the details one time for all selected medications. Click the first medication then hold down the CTRL key and select the additional medications needed.**

STEP 2: Click **Add/Modify Compliance**.

STEP 3: Click the **Status** dropdown arrow.

STEP 4: Click the appropriate status.

STEP 5: Input additional compliance information as needed.

STEP 6: Click **Document History** once completed.

STEP 7: On the Ambulatory MPage, click the **Refresh** icon.

Add a New Medication (including Herbal Supplements)

- **From the medication list in the patient's chart:**

STEP 1: Click the **Add** icon.

STEP 2: Type the name of the medication or supplement in the **Search** field.

NOTE: **Search folders can also be used to find medications. Click the folder matching the first letter of a frequently used medication.**

STEP 3: Click the name of the medication needed from the populated list.

STEP 4: Click **Done**.

STEP 5: Click **Document History** once completed.

STEP 6: On the Ambulatory MPage, click the **Refresh** icon.

Adding a New Medication with Missing Information

- **From the medication list in the patient's chart:**

STEP 1: Click the **Add** icon.

STEP 2: Type freetext; then click **Freetext Item Name**.

STEP 3: Click the appropriate order sentence; then click **OK**.

STEP 4: Click **Done**.

STEP 5: Click the available fields and dropdown arrows to add any available information for the Freetext item in the **Freetext Details** scratch pad. Best practice is only to enter whatever information the patient can remember with certainty.

STEP 6: Document special instructions as needed.

NOTE: **Best practice is to note in the Special Instructions field when and if the patient will get the additional information for documentation.**

STEP 7: Click **Document History** once completed.

STEP 8: Back on the Ambulatory MPage, click the Refresh icon.

Document External Rx History

- **From the Ambulatory View AMB Nursing 2018 Workflow page with the patient's chart:**

STEP 1: Click **Home Medications** from the Amb Nursing 2018 workflow.

STEP 2: Click the blue **Meds History** hyperlink.

STEP 3: Click the **External Rx History** dropdown arrow.

STEP 4: Click **Import**.

NOTE: **An Rx History Patient Consent window will populate if permission was not already given. If the office consent forms were signed, then consent has been given. Click Consent Granted as appropriate.**

STEP 5: Click the **Display** dropdown arrow to set how much information is visible.

STEP 6: Click the **wanted timeframe**.

NOTE: **12 months is the default timeframe.**

STEP 7: Click the **Pill Bottle** icon for medications that need to be converted to a prescription.

STEP 8: Click the **Paper Scroll** icon for medications that need to be documented as a home medication.

STEP 9: Document **Order Sentences** as needed.

STEP 10: Click and drag up the scratch pad with a selected medication as needed to document medication details.

STEP 11: Click the appropriate fields and tabs to document details as appropriate.

NOTE: **Best practice is to complete Rx compliance when reviewing medications with the patient.**

STEP 12: Scroll left to view medication details.

STEP 13: Click **Document History**.