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This User Guide is developed to help you understand how to document a patient’s best possible medication history (BPMH).

**MEDICATION SAFETY**

Safe patient care depends on accurate medication information. Patients benefit when clinicians work with patients, family and their colleagues to collect and share current and comprehensive medication information.

Documenting the best possible medication history (BPMH) is the cornerstone of the medication reconciliation process. All subsequent steps in the process depend on an accurate and complete BPMH.

**MEDICATION ERRORS IMPACT EVERYONE**

Adverse medication events affect patients, family and our health care system. Communicating effectively about medications is a critical component of delivering safe care. Without it, patients are at risk.

**WHO SHOULD OBTAIN THE BPMH?**

The most appropriate regulated health professional who sees the patient. This could be a nurse, nurse practitioner, provider, pharmacist, pharmacy technician or others whose scope of practice includes this activity.

The professional assigned the role of obtaining the BPMH should:

1. receive formal training on how to obtain a BPMH;
2. use a systematic approach/process;
3. be responsible for verifying medication information with the patient or family member.

**WHEN IS THE BPMH OBTAINED?**

The BPMH must be completed within 24 hours of admission.

You need to:

1. conduct patient interview and obtain history;
2. document medication history in PowerChart.
THE BPMH INTERVIEW

Be proactive

Gather as much information as possible prior to seeing the patient. Include primary medication histories, provincial database information (i.e. Ontario Drug Benefit, Drug Profile Viewer) and medication vials/lists.

A good BPMH uses at least two different sources of information.

Suggested sources:

- Electronic provincial medication record
- Medication vial/community pharmacy records
- Patient own medication list (paper or electronic)
- Prescriber referral/consultation notes
- Previous admission records
- Home care reconciled medication list
- Ambulatory clinic medication records
- Most current MAR
- Discharge medication plan
- Pharmacy records

Use a systematic approach

Some clinicians like to take a head-to-toe approach when interviewing a patient, but you may have a different approach.

Ask the right, specific questions to obtain an efficient, comprehensive and accurate best possible medication history.
## Ask about different types of medications

It is important to ask your patient about several types of medications they may be taking. The next section provides you with some sample interview questions.

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Interview Questions</th>
</tr>
</thead>
</table>
| **Prescriptions**                                    | **What prescription medications do you take?**  
These include anything you can only obtain with a doctor’s order, such as heart pills and sleeping pills. |
| **Antibiotics**                                       | **Have you used antibiotics in the past three (3) months?**  
What are they? Why were you taking these? |
| **Inhalers, patches, creams, ointments, injectables, samples** | **Do you use inhalers, medicated patches, medicated creams or ointments, injectable medications, e.g., insulin?**  
How do you take these, including name, strength and how often?  
Did your doctor give you any medication samples to try in the last few months?  
What are the names? |
| **Eye, ear, nose drops**                              | **Do you use any eye drops?**  
* What are the names?  
* How many drops do you use?  
* How often?  
* In which eye?  

**Do you use ear drops?**  
* What are the names?  
* How many drops do you use?  
* How often?  
* In which ear?  

**Do you use nose drops/nose sprays?**  
* What are the names?  
* How do you use them?  
* How often? |
| **Over-the-counter**                                  | **Do you take any medications that you buy without a doctor’s prescription?**  
Give examples, i.e., Advil, Aspirin.  
How do you take the medication? |
| **Vitamins, minerals, supplements**                   | **Do you take any vitamins, minerals, supplements?**  
How do you take them?  
Do you ever take recreational drugs, e.g., alcohol, marijuana?  
How do you take them and how often? |
DOCUMENTING MEDICATION HISTORY ELECTRONICALLY

1. Login to PowerChart and open patient’s chart to the Medication List page.
2. Click Document Medication by Hx.

Documented medications will continue to appear on the electronic health record (EHR) as the patient moves through subsequent encounters, such as clinic, emergency or inpatient visits.

3. So, if your patient has been a patient at a London or regional hospital there may be medications documented here from previous encounters.

4. However, if your patient has not been a patient at a London or regional hospital there will be no medications documented here from previous encounters.

When a medication history is unknown or non-existent

When a medication history is unknown or non-existent, the proper method for indicating this is found in the check boxes located in the upper left-hand corner of the Document Medication by Hx window.
Let’s learn about each of these checkboxes.

<table>
<thead>
<tr>
<th><strong>No Known Home Medications</strong></th>
<th>Only available as a selection if the patient has NOT had any medications entered in the system in the past. Should be checked off when the patient has no known home medications.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unable to Obtain Information</strong></td>
<td>If you are unable to obtain medication information, e.g., the patient is confused or unable to speak and no family is present, then this option should be selected. The nurse will try to gain information within 24 hours of the admission time, and if that time passes, a system-generated reminder to re-address BPMH will appear the next time the nurse logs in to PowerChart (Orders page and Task List).</td>
</tr>
<tr>
<td><strong>Use Last Compliance</strong></td>
<td>Only available if the patient HAS had a prior encounter with entries made. Should only be used if ALL of the medications and compliance details are unchanged since the last encounter.</td>
</tr>
</tbody>
</table>

Adding known medications to medication history

1. Click the Add icon in the Document Medication by Hx window.
2. The Add Order window opens.
3. Use the Search field to type the name of the medication you are documenting or click one of the Common Home Meds folders to search for it.
4. If typing the medication in the **Search** field, the most relevant orders are displayed in a pop-up list to help speed your selection.

![Image of a pop-up list with medication orders]

5. If you don’t see the order you need in the pop-up list, press **Enter** on your keyboard to view all of the other search results by relevance.

6. Notice that many of these results include an order sentence.

   **If you know the dose, route and frequency of the medication the patient is taking:**

   ✓ **Choose an order sentence.**

   ![Image of a selected order sentence]

   ✓ The order sentence particulars will auto fill into the **Details** pane, which saves time in documenting the history.

   ![Image of the Details pane filled with order sentence details]

   These details can, however, be modified if needed.
If you don’t know the dose, route and frequency of the medication the patient is taking:

✓ Choose the primary drug name.

✓ You will then be required to complete each field in the Details pane, which takes longer documenting the history, but is necessary for accurate documentation downstream.

Important Note: If typing information into a field in the Details tab, you must press the ENTER key on your keyboard to accept the information that was typed. Sometimes PowerChart will prompt you to do so with a yellow information box, but not always.

7. Once you add your first medication, notice that the Add Order window remains open with the Document Meds by Hx window in the background.
8. This allows you to continue searching and adding other medications – you do not need to add each medication separately.

You can search for and document most commercially-available vitamins, minerals and supplements from the medication catalogue. However, the medication catalogue does not include any homeopathic remedies and research medications.

9. Once you have added all of your patient’s home medications, click the button in the Add Order window.

Addressing medication details for each documented medication

The medications will be listed in the Document Medications by Hx window. The top portion of the window displays the medications you documented. The bottom portion displays order details, order comments and compliance.

Next, you need to review the details of each medication and revise, if necessary.
Details tab

1. You may have chosen an order sentence closest to the information your patient indicated, i.e., frequency of daily but the patient actually takes the medication on alternate days. You would need to change the Frequency field here from daily to alternate days.

   **Remember:** If typing information into a field in the Details tab, you must press the ENTER key on your keyboard to accept the information that was typed.

2. However, compliance information should NEVER be entered in the Details tab.

Compliance tab

Address compliance for EACH medication using the Compliance tab.

1. Click the medication name and then click the Compliance tab.

2. The Status field defaults to Still taking, as prescribed.

3. Click the down-arrow beside this field to see other options, if you need to change.

   - Still Taking Not As Prescribed compliance

   If you change the compliance to Still Taking Not As Prescribed, you must type a comment in the *Comment field – the title will flash – e.g., Still taking but only every other day.
Started in Sending Hospital compliance

When patients present to one of our hospitals from an external hospital, it can be difficult for providers and health care staff to determine which medications in the medication history are actually home medications and which ones were started at the sending hospital.

A new compliance code was added to make this documentation simpler. It also provides face-up information for providers when completing Discharge Medication Reconciliation.

It is to be used for those medications that a patient was not taking at home but has started at the referring hospital and will appear as Started in Sending Hospital on the Discharge Medication Reconciliation.

4. Always double-check the **Information source** and document the **Last dose date/time** if the patient knows it.

| Details for levothyroxine (Synthroid 75 mcg (0.075 mg) oral tablet) |
|----------------|----------------|----------------|
| **Status** | **Information source** | **Last dose date/time** |
| Still taking, as prescribed | Patient | 2015-09-24 |

Adding unknown medications to medication history

Search for and use the **medication template/nonformulary** only when unable to find the medication or to use as a placeholder while investigating exactly what the patient is taking, e.g., “I take a pink pill for blood pressure.” It is useful to check other resources, i.e., community pharmacy list, to see if this medication can be named and thus entered correctly into the EHR.

It is important to know that the entries generated through this method cannot be reconciled. They will appear on the list of medications but will not be matched to any entries in the pharmacy catalogue of existing or formulary medications.

1. Click the ✗ Add icon in the **Document Medication by Hx** window.
2. The **Add Order** window opens.
3. Type medication in the **Search** field.
4. Click **medication template/nonformulary** from the list of results.

5. Remember, once you have added all of your patient’s home medications; click the **Done** button in the Add Order window.

6. Complete the details accordingly.

7. For the **medication template/nonformulary** there are no mandatory fields to complete.

**CLEANING UP A MEDICATION HISTORY LIST**

Completing a medication

There may be situations where it is necessary to remove medications from a patient’s documented medication history. There may be medication duplications in the form of previous discharge prescriptions, trade name vs. generic name errors, or the patient is no longer be taking the medication.

To complete a medication:

1. From the Document Medication by Hx page, right-click the medication you need to remove (complete).
2. Click Complete.

3. When all Document Medication by Hx medications have been reviewed, added, and/or modified and medication history is complete, click the button.

Modifying a medication

There may be situations in which a patient:

a. is still taking a medication on the Medication by Hx page, but some of the medication order details have changed and you need to modify these details, or
b. is still taking a medication on the Medication by Hx page but the compliance details have changed and you need to modify these compliance details.

To modify a medication or modify compliance:

1. From the Document Medication by Hx page, right-click the medication you need to modify.
2. Click Modify if changes need to be made to the order details.
3. Click Add/Modify Compliance if only the compliance information needs to be updated in the Compliance tab.
4. Make the appropriate changes to the medication order and/or compliance.

5. When all Document Medication by Hx medications have been reviewed, added, and/or modified and medication history is complete, click the button.

Remember documenting an accurate BPMH is the cornerstone of medication reconciliation. An inaccurate BPMH may have adverse downstream consequences.

MEDICATION HISTORY IS INCOMPLETE – NEED TO FINISH LATER

1. Notice the Leave Med History Incomplete - Finish Later check box is unchecked by default.

2. Only check this box if you are unable to obtain a complete medication history, so others will know the BPMH has not been fully completed.

MEDICATION HISTORY IS COMPLETE – FINAL STEPS

Once you have obtained and documented a complete medication history for your patient, you are ready to save this best possible medication history and return to the patient’s chart.

1. Click the button at the bottom right of the Document Medication by Hx window.

2. You are returned to the patient’s chart. The icon in front of each medication on the Medication List indicates it was documented manually (home medication) and is not a medication order.
3. Also the **Reconciliation Status** dashboard, located at the top right of the **Medication List** page displays a ✅ to indicate **Meds History** is complete.

![Reconciliation Status](image)

**CHANGE MEDS HISTORY FROM COMPLETE TO INCOMPLETE**

If **Meds History** has a green checkmark and you know the history is incomplete, you can change the green checkmark to an incomplete status.

1. Right-click **Meds History** in the **Reconciliation Status** dashboard.
2. Click **Reset**.
3. The ☠️ beside **Meds History** indicates that the medication history is not complete.
4. Click **Document Medication by Hx** to complete the history.

**UNDERSTANDING THE MEDICATION HISTORY SNAPSHOT**

**Medication History Snapshot** is a view-only window that provides static views of a patient’s home medication list at known points in time.

**Benefits of the Medication History Snapshot**

- Ability to view clinicians that contributed to patient’s medication list.
- Ability to view home medications known at a point in time to make clinical decisions.
- Ability to view home medications known at a point in time for reporting purposes.
- Ability to show the progression of changes in the patient’s medication list.
- Ability to view home medications before changes were made, such as discharge reconciliation, when the patient’s condition changed.
Opening and using the Medication History Snapshot

The Medication History Snapshot is available from the navigation pane within the Orders and Medication List page.

The Medication History Snapshot is recorded each time a change to the medication history is documented; for instance, when:

- additional home medications or prescriptions are added;
- any documented home medication or prescription has been modified, canceled/discontinued, completed, etc.;
- compliance information is updated; and
- there is a change in Hx or Rx status due to medication reconciliation.

The snapshots within each time frame are sorted reverse chronologically and the individual orders within the snapshots are sorted alphabetically.

Each snapshot has a header row that specifies the date and time the snapshot was generated and the name of the clinician who took an action that caused the snapshot to be generated.
You can change the time frame for the displayed snapshots to **This Visit**, **6 Months**, **1 Year**, or **All Visits**.

<table>
<thead>
<tr>
<th>Order Name/Details</th>
<th>Last Updated</th>
<th>Compliance Status</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin (500 mg oral capsule)</td>
<td>2015/09/25 08:41</td>
<td>Discharge Reconciliation</td>
<td>Heds History</td>
</tr>
<tr>
<td>Cholecalciferol (Vitamin D3 1000 IU units oral bottle)</td>
<td>2015/09/25 08:41</td>
<td>Documented</td>
<td></td>
</tr>
<tr>
<td>Fluoxetine (30 mg oral tablet)</td>
<td>2015/09/25 08:41</td>
<td>Documented</td>
<td></td>
</tr>
<tr>
<td>Levothyroxine (Synthroid 50 mcg (0.5 mg) oral tablet)</td>
<td>2015/09/25 08:41</td>
<td>Documented</td>
<td></td>
</tr>
</tbody>
</table>

The **Expand All** hyperlink displays all medication details for each snapshot. The **Collapse All** hyperlink displays only the header rows of each snapshot.

Individual snapshots can be expanded or collapsed by clicking the rotating triangles in the snapshot header row.
Selecting a medication from one snapshot will highlight that same medication in other snapshots.

<table>
<thead>
<tr>
<th>Order Name/Details</th>
<th>Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>amoxicillin (amoxicillin 500 mg oral capsule)</td>
<td>2015/09/25 08:41</td>
</tr>
<tr>
<td>cholecalciferol (vitamin D3 1000 IU units oral tablet)</td>
<td>2015/09/25 08:41</td>
</tr>
<tr>
<td>furosemide (Lasix 20 mg oral tablet)</td>
<td>2015/09/25 08:41</td>
</tr>
<tr>
<td>levothyroxine (Synthroid 50 mcg (0.05 mg) oral tablet)</td>
<td>2015/09/25 08:41</td>
</tr>
<tr>
<td>levothyroxine (Synthroid 75 mcg (0.075 mg) oral tablet)</td>
<td>2015/09/25 08:41</td>
</tr>
<tr>
<td>cyanocobalamin (Vitamin B12 1200 mcg oral tablet, extended release)</td>
<td>2015/09/24 13:00</td>
</tr>
<tr>
<td>levothyroxine (Synthroid 75 mcg (0.075 mg) oral tablet)</td>
<td>2015/09/24 13:00</td>
</tr>
<tr>
<td>pyridoxine (vitamin B6 100 mg oral tablet)</td>
<td>2015/09/24 13:00</td>
</tr>
<tr>
<td>cyanocobalamin (Vitamin B12 1200 mcg oral tablet, extended release)</td>
<td>2015/09/24 13:00</td>
</tr>
<tr>
<td>levothyroxine (Synthroid 75 mcg (0.075 mg) oral tablet)</td>
<td>2015/09/24 13:00</td>
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</table>