

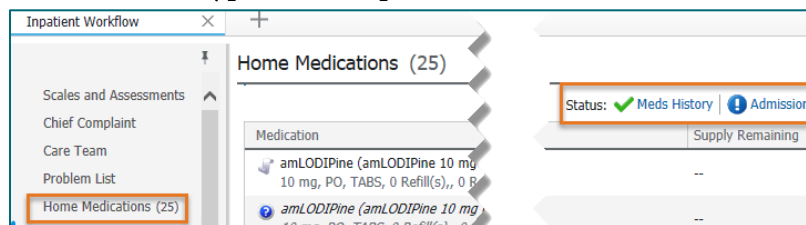
**Medication Reconciliation must be completed electronically when there is a change in level of care, within 24 hours of an admission, and at discharge.**






## Admission Reconciliation Process

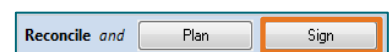
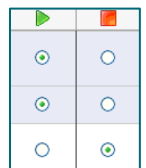
Medication Reconciliation should be completed **prior** to placing admission orders. If a completed Medication History is not available at the time of ordering, the Provider will continue placing the necessary admission orders and complete the reconciliation at a later time.

### ➤ Admission Process

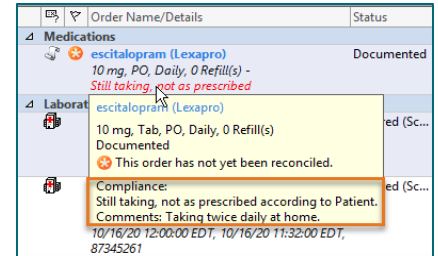
- Navigate to the **Home Medications** component on the Workflow MPage.
  - Verify the Medication History has been reviewed and updated, as noted by the green checkmark.
  - Select the **Admission** hyperlink to open the **Reconciliation** window.



- 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 not **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.



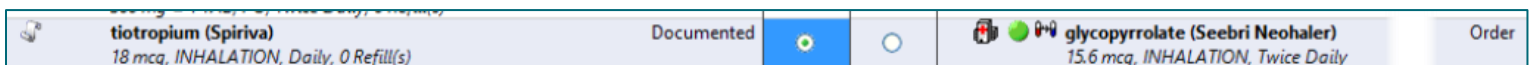
➤ **Provider Consults for Reconciliation**

- 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**

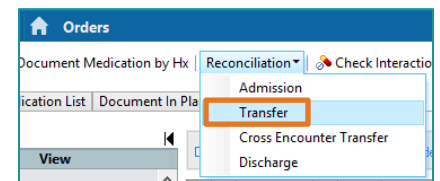
- For most medications not on hospital formulary there is a Northern Light Health approved therapeutic substitution available. When continuing a non-formulary home medication, the system will automatically substitute the approved therapeutic alternative along with its appropriate dose conversion.



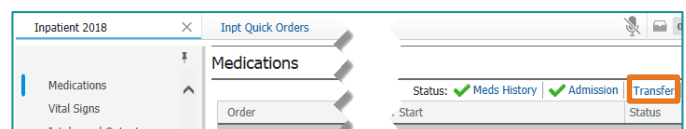
- Free-text items can never be converted to an inpatient medication.

**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 drop-down list
  - Option 2: Navigate to the **Medications** component on your 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.

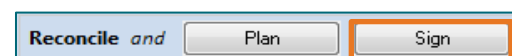
**NOTE:** The **Discharging Provider** must reconcile all the items within the list (Home Medication and Inpatient Medication).

- 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, frequency etc.) that need to be updated before selecting **Continue Remaining Home Meds**.
- Select **Do Not Continue 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 Continue 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.

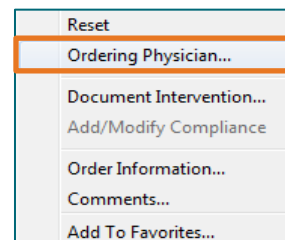
- A Pending Indicator  will display in the Reconciliation Status Toolbar when there is a **Planned Reconciliation**.
  - Hover the mouse of the indicator to display additional information.
  - Orders in the pending status will not appear on the **Orders Profile** until signed.

**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.