Introduction to medication reconciliation in Epic

Medication reconciliation (med rec) is the process of comparing a patient's current orders with new orders you're writing. To maintain a complete and accurate list of medications, reconcile medications at the following times:

- Upon admission
- Before transferring a patient to another inpatient unit with a different level of care
- Upon discharge

Reconcile medications upon admission

To begin, open the Admission Orders section of the Admission Navigator. The Admit Orders Navigator opens.

A. The navigator sections guide you through the five stages of admission medication reconciliation, described in more detail on the following pages.

B. The summary pane on the right shows a summary of your ordering decisions and orders that still need reconciliation.

Review Home Medications

The nurse or pharmacy tech usually updates the Review Home Medications section (also known as the Review Prior to Admission Medications section), but you can if needed. Review and update home medications as you verbally verify them with the patient. Prescriptions from previous visits and patient-reported medications appear here.

- To document the last time the patient took each medication, click a time button (Today, Yesterday, etc.).
- To add a patient-reported medication to the list, look it up in the Add field as you do when entering a new order. Document the time of the last dose and click Accept.
- To indicate that a patient is no longer taking a medication, click , enter a discontinue reason, and click Accept. The medication is removed from the home medications list.
- To delete a medication that was added in error, click , click Delete, and click Accept.
- To add a comment about a medication, click . The comment appears highlighted in yellow for you and other clinicians.
- If a nurse has flagged a medication to be discontinued, it appears with a reason as pictured below.
  - If you agree, discontinue the medication in the Reconcile Home Medications section.
  - If you disagree, hover over the medication and click to keep the order on the home medications list.
  - If the medication was added in error or the patient is no longer taking the medication, hover over the medication and click and delete or discontinue it as appropriate by clicking X.
• To indicate that the home medications are up to date, select Provider Complete in the Med List Status field and click ✓ Mark as Reviewed.

I. Review Current Orders

In the Review Current Orders section, determine which orders to continue during the admission. Typically, only patients being admitted from the ED or OR have orders to review here. Direct admit patients might have orders to review if you placed verbal or telephone orders before starting medication reconciliation.

• To continue an order as written, click Continue.
• To discontinue an order, click Discontinue.
• To continue an order with changes, click Modify and edit the order details. Click Accept when finished.
• To review your decisions and find out which orders still need review, refer to the summary pane. The header turns green when you've reviewed all the orders.

Click Find Orders Needing Reconciliation to highlight the orders you haven't reviewed.
2. Reconcile Home Medications

In the Reconcile Home Medications section (also known as the Reconcile Prior to Admission Medications section), determine which home medications to order for the admission. Click a button next to each order to indicate your decision. To review your decisions and find out which orders still need review, refer to the summary pane.

<table>
<thead>
<tr>
<th>If the patient...</th>
<th>Then click...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should continue to receive the medication while admitted</td>
<td>Order (A new inpatient order is written)</td>
</tr>
<tr>
<td>Shouldn’t receive the medication while admitted</td>
<td>Don’t Order (Hold during admission)</td>
</tr>
<tr>
<td>Should receive an alternative medication</td>
<td>Replace (and select another medication)</td>
</tr>
<tr>
<td>Was taking the medication prior to admission but should stop when discharged</td>
<td>Discontinue</td>
</tr>
</tbody>
</table>

Reconcile Prior to Admission Medications

Flag for Review

*Hasn’t been taking regularly because it upsets her stomach* (Edit Note)

Orders Needing Review

- aspirin-acetaminophen-caffeine (EXCEDRIN MIGRAINE) 250-250-65 MG per tablet
  - None Entered Informant: Self, Last Dose: 9/1/2015 at 0700
- fluticasone-salmeterol (ADVAIR DISKUS) 250-50 MCG/DOSE diskus inhaler 1 puff
  - 1 puff, Inhalation, 2 times daily, First Dose Today at 2135
  - Rinse mouth with water after use to reduce aftertaste and incidence of candidiasis. Do not swallow.
  - This order was created from fluticasone-salmeterol (ADVAIR DISKUS) 250-50 MCG/DOSE diskus inhaler
3. New Orders
In the New Orders section, write new orders individually or using an Order Set.

A. To write orders individually, use the **Additional Admission Orders** field.

1. Enter a few letters of the order name in the **Search** field and press **Enter**. A list of matching orders appears.
2. Double-click an order to select it.
3. If necessary, click the order details to modify them. 🟠 means that an item is required.

B. To quickly place multiple orders related to a specific problem or diagnosis, use an Order Set. Select one of the suggested Order Sets, or search for one in the Order Sets and Pathways field.

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You can use an Order Set for some orders and then add more orders individually.
- If an order is related to orders in the Order Set, click **Add Order** at the top or bottom of the Order Set and search for the order as usual. The order will be grouped with the Order Set orders in reports. Note: The order isn't permanently added to the Order Set.
- If an order isn't related to the Order Set, scroll to the **Additional Admission Orders** field below the Order Set and search for the order as usual.

Refer to the Orders guide for more information about writing orders.
4. Review and Sign

In the Review and Sign section (also known as the Summary section), review all ordering decisions in the summary pane. You can change the details of an order by clicking the order name. To discontinue an order or place new orders, go back to the appropriate section of the Admit Orders Navigator.

When all of the orders are correct, click **Sign** or **Sign & Hold - Will Be Initiated by Receiving Unit**. The button that appears depends on whether the patient has arrived on your unit.

If you sign admission orders and then need to make a change, go back to the Admit Orders Navigator and make your changes in the Review Current Orders section. Then go to the Review and Sign section and sign or sign and hold the modified orders.
Reconcile medications upon transfer

Open the Transfer Orders section of the Transfer Navigator. It's similar to the Admit Orders Navigator, but has fewer sections. Work through the following sections:

1. **Review Current Orders**: Determine which orders to continue on the new unit.
2. **Reconcile Home Medications**: Change decisions made about home medications upon admission, based on changes in the patient’s condition.
3. **New Orders**: Write the order to transfer the patient and any new orders to be carried out on the new unit.
4. **Review and Sign**: Review all your ordering decisions in the summary pane and sign and hold the orders. The order to transfer is sent to bed planning staff. All other orders are held until the patient arrives in the new unit and the staff there release them.

If you sign and hold transfer orders and then need to make a change, go back to the Transfer Navigator and open the Transfer Orders section. Make your changes to the order in the Review Current Orders section. Then go to the Review and Sign section and click **Sign & Hold - Will Be Initiated by Receiving Unit**.

Refer to p. 1 for more details about each section.
Reconcile medications upon discharge

Open the Discharge Orders section of the Discharge Navigator. It’s similar to the Admit Orders Navigator, but has fewer sections. Work through the following sections:

**Review Home Medications**: Review and update home medications, if needed.

1. **Review Orders for Discharge**: Determine which home medications to resume and which inpatient orders to prescribe. If a home medication was ordered for the patient upon admission, both the original home medication and the associated inpatient order appear linked for your reference.

2. **New Orders**: Write the order to discharge the patient, any final inpatient orders (indicated by 🏥), and any additional discharge orders (indicated by 🏥).

3. **Review and Sign**: Review all of your ordering decisions in the summary pane and sign the discharge orders. If you are entering discharge orders in advance, click **Save Work - Complete Later** to save the orders. Otherwise, click **Sign - Print and/or E-prescribe Now**.

Refer to p. 1 for more details about each section.
**Discharge and readmit a patient**

If the patient is being discharged and readmitted to another facility using Epic, go to the Discharge Navigator and select the **Discharge Readmit** tab. Then open the D/C Readmit Orders section to reconcile medications.

1. **Review Current Orders**: Determine which orders to continue during the readmission.
2. **Reconcile Home Medications**: Determine which home medications to order for the readmission.
3. **New Orders**: Write the order to discharge the patient, and any additional orders for the readmission.
4. **Review and Sign**: Review all your ordering decisions in the summary pane and sign and hold the discharge orders. The orders will be released and carried out when the patient is readmitted.

If the patient is being readmitted to a facility that doesn’t use Epic, follow the standard discharge medication reconciliation process.
Send electronic care summaries to other clinicians

When you discharge patients, summary of care documents are sent automatically to the patient’s next provider based on the orders you enter for follow-up. This streamlines your workflow while improving transitions of care and patient outcomes. Providing a summary of care document for at least 50 percent of discharged patients is a Meaningful Use requirement. At least 10 percent of the documents must be sent electronically.

If you know the name of the provider who should follow up

1. In a discharge Order Set, go to the Referrals and Follow-ups subsection and select the appropriate referral or follow-up order. Click the order details to modify them.
2. Click Provider Search. The Provider Search window opens.
3. Look up the clinician who should follow up by name, specialty, ZIP Code, or city.
   - If there are too many results, enter more information.
   - If the clinician you’re looking for isn’t in the results, remove some of the information you entered.
4. Select the appropriate clinician and click Accept.
5. If other clinicians should also follow up, enter additional follow-up orders as needed.
6. Finish medication reconciliation as usual. At discharge, summary of care documents are sent to the specified clinicians electronically or by fax. This information also appears in the After Visit Summary.

If you don’t know the name of the provider who should follow up

1. In a discharge Order Set, go to the Referrals and Follow-ups subsection and select the appropriate referral or follow-up order. Click the order details to modify them.
2. Enter the specialty that should follow up in the To dept spec field.
3. Click Accept.
4. If other specialties should also follow up, enter additional follow-up orders as needed.
5. Finish medication reconciliation as usual. A case manager, nurse, or unit clerk will identify a specific clinician who should follow up and enter contact information in the order. At discharge, summary of care documents are sent to the specified clinicians electronically or by fax. This information also appears in the After Visit Summary.