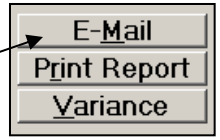
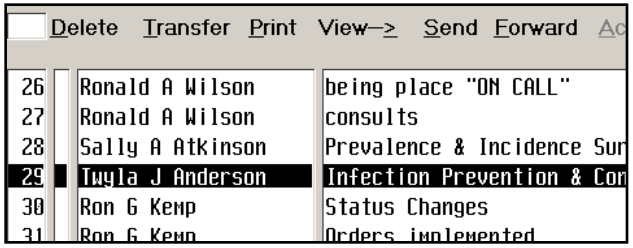
E-Mail (MOX)

This is the primary communication method employed by Memorial. You are accountable for reviewing this regularly and knowing/understanding information sent to you in this manner.

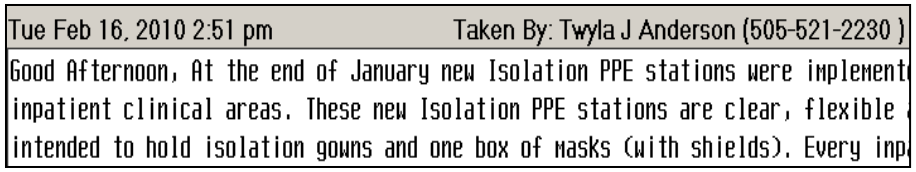
- From Status Board click **E-MAIL** icon



- The highlighted message will be the opened message at the bottom

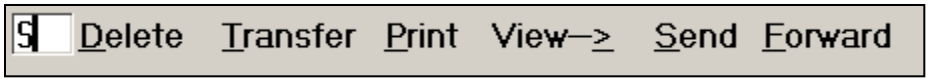


- If message bigger then box, [Right Arrow] to open complete message



SEND

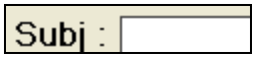
- Enter the letter '**S**' or click on **Send**



Under '**Recipients**' enter the first three letter of the persons last name to MOX

- then [**ENTER**]. This provides a list of all employees who's last name starts with those letters, pick the person you need.

- Hit the **[ENTER]** key three times until you get to Subject, enter a message heading.



[**ENTER**] and then type your message in the large box.

- To **send**, hit [**F12].**

DELETE

- Highlight or put a check mark (**RT CTRL key**) next to the message(s) to delete.

- Enter the letter **'D'** or click on **Delete.**

- Hit the [**ENTER**] key.

MEDICATION RECONCILATION PROCESS

Entering "New" Reported Home Medication

1. In Medication Reconciliation routine, click the UPD MED LIST button.
2. Type the first 3-4 letters of the medication name in the type-ahead field.
3. Click the correct medication formulation as reported by the patient (if the patient does not know the exact medication name, dose or dosage form, see the "Undefined med" instructions below).
4. Click the SELECT button.
5. Click the med string with the correct frequency; the information will default into the fields above the string listings. If there is not an exact string available, pick closets one and manually enter correct Dose, Unit, Route, or Frequency.
6. Click the DONE button.
7. Last Taken screen will display. Enter Date and Time medication last taken and Information Source. If unknown check unknown date and time box on bottom left corner
8. Click the OK button.
9. The system will return you to Update Med List screen; repeat steps 2 - 8.

Entering “No Home Meds Reported” by Patient

- Access Med Rec
- Click the “No Meds” button.
- Click the “Unobtn” button if the patient cannot answer.
- Click the “Review” radio button then click “Submit”
- Click RETURN button to exit the Medication Reconciliation screen and return to Nursing routines.

Entering “Undefined” Medication (Unknown Name/Dose/Dosage Form)

- *If a medication cannot be found or if patient does not know information about a medication, enter it as an “undefined” medication and mark it as “Attention required” for later follow-up once more information can be obtained.*
- From the Update Med screen, click the UNDEFINED MED button.
- Enter any known information.
- Click the DONE button.
- In the Last Taken screen, enter any known information.
- Enter Yes for “Attention Required”.
- The Last Taken column will display with yellow shading.

Reviewing & Verifying "Existing" Reported Home Medication from Previous Visit

- *The system recalls reported home medications from a previous visit into the Medication Reconciliation list for the current visit (no last taken information).* ***YOU MUST REVIEW THESE MEDICATIONS WITH THE PATIENT FOR CURRENT ACCURACY.***
- Click the REVIEW radio button next to each medication (places a dot in the circle).
- Enter the last taken date/time and other information; the Last taken screen displays when you click the LAST TAKEN section.
- Once finished, click the SUBMIT button.
- The Summary Screen will display the activity type action performed. The Audit Trail will display the activity type and the Last Taken information.
- If previously reported home medications are only reviewed, the action "REVIEW" will display in the Summary screen and the Audit Trail report will display "Reviewed".

Editing a Reported Home Medication

- Highlight the medication to edit.
- Click the CHANGE button.
- Edit Dose, Route, or Frequency ** OR **
- Click the REPLACE/CHANGE button.
- Select the medication string.
- Click the Last taken field to enter the information for the last does taken.
- The Audit Trail displays the changes made

Discontinuing Reported Home Medication

- *If the patient is no longer taking a medication reported in prior visits, discontinue (DELETE) this old home medication.*
  **** **ONLY** use this function if patient reports they are **NO LONGER TAKING MEDICATION** ****
- Click the DC radio button.
- A discontinue reason box displays. Click a reason or enter free text (limited to 10 characters)
- Click the SUBMIT button.
- Review the Summary screen and click OK.

Updating “Undefined” Medication

- Highlight undefined medication to edit.
- Click the CHANGE button.
- Click the REPLACE/CHANGE button.
- Using the type-ahead feature, select the identified medication.
- Select the medication string.
- The information entered in the Last Taken field previously will default into the updated medication entry. Edit this screen with any new information received

Printing Medication Reconciliation Report

- From Med Rec Screen click on PRINT button and choose report to print. All reports will print to patient location printer.

Viewing in Clinical Review

- Launch Clinical Review
- Click the PATIENT SUMMARY button to view home medications.
- To view the details of the home medication, click the radio button to the left of the medication name

Charting Routine

Daily Meditech Charting

- Prioritizing Plan of Care and document on Care Plan part A
- Document Shift Assessment
- Document Activities of Daily Living, IV Assessment and Education as appropriate
- Check for Vaccination and Core Measure needs; ensure these are addressed and documented
- Document on Care Plan part B and Routine Care/End of Shift Note at end of shift
- Update uncoded Allergies and Med Rec items in need of follow up

Required Charting for Admissions

- Document Admin Data (Height, Weight, IV, Oxygen, Code Status, Religion and Allergies)
- Document Quick Start, Admission Assessment, and Admission History. If unable to complete History d/t patient confusion/unconsciousness, answer ALL mandatory fields with 'N' for no and write in free text box why you were unable to complete history; state that ALL mandatory questions answered No as a result)
- Document Education given at admission (Diet, Plan of Care, call light, bed controls, contact precautions)
- Prioritize Care Plan