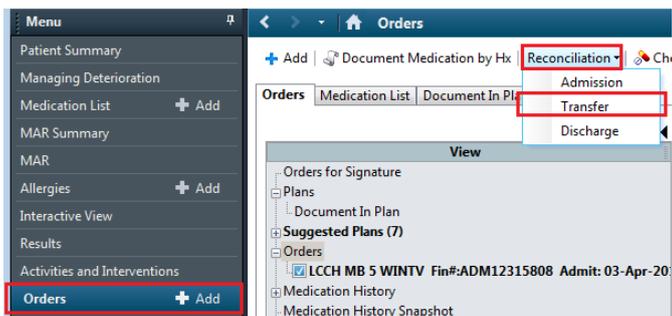# Medication reconciliation – transfer PICU to inpatient ward

Medication Management

**Quick Reference Guide**

Medication Reconciliation: Transfer can be utilised to plan the transcription of medications and infusion orders for patients transferring from PICU (MetaVision) to an Inpatient Ward (ieMR).

1. Navigate to the Orders tab and select Transfer from the Reconciliation drop down menu.

2. The Transfer Medication Reconciliation window will display.

3. Click on the Transfer To drop down menu and select the appropriate transfer location.
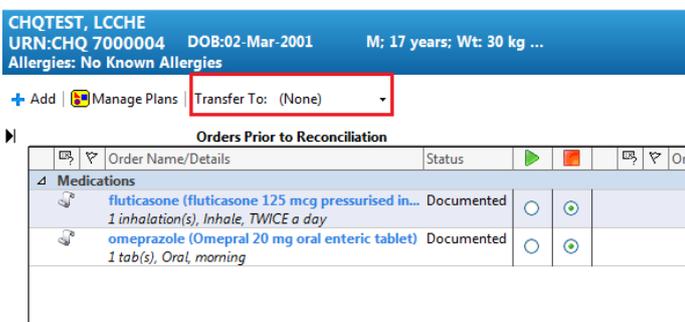
Home Medications

1. Any active Home Medications previously documented in ieMR (prior to reconciliation) are listed on the left of the window, as indicated by the scroll icon.

Note: It is important to thoroughly review the home medications documentation in case there have been any changes since documented. Home medications should only be used in Transfer Reconciliation if they align with the existing inpatient order in MetaVision.

2. From this window, there are two options:

   a. Convert the selected home medication to an inpatient order by selecting the radio button(s) under the Continue column .

   b. Do not convert the selected home medication by selecting the radio button(s) under the Do Not Continue column . This is selected by default and will not discontinue the home medication when using Transfer Reconciliation.

3. The right side of the window will display the converted inpatient orders after reconciliation signified by the hospital icon . It is important that you check these orders carefully to ensure that you are prescribing what is intended.

Note: Most documented home medications are configured to convert directly to the equivalent inpatient medication. If the medication is Non-LAM and has a similar LAM product available, the Therapeutic Substitution window will display. Many non-LAM products do not have a suitable substitute.

Note: The Manage Plans option in the Transfer Reconciliation window **will not be utilised**. Any medications ordered as a PowerPlan (e.g. Heparin Infusion, PCA/NCA etc.) are managed outside of Transfer Reconciliation - outlined below.


4. The image below shows the Therapeutic Substitution window. This will appear when the prescriber is ordering a medication that is not stocked in pharmacy.


5. From this window, there are two options:

   a. To accept the selected therapeutic substitution, and convert the order to a LAM, click OK.

   b. Alternatively, if you did not want to accept the substitution (for example, the patient has brought their own supply), select a Decline Reason from the menu and click OK.

Inpatient Medications (non-PowerPlan)

1. Click on the Add button to add Inpatient medications required for the patient.
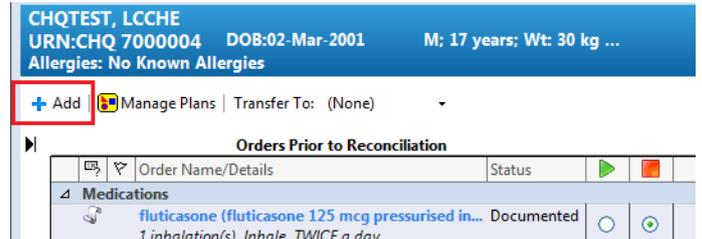
2. Select the appropriate medications and order sentence.

3. Click Done to close the search window.

4. Pending Inpatient Medications will appear on the right side of the window as signified by the hospital icon .

5. Single click on the Inpatient Medication order to open the Order Entry Field.

6. In the Details tab, ensure the First dose priority has been set as Routine.
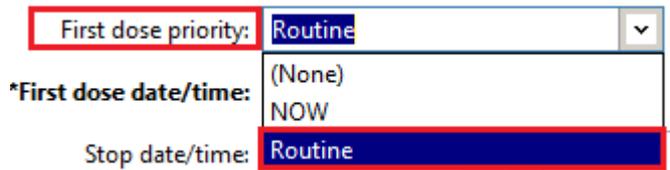
7. Amend the First dose date/time to when the patient is anticipated to receive the first dose on the ward, based on the current dosing schedule in ieMR. Check the Next dose date/time in this view to ensure it is clinically appropriate.
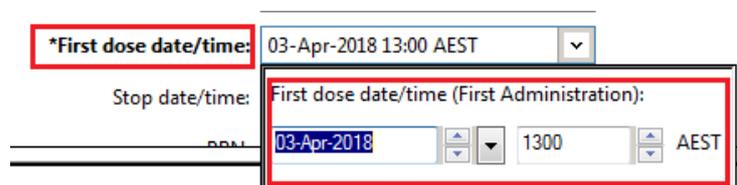
8. Complete any additional order details and order comments as required.

9. **If the patient's transfer is still pending** (e.g. expected discharge on following day), click Plan and enter your password. This will place orders in a 'Planned' state and they will not be available for administration. Planned orders can be modified again prior to signing.

10. If modifications are required to the planned medication or infusion orders, re-open the Medication Transfer Reconciliation window from the Orders profile.

11. Inpatient medication or infusion orders that were previously placed into a 'Planned' state will have a blue circle with question mark symbol next to them:
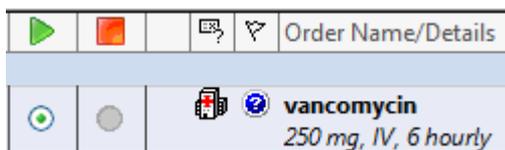
12. If required, right click the relevant medication order(s) and select Modify to make any changes to the order details. Additional orders may also be added.

IMPORTANT: Administration times **cannot** be amended on a pending order that was previously 'Planned' in Transfer Reconciliation. First dose date/time **can** be amended, where appropriate. Administration times can only be changed after the order is signed via the rescheduling function on the Medication Administration Record (MAR) or the Orders profile. Refer to the relevant QRGs.

Note: When using a scheduled frequency (e.g. TWICE a day, THREE times a day), the system will generate the administration schedule for set times of day (e.g. 0800 and 2000). When using an interval frequency (e.g. 6 hourly, 8 hourly), the system will generate the subsequent doses at the prescribed interval after the first dose. Interval frequencies are preferred for parenteral medications.

13. When the patient's transfer is confirmed as imminent and the medication orders are ready to be signed, the Transfer Reconciliation window can be re-opened to review any previously planned medication and infusion orders.

14. Once reviewed, click Sign, enter your password and Refresh.

15. Navigate to the MAR to review the orders and ensure the first dose is at an appropriate time in the context of the last dose administered in PICU.

Inpatient Medications (ordered as a PowerPlan)

1. Any medications ordered as a PowerPlan (e.g. Heparin Infusion, Insulin etc.) will need to be ordered separately in the Orders profile. PowerPlans must not be managed within the Transfer Reconciliation window.
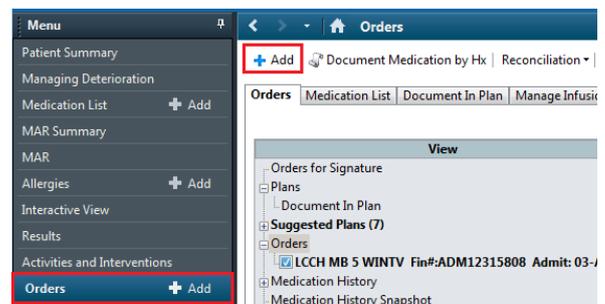
2. Refer to the individual medication PowerPlan Quick Reference Guides for further detail on ordering PowerPlans.

3. Click on Sign, rather than Initiate, to place the PowerPlan in a 'Planned' state so it can be initiated once the patient is imminently ready for transfer.

4. Modifications can be made to the planned PowerPlan prior to initiating.

5. A PICU medical officer must Initiate the phases of the plan containing medications or infusions once the patient is ready to be transferred.

Pharmacist Review

A pharmacist may review medication and infusion orders planned using Transfer Reconciliation prior to patient transfer. This step will occur prior to a PICU medical officer signing the orders in Transfer Reconciliation.

> **Note:** Planned medication orders cannot be viewed or verified in PharmNet. Clinical checks must be performed against the orders within PowerChart and the review documented in the Order Comments field. Ward pharmacists may review and verify the medications in PharmNet once signed and the patient is transferred to the ward.

1. Navigate to the Orders tab and select Transfer from the Reconciliation drop down menu.
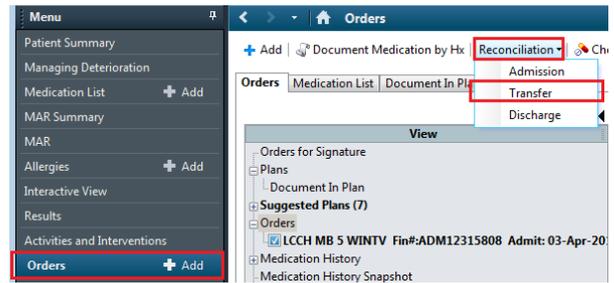
2. The Transfer Medication Reconciliation window will appear with any planned orders displayed with a blue circle with question mark symbol next to them:

3. Right click and Modify the planned order.

4. In the Order Comments tab, enter any relevant administration information and the initials of the pharmacist who has performed the review e.g.

   Pharmacy reviewed DT 09/04/18

5. Click Reconcile and Plan (**not** Sign) to save the updated order details.

The planned orders will be signed by a PICU medical officer when the patient transfer to the ward is imminent.