FAQs for the 2006 National Patient Safety Goals
(Updated 2/06)

Goal 8 (Reconcile medications)

[New—8A&B] A flow chart of the medication reconciliation process is provided at the end of this document. [New 2/06]

[8A&B] What is meant by “completely reconcile?”
To “reconcile” is to compare and reach agreement. In the context of this safety goal, reconciliation is the process of comparing the medications that the patient has been taking prior to the time of admission or entry to a new setting with the medications that the organization is about to provide. The purpose of the reconciliation is to avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions, etc. It is up to each organization to determine how this process takes place. Whenever and however the comparison takes place, it should take place early enough to improve the safety of the organization’s medication management processes, and hence patient safety. Ideally, the information will be available prior to ordering new medications. [Revised 2/06]

[8A&B] What is the definition of “medication?”
A medication, as defined in the Medication Management standards, includes any prescription medications; sample medications; herbal remedies; vitamins; nutriceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition of medication does not include enteral nutrition solutions, which are considered food products, oxygen, and other medical gases.

Obviously, this is a very comprehensive definition and for most patients coming from home, many of the items will not be relevant. However, you should at least inquire about prescription meds, over-the-counter or sample medications, herbal products, vitamins, nutriceuticals, and respiratory therapy-related drugs such as inhalers. [Revised 2/06]

[New—8A&B] Who is supposed to do the reconciliation?
Neither the Goal nor its requirements or Implementation Expectations specify who is to do the reconciliation. We are seeing two models: one in which the physician does the reconciliation when the orders are written and another in which the pharmacist or nurse does the reconciliation before preparing or administering the medications, and then notifying the physician if there are any concerns. Either is acceptable for meeting the requirements of this safety goal. [New, 2/06]

[New—8A] Should the list of medications that we obtain at the time of the patient’s entry into the organization include everything that the patient has ever taken or only what the patient is currently taking?
The list of medications obtained at entry should include only what the patient is currently taking. It is not intended to be a complete medication history. [New, 2/06]

[New—8A] What is the required time frame for completing the medication list when the patient enters the organization?
The ideal is to have the medication list completed before any new medications are ordered. If this is not possible, a decision must be made, based on the patient’s condition and care needs, whether to wait until the medication list is available or to order the medications and do the reconciliation as soon as the list becomes available. This is a clinical decision to be made by the responsible licensed independent practitioner based on relative risk to the patient. For inpatients, at a minimum, the list should be completed within 24 hours (as is required for other initial assessments for inpatients). It is recommended that inpatient facilities consider establishing a shorter time frame for gathering information about any high-risk medications that the patient might be on, such as insulin, opiates, or anticoagulants. In other settings of care, the organization should define the time frame requirements for completing the medication list. [New 2/06]

[8A] What is meant by “patient involvement?”
Simply put, the organization asks the patient about his/her current medications. When the patient is unable to provide this information, the organization should have a process to acquire this information, such as from a family member or the patient’s primary care provider or pharmacist. [Revised 2/06]

[New—8A&B] What if we are unable to obtain a complete list of the patient’s current medications?
This safety goal requires a process to obtain a complete list. As long as you have a process in place and it is implemented for each patient, when appropriate, and you have made a good faith effort to obtain as complete a list as possible, you will be considered in compliance with the requirements. [New, 2/06]

[New—8A&B] Is this just an inpatient requirement?
No, it is not just for inpatients. As the Goal states, it applies “across the continuum of care.” Any time a patient enters a health care organization—whether an emergency department, an ambulatory clinic, a home care service, or other setting or service—if medications are to be used or the patient’s response to the treatment or service could be affected by medications that the patient has been taking, then this Safety Goal applies. [New, 2/06]

[New—8A&B] In a clinic or office-based setting where a patient comes for repeat visits, is it necessary to develop a complete list of the patient’s medications at each and every visit and generate a new “discharge” list before sending the patient home each time?
It’s not a matter of redoing everything each time the patient comes in. Certainly, we do expect that at the initial visit a complete list of the patient’s medications will be generated. Thereafter, it is simply a process of looking at the list when new meds are ordered, updating the list to reflect any changes in the medication regimen, and giving the list back to the patient. If there are other providers of care who are not part of the clinic but who are currently participating in the care of the patient, the list should also be communicated to them whenever it is updated. These are the essential requirements of Goal #8. They apply across the continuum of care wherever medications are used.

[New—8A&B] There are some “minimal medication use” situations that would seem to carry little risk of duplication, omission or drug interaction—things like topical fluoride in dentistry, local infiltration anesthesia for dental work or suturing lacerations, enteric
barium for imaging studies. Is a full medication reconciliation process required in these situations?

These situations typically occur as brief outpatient encounters, not involving other medication use, discharge prescription of medications, or any other changes in medications that the patient has been taking. However, all of the items mentioned in the question are “medications,” which carry a risk for drug interactions and allergic reactions. Therefore, for all medication use, including the “minimal use” scenarios noted above, a list of the patient’s current medications and a history of the patient’s allergies and past sensitivities must be obtained. Note that this is not a “new” requirement introduced by Goal #8. It has been an established expectation of the Medication Management standards (MM.1.10, Element of Performance #2).

“Reconciliation,” in this context, simply means checking the patient information (current medications and history of allergies and past sensitivities) to make an informed decision about the use of these “minimal medications.” Specific organization policies on reconciliation documentation may be modified in these circumstances. Further, if all of the following conditions apply, a discharge reconciliation or communication of the list of the patient’s current medications (requirement 8B) is not necessary:

- The “minimal medication use” is in the context of a brief outpatient encounter
- The medications in question act locally with negligible systemic effect (for example, minimally absorbed topical agents; low volume local infiltration anesthetics; non-absorbable enteric contrast agents)
- These medications are administered under the direct control of a licensed independent practitioner or have been reviewed by a pharmacist before administration
- No other medications are used during the encounter
- No new medications are prescribed for or provided to the patient for use after discharge
- There are no changes to the patient’s “current medications”
- Any provider of care to whom the patient is being referred, already has the patient’s current medication information. [New, 2/06]

[New—8A&B] Are we required to have the process in place throughout the organization at the start of 2006 or will it be sufficient to have implemented it in a few units with a plan to complete the implementation during the rest of the year?

In 2005, the requirement was to “develop a process” for medication reconciliation. The 2006 requirement is to “implement a process.” The expectation is for full implementation throughout the organization as of January 1, 2006. While it is generally accepted that medication reconciliation is a necessary component of a safe medication use process, implementing a consistent process throughout a complex organization can be challenging. For this reason, a full year (2005) was provided for organizations to plan, design, and test their processes. [New, 2/06]

[New—8A&B] If a patient is admitted to the hospital from home, we create a list of the patient’s home medications and use it to reconcile against the admitting orders. Those new orders now become the patient’s “current medications. That list will be further modified as the patient changes setting or level of care within the hospital. How many lists should we be keeping?

You should keep two lists during the hospitalization. The “home medications” list should be maintained unchanged and available for subsequent use in the reconciliation process. The list of
the patient’s current medications while in the hospital is a dynamic document that will require updating whenever changes are made to the patient’s medication regimen. Whenever reconciliation is carried out, both lists should be considered. The reason for referring back to the “home” medication list is that some “home” medications may be held when a patient is admitted or goes to surgery. They may need to be resumed upon transfer to a different level of care, return from the OR, or at discharge. [New, 2/06]

**[New—8B]** At discharge, do we reconcile against the patient’s current (inpatient) medication list or the home medication list?
At discharge, a complete list of the medications that the patient is to be taking following discharge should be developed and reconciled against both the current inpatient list and the home medication list. The discharge medication list should include not only the medications that are prescribed at the time of discharge, but any other medications the patient will be taking, including over-the-counter meds, vitamin, etc. [New, 2/06]

**[New—8B]** When the patient changes level of care, is it necessary to reconcile both the current medication list and home med list? Would it be okay to reconcile only the current medication list?
For internal transfers, change in level of care, etc, it is usually not necessary to reconcile against the original list of “home” medications. However, for changes to a less intensive level of care, it might be useful to review the home list to see if some medications that were discontinued on admission should be resumed now that patient is at a lower level of care. Of course, the home medication list must be considered in the reconciliation at the time of discharge. [New, 2/06]

**[New—8B]** Our doctors don’t feel they should be taking responsibility for ordering or reordering drugs such as herbal preparations or OTC drugs that the patient was taking at home, especially when they are not the patient’s primary care provider. What do we do?
The discharging physician is not expected to order or reorder any medications that the patient was already taking prior to admission. The discharge medication list is not a doctor’s order. It is simply a list of all medications that the patient will be on following discharge. Certainly, the discharging physician should review this list to determine whether there are any items that should be discontinued or that might interact with newly prescribed medications. [New, 2/06]

**[New—8B]** So, if the discharging physician doesn’t have to reorder the patient’s home meds, can we just instruct the patient to “resume previous home medications?” Isn’t this a violation of the standards?
Three related terms are relevant to this discussion: discharge orders; discharge instructions; and the discharge list of the patient’s medications, as required by Goal 8. They are all different and have different purposes. Discharge instructions are not orders. Nor is the complete list of the patient’s medications at discharge an order. While the discharging physician doesn’t have to reorder patients’ OTCs or herbals that they were taking pre-admission, those OTCs and herbals should be on the list of medications that the patient is to be taking post-discharge if the patient intends to continue them and there are no contraindications.

Discharge instructions are directed to the patient. Discharge orders are directed to other caregivers. The requirement in the Medication Management standards that prohibits blanket reinstatement orders applies only to orders, not to discharge instructions, so it is permissible—
although, perhaps, not the best practice—to instruct the patient to “resume home medications” if, in fact, that is what the patient and physician want to happen. [New, 2/06]

[8B] What is the expectation under 8b, for communicating information to the next provider of service?
When discharging, referring, or otherwise handing over responsibility for the patient’s care to another setting, service, practitioner, or level of care within or outside the organization, it is expected that each organization has a process to communicate to the next provider or setting a list of all the medications that the patient is to be on following discharge or transfer. It is up to each organization to determine the method of communication of this information. For example, the complete list of medications may be written or communicated via electronic system such as an up-to-date electronic MAR that can be accessed by the receiver, etc. [Revised 2/06]

[New—8B] How soon must the discharge list be communicated to the next provider of care?
The discharge medication list must be communicated to the next provider of care in a time frame that is consistent with the anticipated follow-up activities. In other words, the information should get to the next provider no later than the next follow-up visit. If there is no scheduled follow-up visit, then the information should be communicated within a reasonable time frame as determined by the organization. [New 2/06]

[New—8B] Is it sufficient to give the discharge list to the patient with instructions to give it to the next provider of care?
No. The requirement is to communicate the list directly to the next provider of care. Only when a next provider of care is not known, should the patient be made responsible for communicating this information. This does not mean that the list should not also be provided to the patient. In fact, this is an expectation under the discharge planning standards (PC.15.20). [New, 2/06]

[8A&B] If, based on the provision of care, treatment or services to be rendered, there is no reason to ask a patient about his/her medications is the organization still required to inquire about the patient’s medications?
No. For example, if the patient comes to the organization for an x-ray without contrast, medication reconciliation would not be required. However, if parenteral contrast is used or if the patient receives sedation or other medications, reconciliation must be done because of the potential for drug interaction. [Revised 2/06]

[New—8A&B] What about upper GI series or barium enemas? There doesn’t seem to be any significant risk with these “medications.” Do we need to do a full medication reconciliation for this case?
For an x-ray with enteric (oral or rectal) contrast, such as an upper GI series or a barium enema, a full medication reconciliation is not required if the following conditions are met:
  • This applies only to outpatient radiological procedure(s) and only to situations in which oral or rectal contrast agents are the only medications that are to be administered to the patient. This exemption does not apply when IV contrast will be used, conscious sedation may occur, or other medications besides contrast agents may be administered.
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- The organization employs a screening process designed to address the safe administration of contrast media. In the case of hospitals, this screening process must be approved by the medical staff and pharmacy to address all potential drug interactions and other medication-related problems or adverse drug events.
- The appropriateness of the medication (contrast media) is reviewed by a health care professional determined to be qualified
- A pharmacist is available on-call if needed
- Retrospectively, the organization evaluates its system by sampling records where contrast media were administered without medication reconciliation to determine if the system as designed is working or if there are opportunities for improvement

[8B] If I have a patient’s current medication list, am I required to communicate that information regardless of the type of care, service or treatment the patient is being referred or transferred to? Are there any exceptions?
As in the question above, the organization should consider whether the communication of medication information is relevant to the care that will be provided by the referral or transfer and identify what if any exceptions are appropriate. This should not be based only upon whether the referral or transfer destination provides medications but whether the patient’s medication information is relevant to the patient’s safety/health in that setting. [Revised 2/06]

[8A&B] Do I have to acquire the list of patient medications in an emergent or urgent admission/entry situation?
In urgent situations or when the resulting delay would harm the patient/resident/client, including situations in which the patient/resident/client experiences a sudden change in clinical status, immediate care takes precedence. However, as soon as possible thereafter, the organization should take steps to acquire this information and compare it to the medications it is providing. [Revised 2/06]

[8A&B] Will the Joint Commission be expecting to see a specific form or document in the chart?
No. On admission/entry to a care setting, the expectation is that the patient’s current medication list is documented in some identifiable fashion as part of the patient’s record. The organization should specifically define the expected time frame for that to occur. A surveyor may during the course of a patient tracer review a patient’s chart to see if the medications on admission/entry were noted. If this information is only available electronically, the surveyor may ask the organization to describe or demonstrate how information about medications upon admission/entry is obtained and made available to appropriate staff.

[8A&B] Is documentation of the reconciliation required and if yes, what type of documentation is required?
The only required documentation is the list itself. It is up to each individual organization to determine how it will monitor its compliance with the medication reconciliation requirements. This may or may not be supported by documentation that the organization requires for its own purposes. If you can answer the question, “How do I know the comparison process is
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consistently happening in my organization?” then you will be prepared to answer any surveyor’s question in this regard. [Revised 2/06]
The Medication Reconciliation Process

NPSG 8A & 8B

Patient Enters - ED, Admit to Floor, Outpatient/Ambulatory

Obtain Current Medication List (MM.1.10, EP #2)

Documentation Required

Write initial orders for treatment
RECONCILE: Check “List” for duplication, omission, or potential interaction. - Update “List” as appropriate.

Internal Transfer/Move With New or Re-written orders?

Yes

Write orders for treatment
RECONCILE: Check “List” for duplication, omission, or potential interaction. - Update “List” as appropriate.

Assure that Medication List is communicated to next provider of care.

No

Discharge: Next Provider Known?

No

Write discharge medication orders. Provide complete List of Current Medications to patient. (PC.15.20, EP #9)

Yes

Write discharge/transfer medication orders. Provide a complete List of Current Medications to the next provider (PC.15.30, EP #1) and to the patient (PC.15.20, EP #9).

Note: Standard and Elements of Performance (EP) noted in parentheses are existing requirements.