

**Overview: NPSG 3.06.01: Improve the safety of using medications:** Maintain and communicate accurate **patient medication information.**

**Why this goal is important to patient safety**

Medication discrepancies can negatively affect a patient's outcome; these discrepancies include duplications, omissions, and interactions. The large number of people receiving health care who take multiple medications and the complexity of managing those medications make avoiding discrepancies an important safety issue.

The Joint Commission recognizes that medication reconciliation is challenging to organizations because it can be difficult to obtain a complete list of a patient's medications. As more sophisticated systems evolve such as databases that track a patient's medications, the risk will diminish. In the interim, Joint Commission accepts a good faith effort to collect the information as meeting the requirements of the goal.

**Elements of Performance**

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.  
Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.  
Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.
2. Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.  
Note 1: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.  
Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.
3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.  
Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.
4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).  
Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications.
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.  
Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations.