

2009 Joint Commission National Patient Safety Goals (NPSG)

Focus on Anticoagulation & Medication Reconciliation

2009 Anticoagulation NPSG

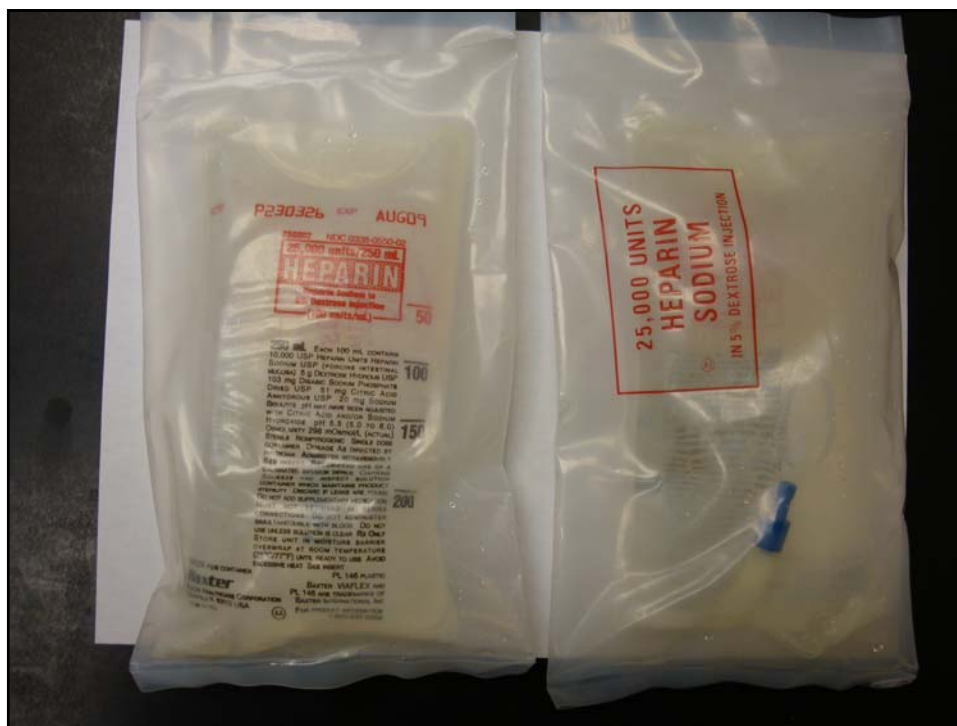
- 3E: Reduce likelihood of patient harm from associated with anticoagulant therapy
 - ◆ April 1, 2008 – Assign responsibility
 - ◆ July 1, 2008 – Implementation work plan
 - ◆ October 1, 2008 – Pilot on one unit
 - ◆ January 1, 2009 – Full implementation

Anticoagulation - Applicability

- This requirement applies only to organizations that provide anticoagulation therapy and/or long-term anticoagulation prophylaxis:
 - ◆ Clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values (IV UFH, therapeutic LMWH, warfarin)
 - ◆ Does not apply to short-term prophylactic anticoagulation if used for venous thromboembolism prevention
 - ◆ Applies to outpatient pharmacy

Anticoagulation NPSG: Elements of Performance (1-9)

1. Implements a defined anticoagulation management program to individualize care to each patient.
2. To reduce compounding and labeling errors, the hospital uses only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags when these types of products are available.
 - ◆ Note: For pediatric patients, pre-loaded syringe products should only be used if specifically designed for children.



Anticoagulation NPSG: Elements of Performance (1-9)

3. Uses approved protocols for initiation and maintenance of anticoagulation therapy appropriate to the medication used, to the condition being treated, and to the potential for medication interactions.

Shands UF Heparin Protocol

FULL - INTENSITY for DVT / PE

Date _____ **Time** _____ **Pt Weight** _____ **kg**

(All orders with a must be checked to activate. All orders with a are activated.)

1. Orders to be followed for protocol:

a. Obtain baseline aPTT, PT, and CBC with platelet count prior to initiating heparin therapy.

b. Heparin dosing calculations:

i) Obtain patient's total body weight (TBW) = _____ kg

ii) **If patient is greater than 125 kg please consult pharmacy for assistance with heparin dosing.**

c. Labs:

i) Obtain unfractionated heparin level every 6 hours after starting or changing rate of heparin infusion. When unfractionated heparin level is therapeutic for 2 consecutive lab draws, decrease unfractionated heparin level frequency to every AM.

ii) Obtain CBC with platelet count every day while receiving maintenance infusion of IV heparin

d. Notify physician if:

i) Platelet count decreases to less than 150,000 / mm³ or by 50% from baseline.

ii) Patient requires greater than 48,000 units / day of IV heparin without reaching a therapeutic unfractionated heparin level.

e. Institute Bleeding Precautions.

f. Discontinue all previous orders for unfractionated heparin (excluding flushes), dalteparin, enoxaparin, fondaparinux, argatroban, and/or lepirudin orders.

g. Dosing Recommendations

i) IV heparin bolus: Administer _____ units (80 units/kg using TBW). Round bolus to the nearest 100 units. Do not exceed 5,000 units if patient has received thrombolytic therapy within the past 24 hours.

Reason for protocol alteration:

ii) Maintenance Heparin infusion (25,000 units/250 mL D5W): Administer _____ units/hr (18 units/kg/hr x _____ kg using TBW). Round maintenance heparin infusion rates to nearest 50 units/hr.

Reason for protocol alteration:

iii) Maintain unfractionated heparin level of 0.3 - 0.7 units/mL.

iv) Adjust heparin infusion rate based on unfractionated heparin level using table below:

Unfractionated heparin level (units/mL)	Bolus Dose TBW	Stop Infusion (min)	Rate Change
less than 0.2	80 units/kg	-	increase by 4 units/kg/hr
0.2 - 0.29	40 units/kg	-	increase by 2 units/kg/hr
0.3 - 0.7	No	-	No change
0.71 - 0.8	No	-	decrease by 1 unit/kg/hr
0.81 - 0.9	No	30	decrease 2 units/kg/hr
greater than 0.91	No	60	decrease by 3 units/kg/hr

TABLE CANNOT BE MODIFIED FOR ANY REASON.

MD Signature _____ MD # _____

Pharmacy Use Only: 031337-G-1

Shands
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Gainesville, Florida 32610

RX0001

Physician's Orders
(page 1 of 2)

Distribution: Medical Record - Be sure to fax to Pharmacy. Rev. 11/05/08 PG11337-G

Patient Name: _____ Patient Identification #: _____

Shands UF Heparin Documentation Tool

FULL INTENSITY FOR DVT / PE

Full Intensity (Standard) DVT/PE Unfractionated Heparin Protocol Documentation Tool

Date _____ **Time** _____ **Pt Weight** _____ **kg**

Initial Bolus _____ **Date** _____ **Time** _____ **Initial Infusion Rate** _____ **Time Hung** _____

RN / LPN Signature _____ **RN Verification Signature** _____

See reverse side for rate adjustment table. Initial unfractionated heparin level due _____

Unfractionated Heparin Level (units/mL)	Bolus Dose TBW or ABW	Actual Bolus Dose	Stop Infusion (min)	Rate Change (units/kg/hr)	Actual Rate Change (mL)
less than 0.2	80 units/kg		-	↑ 4 units/kg/hr	
0.2 - 0.29	40 units/kg		-	↑ 2 units/kg/hr	
0.3 - 0.7	No		-	No change	
0.71 - 0.8	No		-	↓ 1 unit/kg/hr	
0.81 - 0.9	No		30	↓ 2 units/kg/hr	
greater than 0.9	No		60	↓ 3 units/kg/hr	

- Round maintenance infusion rates to nearest 50 units/hr. Round bolus to the nearest 100 units.
- Change unfractionated heparin level monitoring to daily when 2 consecutive unfractionated heparin levels are within therapeutic range. Readjust infusion daily according to the above table.
- Obtain CBC with platelet count daily while patient is receiving maintenance infusion of IV heparin.

Date / Time	Unfractionated Heparin Time	Unfractionated Heparin Value	Action Taken		New Rate	Next Unfractionated Heparin Due	Signature / Co-Signature
			Bolus	Rate Change			

Notify physician if:

- Unfractionated heparin level is less than 0.3 units/mL or greater than 0.7 units/mL.
- Platelet count decreases to less than 100,000 or by 50% from baseline
- Patient requires greater than 48,000 units/day of IV heparin without reaching a therapeutic unfractionated heparin level

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MA0002

Full Intensity (Standard) DVT/PE Unfractionated Heparin Protocol Documentation Tool (page 1 of 2)

Rev. 11/05/08 PG11021



Patient Name: _____ Patient Identification #: _____

FULL INTENSITY FOR DVT/PE									
DVT / PE Heparin Rate Change Grid									
Change the rate of infusion (mL/hr) of heparin according to the weight of the patient and a heparin concentration of 100 units/mL (25,000 units in 250 mL D5W).									
	Weight (kg)								
	50	60	70	80	90	100	110	120	130
Increase by 4 units/kg/hr (mL/hr)	+2 (mL/hr)	+2.5 (mL/hr)	+3 (mL/hr)	+3 (mL/hr)	+3.5 (mL/hr)	+4 (mL/hr)	+4.5 (mL/hr)	+5 (mL/hr)	+5 (mL/hr)
Increase by 2 units/kg/hr (mL/hr)	+1 (mL/hr)	+1 (mL/hr)	+1.5 (mL/hr)	+1.5 (mL/hr)	+2 (mL/hr)	+2 (mL/hr)	+2 (mL/hr)	+2.5 (mL/hr)	+2.5 (mL/hr)
Decrease by 1 units/kg/hr (mL/hr)	- 0.5 (mL/hr)	- 0.5 (mL/hr)	- 1 (mL/hr)	- 1 (mL/hr)	- 1 (mL/hr)	- 1 (mL/hr)	- 1 (mL/hr)	- 1 (mL/hr)	- 1.5 (mL/hr)
Decrease by 2 units/kg/hr (mL/hr)	- 1 (mL/hr)	- 1 (mL/hr)	- 1.5 (mL/hr)	- 1.5 (mL/hr)	- 2 (mL/hr)	- 2 (mL/hr)	- 2 (mL/hr)	- 2.5 (mL/hr)	- 2.5 (mL/hr)
Decrease by 3 units/kg/hr (mL/hr)	- 1.5 (mL/hr)	- 2 (mL/hr)	- 2 (mL/hr)	- 2.5 (mL/hr)	- 2.5 (mL/hr)	- 3 (mL/hr)	- 3.5 (mL/hr)	- 3.5 (mL/hr)	- 4 (mL/hr)

Rounding Patient's Weight: If less than 5 kg round down, if greater than or equal to 5 kg round up.
 Example: If the patient weighs 54 kg round to 50 kg.
 If the patient weighs 56 kg round to 60 kg.

Full Intensity (Standard) DVT/PE Unfractionated Heparin Protocol Documentation Tool (page 2 of 2) If printed electronically, pages 1 & 2 must be stapled. Rev. 7/16/06 PSD11001

Shands UF VTE Protocol

Date	Adult Venous Thromboembolism (VTE) Prophylaxis Order Form					
Time	(All orders with a <input type="checkbox"/> must be checked to activate. All orders with a <input checked="" type="checkbox"/> are activated.)					
1. Risk factors for the development of VTE:						
Age greater than 40y	immobility / paralysis	Obesity	ICU admission	Serious infection	Hip, leg, pelvic fracture	
Heart failure	Inflammatory disorder	Pneumonia	Respiratory failure	Chronic lung disease	Thrombophilia	
Malignancy	Pregnancy	Varicose veins	Nephrotic syndrome	Estrogen use	Active collagen vascular disorder	
Prev history of DVT / PE	Ischemic stroke	COL cancer	Surgery	Neuro trauma		
2. Select risk stratification for acquiring VTE (check indication):						
HIGH RISK	<input type="checkbox"/> Major orthopedic procedures (including lower extremity arthroplasty / fracture) <input type="checkbox"/> Spinal cord injury, multiple major trauma <input type="checkbox"/> Abdominal / pelvic cancer undergoing operative procedure					
MODERATE RISK	<input type="checkbox"/> Non-ICU patient or stable medical patient with at least one risk factor <input type="checkbox"/> Moderate surgery without risk factors <input type="checkbox"/> Major surgery or moderate surgery with risk factors <input type="checkbox"/> ICU, major medical problem (CHF, mechanical ventilation, sepsis, burns)					
LOW RISK	<input type="checkbox"/> Medical patient - fully mobile, brief admission (participate less than 48 hr admission) <input type="checkbox"/> Surgical patient - Procedure less than 30 minutes, mobile, no additional risk factors					
3. Select VTE prophylaxis (select therapy consistent with risk stratification identified above):						
HIGH RISK	Required - Choose one of the following pharmacologic regimens: <input type="checkbox"/> enoxaparin (LOVENOX) 40 mg subcutaneously q24hr <input type="checkbox"/> enoxaparin (LOVENOX) 30 mg subcutaneously q12hr (preferred in trauma) <input type="checkbox"/> enoxaparin (LOVENOX) 30 mg subcutaneously q24hr (C-Cl less than 30 mL/min) <input type="checkbox"/> fondaparinux (ARXTRA) 2.5 mg subcutaneously q24hr (Contraindicated if CrCl less than 30 mL/min) <input type="checkbox"/> warfarin (COUMADIN) _____ mg PO daily (maintain INR 2 - 3) Required - Adjunct to pharmacologic regimen: <input checked="" type="checkbox"/> sequential compression devices (SCD) at all times while in bed					
MODERATE RISK	Required - Choose one of the following pharmacologic regimens: <input type="checkbox"/> heparin 5,000 units subcutaneously q8hr <input type="checkbox"/> heparin 5,000 units subcutaneously q12hr (age greater than 75 y or weight less than 50 kg) <input type="checkbox"/> enoxaparin (LOVENOX) 40 mg subcutaneously q24hr <input type="checkbox"/> enoxaparin (LOVENOX) 30 mg subcutaneously q24hr (C-Cl less than 30 mL/min) <input type="checkbox"/> fondaparinux (ARXTRA) 2.5 mg subcutaneously q24hr (Contraindicated if CrCl less than 30 mL/min) Optional - Select as adjunct to pharmacologic regimen if indicated: <input type="checkbox"/> sequential compression devices (SCD) at all times while in bed					
LOW RISK	<input type="checkbox"/> early ambulation					
4. <input checked="" type="checkbox"/> CBC now and every other day with morning labs (moderate or high risk patients as checked above) Notify physician if platelet count less than 150,000/mm ³ or 50 % decrease from baseline. <input type="checkbox"/> INR daily (if patient receiving warfarin)						
5. If evidence of any bleeding, hold next dose and notify MD.						
6. <input type="checkbox"/> No pharmacologic VTE prophylaxis indicated at this time. Must document reason:						
MD Signature _____						MD # _____
Pharmacy Use Only: 0167026-1						Patient Name: _____ Patient Identification #: _____
  RX0001						
Physician's Orders (page 1 of 1) Distribution: Medical Record - Be sure to fax to Pharmacy.						152097 P878760

Shands UF INR Requirements

4. Baseline INR required for all patients started on warfarin and for all patients receiving warfarin, a current INR is available and is used to monitor and adjust therapy.
 - ◆ If an INR is not ordered as indicated above, a pharmacist will order an INR per P&T Committee authorization and hold the dose of warfarin until the results are available. If the baseline INR is greater than 4, a pharmacist will continue to hold the dose per P&T Committee authorization and contact the provider for further instructions.
 - ◆ The frequency of INR monitoring must be at least every 5 days for patients on daily warfarin therapy. If an INR is not ordered at least every 5 days, a pharmacist will order an INR per P&T Committee authorization.

Anticoagulation NPSG: Elements of Performance (1-9)

5. Dietary is notified of all patients on warfarin and responds according to its established drug-food interaction program.
6. Continuous IV heparin is administered only via a programmable infusion pump.
7. Has a written policy regarding baseline and ongoing lab tests required for heparin and LMWH.

Anticoagulation NPSG: Elements of Performance (1-9)

8. Provides education on anticoagulation therapy to prescribers, staff, patients & family.
 - Patient/family education includes importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for ADRs and side effects.
9. The hospital evaluates its anticoagulation safety practices, takes appropriate action to improve its practices, and measures the effectiveness of those actions on a regular basis.

<http://www.ahrq.gov/consumer/coumadin.pdf>

Your Guide to Coumadin®/Warfarin Therapy



Anticoagulation NPSG – Ideas for Evaluation and Follow-up

- Process
 - Compliance with warfarin discharge counseling.
 - Compliance and effectiveness of pharmacist warfarin interventions for lack of INR, supratherapeutic INR, and INR monitored at least every 5 days.
 - Compliance with use of weight-based heparin pre-printed order sets (MD and RN).
 - Appropriateness of therapeutic LMWH dosing in patients with renal insufficiency.
 - Appropriateness of platelet count monitoring in patients receiving therapeutic LMWH dosing.

- Outcomes
 - Decreased length of stay for inpatients initiated on warfarin.
 - Proportion of patient days with INR>5
 - Percent of patients reaching therapeutic heparin levels in first 24 hours of therapy.
 - Reduced incidence and complications of heparin-induced thrombocytopenia.

LMWH Report Feb 2009

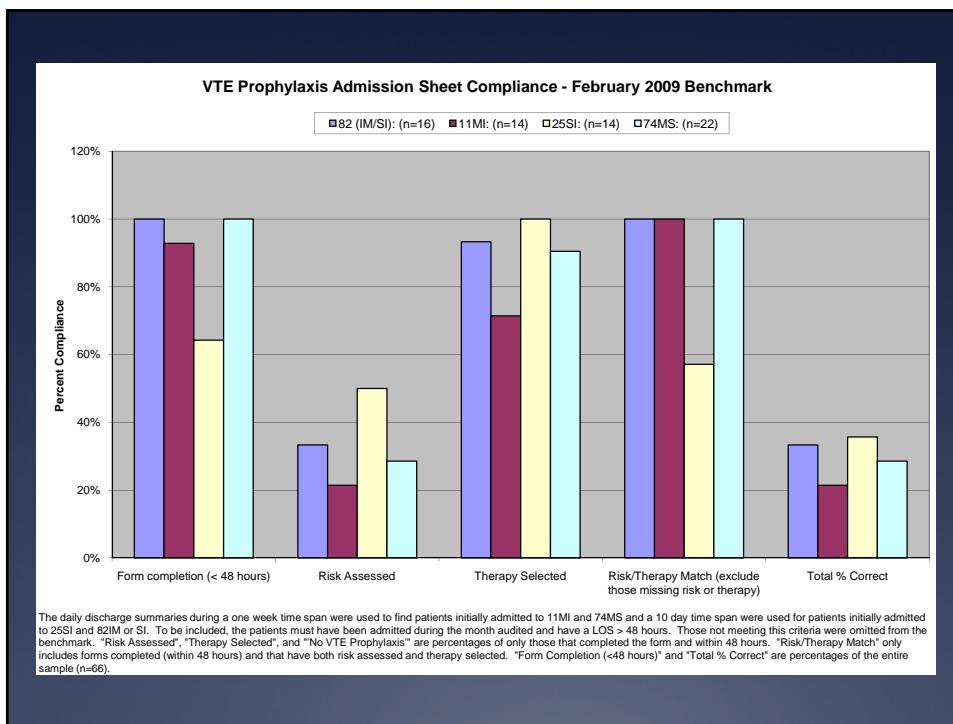
Charge Pcu	Item Description Strength Form	Dose Strength	Qty	Therapy Startdate	Therapy Stopdate
94IM	ENOXAPARIN 100 MG/ML INJ	70 MG/0.7 ML	0.00	2/14/2009	2/14/2009
44PC	ENOXAPARIN 100 MG/ML INJ	10 MG/0.1 ML	0.00	2/3/2009	2/4/2009
10PI	ENOXAPARIN 100 MG/ML INJ	25 MG/0.25 ML	1.00	1/30/2009	2/3/2009
42MT	ENOXAPARIN 100 MG/ML INJ	120 MG/1.2 ML	8.40	2/11/2009	2/13/2009
	ENOXAPARIN 100 MG/ML INJ	120 MG/1.2 ML	2.40	2/11/2009	2/13/2009
45PC	ENOXAPARIN 100 MG/ML INJ	14 MG/0.14 ML	0.56	2/20/2009	2/26/2009
74MS	ENOXAPARIN 100 MG/ML INJ	50 MG/0.5 ML	0.50	2/6/2009	2/6/2009
	ENOXAPARIN 100 MG/ML INJ	50 MG/0.5 ML	0.50	2/6/2009	2/6/2009
74MS	ENOXAPARIN 100 MG/ML INJ	50 MG/0.5 ML	4.50	2/6/2009	2/9/2009
94IM	ENOXAPARIN 100 MG/ML INJ	96 MG/0.96 ML	0.96	2/18/2009	2/18/2009

Rule Log Query in HMM for Warfarin with INR > 4 - February 2009

Rulename	Source Description	Action Description	Transaction Date Time	Transaction Description
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/08/2009 06:46:05	INR 2009-02-08 05:20:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/11/2009 06:29:15	INR 2009-02-11 06:00:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/05/2009 07:24:30	INR 2009-02-05 06:05:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/20/2009 07:27:35	INR 2009-02-20 06:35:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/16/2009 05:49:22	INR 2009-02-16 04:50:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/17/2009 05:01:19	INR 2009-02-17 04:00:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/23/2009 04:50:58	INR 2009-02-23 03:17:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/07/2009 04:31:01	INR 2009-02-07 03:35:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/13/2009 06:22:17	INR 2009-02-13 04:50:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/17/2009 03:58:43	INR 2009-02-17 03:10:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/19/2009 05:13:42	INR 2009-02-19 04:00:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/23/2009 05:37:27	INR 2009-02-23 05:00:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/23/2009 08:39:41	INR 2009-02-23 08:00:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/24/2009 06:02:34	INR 2009-02-24 04:35:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/25/2009 05:01:25	INR 2009-02-25 04:15:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/26/2009 04:36:21	INR 2009-02-26 03:42:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/27/2009 04:41:48	INR 2009-02-27 03:50:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/04/2009 06:46:03	INR 2009-02-04 05:49:00
WARFARIN INCOMING INR >4	PATIENT LAB	Add	02/06/2009 07:39:30	INR 2009-02-06 06:10:00

Rule Log Query in HMM for Warfarin with INR > 4 and Warfarin INR Lab > 5 Days Old - February 2009

Rulename	Source Description	Action Description	Transaction Date Time	Transaction Description
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/26/2009 16:35:58	WARFARIN 5 MG TAB 5 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/03/2009 10:08:59	WARFARIN 2 MG TAB 4 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/04/2009 09:42:51	WARFARIN 7.5 MG TAB 7.5 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/06/2009 11:06:10	WARFARIN 5 MG TAB 5 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/16/2009 06:42:40	WARFARIN 10 MG TAB 10 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/11/2009 07:33:09	WARFARIN 5 MG TAB 5 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/21/2009 06:34:45	WARFARIN 5 MG TAB 5 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/15/2009 12:44:44	WARFARIN 2.5 MG TAB 2.5 MG X1
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/16/2009 19:23:01	WARFARIN 2.5 MG TAB 2.5 MG X1
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/17/2009 16:26:03	WARFARIN 0.5 MG TAB 0.5 MG X1
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/20/2009 16:35:43	WARFARIN 1 MG TAB 1 MG Q1800
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/21/2009 14:51:03	WARFARIN 1 MG TAB 1 MG X1
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/22/2009 15:10:30	WARFARIN 1 MG TAB 1 MG X1
WARFARIN INR LAB >5 DAYS OLD	MED	Add	02/23/2009 14:11:40	WARFARIN 1 MG TAB 1 MG Q1800



Medication Reconciliation

- * NPSG.08.01.01 - A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

Medication Reconciliation

- * NPSG.08.01.01
 - * EP 1: At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient, and family as needed, are involved in creating this list.
 - * EP 2: The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.

Medication Reconciliation

- * NPSG.08.01.01
 - * EP 3: Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.
 - * EP 4: When the patient's care is transferred within the hospital (for example, from the ICU to the floor), the current provider(s) inform the receiving provider(s) about the up-to-date reconciled medication list and document the communication. (See also NPSG.02.05.01, EP 2) Note: Updating the status of a patient's medications is also an important component of all patient care hand-offs.

Medication Reconciliation

- * NPSG.08.02.01 – When a patient is transferred to or transferred from one organization to another, the complete and reconciled list of medications is communicated to the next provider of service and the communication is documented.

Medication Reconciliation

- * NPSG.08.02.01
 - * EP 1: The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.
 - * EP 2: At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications.

Medication Reconciliation

- * NPSG.08.03.01 – When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient, and the patient's family as needed, and the list is explained to the patient and/or family.

Medication Reconciliation

- * NPSG.08.03.01
 - * EP 1: When the patient leaves the hospital's care, the current list of reconciled medications is provided and explained to the patient, and their family as needed. This interaction is documented. Note: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

Medication Reconciliation

- * NPSG08.04.01 – In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.
 - * ED, Urgent Care, Office-based Surgery, Outpatient Radiology, etc.

Medication Reconciliation

- * NPSG08.04.01
 - * EP 1: The hospital obtains and documents an accurate list of the patient's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, local anesthesia, antibiotics) and to assess the potential allergic or adverse drug reactions.
 - * EP 2: When only short-term medications (for example, a pre-procedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the patient's current medication list, the patient, and their family as needed, is provided with a list containing the short-term medication additions that the patient will continue after leaving the hospital.

Medication Reconciliation

- * NPSG08.04.01
 - * EP 3: In these settings, a complete, documented medication reconciliation process is used when:
Any new long-term (chronic) medications are prescribed.
 - * EP 4: In these settings, a complete, documented medication reconciliation process is used when:
There is a prescription change for any of the patient's current, known long-term medications.

Medication Reconciliation

- * NPSG08.04.01
 - * EP 5: In these settings, a complete, documented medication reconciliation process is used when:
The patient is required to be subsequently admitted to an organization from these settings for ongoing care.
 - * EP 6: When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient, and their family as needed, and to the patient's known primary care provider or original referring provider or a known next provider of service.