مؤسسة مستشفى سرطان الأطفال-مصر Children's Cancer Hospital Foundation - Egypt 57357	**Policy Name:** Medication Reconciliation		
Prepared By: إعداد:	Dr. Mohammed Nagy- Pharmacy Director Dr. Salwa Sayed – Section Head Decision Support	**Document Code: IPP-PSSD-024**	
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CPID Director: مدير ادارة تحسين الاداء المستمر:	Dr. Shaimaa El-Meniawy – CPID Director	**Review Date:**	01.01.2023
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Approved By: موافقة:	Dr Moataz Elzemaity – CMO	**No# of Copies:**	01-DMS 01-Depart.
Authorization By: إقرار:	Dr. Sherif Abouelnaga – CEO 57357 Group	**Department:**	**Pharmaceutical Service and Science**

1.0 Change of policy

1.1 No changes

2.0 Purpose

2.1 To demonstrate the process of medication reconciliation as an important task carried out by every pharmacist receiving the patient at any point of care (Admission to the inpatient unit, Transfer to/from any level of care to another level of care, Discharge from the inpatient.

3.0 Policy

3.1 Policy statement:

3.1.1 To ensure Safe Medication ordering process, Medication reconciliation will be done in case of every patient admission, transfer and discharge by the pharmacist responsible in the area of service.

3.2 Scope:

3.2.1 This policy and procedures apply on all CCHE patients.

3.3 Responsibilities

3.3.1 All Health Care Providers

4.0 Definitions /abbreviations:

4.1 CCHE: Children Cancer Hospital – 57357 Egypt
4.2 CPID: Continuous Performance Improvement Department
4.3 MMU: Medication Management & Use

4.4 **MMS:** Medication Management & Safety

4.5 **JCI:** Joint Commission International.

4.6 **DPS:** Department of Pharmaceutical Services.

4.7 **Medications:** prescription medications, sample medications, herbal remedies, vitamins, nutraceuticals, over-the-counter drugs, vaccines, diagnostics and contrast agents, radio-pharmaceuticals, respiratory therapy treatments, parenteral nutrition's, blood derivatives, and intravenous solutions.

4.8 **Medication Reconciliation:** is the process of comparing a patient medication order to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, drug interactions, and adverse events.

4.9 **ADR:** Adverse Drug Reactions.

5.0 Procedure:

5.1 General Guidelines:

5.1.1 JCI has noted that "Patients are most at risk during transitions in care (hand – offs) across settings, services, providers or levels of care." and defined an expectation that medication reconciliation be provided for patients.

5.1.2 Medication regimen review by the pharmacist is an integral element of pharmacy practice and contributes to meeting standards of practice including JCI's expectations for medication reconciliation.

5.1.3 A pharmacist will review and evaluate patient medication regimens for each inpatient admission within 24 hours of admission, transfer to/from intensive care and at discharge.

5.1.4 Patients and patient parents are counseled to bring any home medication has been taken by the patient or any remains from the previous dispensed medications at any time the patient visits the hospital.

5.1.5 There will be a direct pharmacist patient-awareness assessment, education with consultation and communication with the primary physician, nursing staff and other clinical staff regarding that medication.

5.1.6 Pharmacist will review all reasons for returns and he shall perform a Risk assessment for medications (Check the source of medication, its expiry date and how the medications stored at home).

5.1.7 The pharmacist assumes responsibility and accountability for assuring that the medication therapy is consistent with the plan of care defined by the patient's primary physician, protocol dictated treatment, patient clinical status, and concurrent therapy.

5.1.8 The pharmacist will assist the clinical and nursing staff in maintaining the medication profile in the electronic medical record.

5.1.9 Medications reconciliation process is multidisciplinary process shared among physicians, nurses and pharmacists.

5.2 Medication Regimen Review/Medication Reconciliation:

5.2.1 The DPS will work closely with the clinical staff to maintain the accuracy of the medication profile as found in Power Chart.

5.2.2 A medication regimen review will include a pharmacist/patient interaction to reconcile medications, provide patient education regarding medications and assess outcomes of

current therapy when determined necessary based on the pharmacist's assessment or requested by a member of the clinical staff.

5.3 During the review of the medication profile, a pharmacist will:

5.3.1 review the patient's medication list from Power Chart.

5.3.2 Review the medication list with the patient/family ensuring the medication list reflects the medications the patient is currently taking, and the most convenient route of administration.

5.4 Reviews medications brought in by the patient.

5.4.1 Review reasons for returns and shall be performing risk assessment for medications and how the medications stored and their expire dates.

5.4.2 If the patient admitted to inpatient department the round pharmacists will review the medication after medications reconciliation with stopped medication and return to main pharmacy and removes the medications that patient will continue on until patients discharge, it will be handed over to patient, while following the hospital policy in dispensing these medications during the visit as a unit doses.

5.4.2.1 If returns due to incompliance or inconvenience dosage, pharmacist should find alternative solutions for the patient after discussion with patient/ patient's parent.

5.4.2.2 If the patients admitted to inpatient ward and after he had reconciled, the pharmacist found that the patient brought some medications which are non-formulary medications and the hospital did not have any alternative for these medications, the round Pharmacists shall do the following:

5.4.2.3 **He should review:** therapeutic duplications, drug- drug interactions, risk assessment for medications
(how the medications stored, their expiry date and quantities).

5.4.2.4 He will store these medications inside pharmacy medications room cabinets and dispense from them as a unit dose after physician enter these medications on Cerner.

5.5 Identify/Evaluate:

5.5.1 Appropriate indication.
5.5.2 Drug selection.
5.5.3 Dosage Regimen.
5.5.4 Compliance/Adherence.
5.5.5 Allergies.
5.5.6 Adverse drug reactions/events.
5.5.7 Interactions.
5.5.8 Identification of non – prescription medications being taken.
5.5.9 review of a proposed new medication against the list of medications the patient is currently taking
5.5.10 Inquire specifically and document any non-prescription and herbal/nutritional supplements the patient may be taking.
5.5.11 Review the Allergy/Adverse Drug Reaction (ADR) history as recorded in the medical record with the patient/family and document as appropriate in the medical record (power chart). During the interview with the patient/family the pharmacist will ask about any new

allergies/ADRs that may not yet be documented. If necessary, the clinical pharmacist will initiate a new ADR form for any new reactions reported.

5.5.12 Compare admission, transfer and discharge orders to the current medication list and resolve any discrepancies. (Omissions, duplications, dosing errors, or drug/food interactions, contraindicated drug, unnecessary drug, necessary lab monitoring, improper route of administration…)

5.5.13 Upon completion of review, the pharmacist will document reconciliation into power chart Ad-hoc noting that the medication profile tab is up to date.

5.5.14 A pharmacist will complete and document a review of a medication regimen within 24 hours of admission, transfer, or discharge with a clinical pharmacy consult note.

6.0 References:

6.1 N/A

7.0 Appendices:

7.1 Related Forms:

7.1.1 N/A

7.2 Related Policy(S):

7.2.1 N/A

7.3 Related Standards:

7.3.1 JCI standards 7th edition – MMU Chapter. (MMU.4)

7.3.2 GAHAR standards. MMS .10 – NSR.13

7.4 Attachments

7.4.1 N/A