



## **SRI LAKSHMI MEDICAL CENTRE AND HOSPITAL**

**18/121 MTP Road,**

**Thudiyalur, Coimbatore – 641 034.**

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The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH.

### **The authority over control of this manual is as follows:**

<b>Preparation</b>	<b>Approval</b>	<b>Issue</b>
RMO (Residential Medical Officer)	Chairman, Sri Lakshmi Medical Centre & Hospital.	Accreditation coordinator


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## **MOM 1 – PHARMACY SERVICES AND USAGE OF MEDICATION**

### **1.0 PURPOSE:**

- 1.1 To provide guide lines for the organization for Pharmacy services, management and usage of Medication

### **2.0 SCOPE:**

- 2.1 Pharmacy and other Patient Care Areas

### **3.0 RESPONSIBILITY:**

- 3.1 Chairman, Doctors(RMO, Duty Doctor), Departmental Heads, Purchase Officer, Stores Incharge and Pharmacists

### **4.0 ABBREVIATION:**

- 4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers  
4.2 MOM : Management Of Medication


### **5.0 DEFINITION:**

### **6.0 REFERENCE:**


- 6.1 NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2014

### **7.0 POLICY**

- 7.1 SMCH pharmacy is registered under Drug Controller of India.  
7.2 Pharmacy shall comply with the following laws and regulations: Drugs and cosmetics act; Food and drug act; Narcotics and psychotropic substance act; Drugs and magical remedies act.  
7.3 A 24 hours pharmacy services is provided in SMCH. Hospital drug formulary is approved by the pharmacy and therapeutic committee and all the drugs are procured based on the list of drugs available in the formulary.  
7.4 All the medications shall be stored at the temperature specifications given by the manufacturer.

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- 7.5 Only authorized person (treating consultant) shall prescribe medications, other than the treating doctor who prescribes the drug shall not be accepted.
- 7.6 Outside prescription shall not be accepted.
- 7.7 In case if Junior Doctor prescribing the medication the prescription shall be counter signed by the treating doctor or the Consultant incharge.
- 7.8 In case of oral orders / telephonic instructions of the consultant, the same shall be noted in the prescription by the pharmacist/staff nurse and counter signature shall be obtained from the consultant within 24 hours.
- 7.9 Read back policy shall be followed.
- 7.10 All the medications shall be administered by the registered nurse based on the doctor's order, if there is any ambiguity in the prescription same shall be cross verified with the concerned doctor either in person or through telephone.
- 7.11 Prescription not made in the hospital letter head or without Consultant name / signature / date, MCI Registration number and time shall not be accepted in the pharmacy and the same shall be returned back to the concerned doctor with the reason for returning back.
- 7.12 A pharmacies and therapeutic committee organized as per the medication needs of the patients shall guide pharmacy services. The committee shall annually review the appropriateness of the hospital formulary to meet the needs of hospital. Acquisition of medicine shall be as per the procedure.

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## **MOM 02 - POLICY AND PROCEDURES TO GUIDE STORAGE OF MEDICATION**

### **1.0 PURPOSE:**

- 1.1 To provide guidelines on storage of medicines.

### **2.0 SCOPE:**

- 2.1 Pharmacy
- 2.2 All Medication storage areas

### **3.0 RESPONSIBILITY:**

- 3.1 Chairman
- 3.2 Purchase Manager
- 3.3 Pharmacy Incharge
- 3.4 Pharmacists

### **4.0 ABBREVIATION:**

- 4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers
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### **5.0 DEFINITION:**

### **6.0 REFERENCE:**

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2014

### **7.0 POLICY & PROCEDURE:**

- 7.1 All the drugs are stored as per the prevalent laws and regulations:
  - 7.1.1 Pharmacy Act;
  - 7.1.2 Narcotics and Psychotropic substances Act;
  - 7.1.3 Drugs and cosmetics Act;

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7.1.4 Food and Drugs Act;

7.1.5 Drugs and magical remedies Act.

7.2 Cyto toxic drugs are not stored in advance. They are ordered only after prior intimation from the patients or Doctors.

7.3 Medication shall be stored as per the storage requirement specified by the manufacturers, (these should address issues pertaining to temperature (refrigeration), light, ventilation, preventing entry of pests / rodents and vermin's) at all location of storage such as stores and pharmacy.

7.4 The storage of medications is done in alphabetical order of their generic names in all the areas.

7.5 Medications shall be stored in a clean, well lit, and ventilated environment.

7.6 Refrigerator storage temperature shall be recorded 3 times a day in the stores and in the pharmacy, whereas in other storage areas, it shall be recorded 3 times a day and the same shall be verified and counter signed by the in-charge staff.

7.7 Medications shall be protected from loss and theft.

7.8 Sound alike and look alike medications shall be stored separately.

7.9 Emergency medicines should be available all time.


7.10 Emergency medications shall be replenished in a timely manner when used.

7.11 Inventory practices (like first in and first out (FIFO, ABC) shall be followed while issuing inventory.

7.12 The medicine shall be stored by generic name in an alphabetical order.

7.13 Organization shall conduct audits at regular intervals every quarter.



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## **MOM 3 - POLICY AND PROCEDURES TO GUIDE PRESCRIPTION OF MEDICATION**

### **1.0 PURPOSE:**

- 1.1 To establish guidelines and policy for prescription of medications for all health care practitioners involved in this process.

### **2.0 SCOPE:**

- 2.1 This policy is applicable Hospital wide to all clinical areas

### **3.0 RESPONSIBILITY:**

- 3.1 Chairman  
3.2 Doctors,  
3.3 Nursing Superintendent and  
3.4 Pharmacist

### **4.0 ABBREVIATION:**


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### **5.0 REFERENCE:**


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### **6.0 POLICY:**

- 6.1 The authorization of raising medication orders is limited to the registered/credentialed physician only.  
6.2 All medical practitioners shall use only standard Prescription format for prescribing medications for the patients and every prescription shall contain name date and signature of the medical practitioner in the prescription. It is recommended that prescription sheet shall be affixed with the stamp of the medical practitioner.

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- 6.3 Each prescription entry in inpatients shall be signed, named, timed and dated by the Physician ordering; in case of oral order by the consultant name shall be written by the junior doctor and counter signed by the senior consultant within 12 hours.
- 6.4 All the medication orders issued to the patients are to be made in the hospital prescription pad by a registered Medical Practitioner identified and authorized by the Management.
- 6.5 Separate prescription shall be written for every patient.
- 6.6 Medical practitioner shall write all medicines in the prescription form as well in the doctors' order sheet in the patient file.
- 6.7 Medical practitioners name and date shall be entered under each signature with legibility to read.
- 6.8 The prescription shall include the route, dosage, strength, time and frequency of administration of the drug.
- 6.9 The patient record shall facilitate and reflect the medication and coordination of care.
- 6.10 Medical practitioners shall ensure that prescription is legible and pharmacist shall resolve unclear and erroneous prescriptions, if any, received with medical practitioner concerned before dispensing with the medicines.
- 6.11 The prescription shall be transcribed by the licensed pharmacist, checked for completeness and then only medication shall be dispensed.
- 6.12 To avoid errors in interpretation abbreviations must not be used. E.g. "Units" must be written in full and not abbreviated to "U". "Microgram" must be written in full and not abbreviated to "mcg" or "ug". "Six hourly" must be written in full and not abbreviated to "6/24."
- 6.13 Verbal orders shall be utilized only in situations where the ordering doctor is not available to write the order and delay will result in a compromise in patient care. Every effort shall be made to minimize the use of verbal orders.
- 6.14 In case of any emergency, verbal order is given by the treating consultant. Read Back Policy shall be followed by the concerned Staff. The same shall be followed by a written order and verification by the consultant who has prescribed and the same shall be cross signed by the Consultant within 12 hours.


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- 6.15 Whenever there is doubt regarding a particular prescription (such as illegible handwriting, wrongly written strength/dose or frequency, doubt regarding similar sounding medicines, duplication etc.) or when a prescription is incomplete (without sign, date, etc), the junior doctor/pharmacist /nurse shall promptly call the Doctor and get it corrected without causing inconvenience for patient.
- 6.16 Prescriptions & Orders raised by all registered doctors shall be honored as long as the patient is eligible for care.
- 6.17 All medicines shall be checked for name of the drug and expiry date prior to dispensing.
- 6.18 Drugs are ordered from the pharmacy for an individual patient shall be on prescription basis by the registered nurse. The registered nurse shall crosscheck the received drugs for patient's name, drug name, and strength.
- 6.19 In case of any accidental dispensing of defect product, it is the responsibility of the Pharmacy Supervisor to identify and get back those medicines and document in Drug Recall Register.
- 6.20 Pharmacist/ Care providing nurse shall verify the allowable dosage as per standard and prescription for high risk medicines before dispensing. Also special attention shall be paid to educate the patients while using high risk medicines by nursing staff. High risk medicines shall be identified from the high risk medicines list available with the pharmacist.
- 6.21 Nursing station shall request crash cart drugs from the pharmacy using approved pharmacy requisition.
- 6.22 Administering medications is limited to credentialed physicians and credentialed nurses only.
- 6.23 The Pharmacy Service shall be responsible for the proper packaging and labeling of all drugs or chemicals dispensed by the Pharmacy for use in patient treatment. Labels and barcodes used by the Pharmacy shall be distinctive and not used by other Hospital departments.

## **7.0 PROCEDURE:**

### **7.1 Rational prescription of medication:**

- 7.1.1 The patients examined by the doctors are to be prescribed only the medicines required by that particular patient appropriate to his / her clinical needs, in doses that meet their individual requirement, for an adequate period of time and at the lowest possible cost to them and their

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community. None other than a qualified doctor is permitted to prescribe medicines to a patient seeking treatment at the hospital.

7.1.2 When the patients are discharged the remaining medicines shall be handed over to the patients/relatives and they are instructed on how to use them at home. If the medicines are not sufficient they are given fresh continuation prescriptions. If some of the medicines come as balance they can be returned to the pharmacy by the patient and they will be refunded the money of the returned medicines with bill if they are found to be in resalable condition.

## 7.2 Requirements of prescription:

7.2.1 Each prescription or continuation prescriptions should be signed with date / time by the doctor.

7.2.2 The following details shall be contained in all prescriptions, minimum:

7.2.2.1 Patient's ID number;

7.2.2.2 Patient's name & date of prescription;

7.2.2.3 Age and weight of pediatric patients;

7.2.2.4 Generic name of medicine;

7.2.2.5 Dosage regimen;

7.2.2.6 Strength or concentration of drug;

7.2.2.7 Quantity or total number of doses required;

7.2.2.8 Directions for use;


7.2.2.9 Prescriber's signature, name (clinical stamp if provided), time and date shall be mentioned.

7.2.2.10 Each medicines order must be individually signed;

7.2.3 The OP visiting patients shall be prescribed medicines in the particular OP prescription form by the doctor with Name, Sign, time and date.

7.2.4 Repeat prescriptions shall be written on the same prescription form with date, sign or they may be given similarly signed fresh prescriptions.


7.2.5 The patients OP number should be entered on each prescription form and the details of the prescription is also entered on the patient OP card which will be retained by the hospital.

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7.2.6 In the case of inpatients the doctor who visits the patients during rounds in the patient's hospital room may advise medications which should write down in the drug order sheet in the patients file. This order/prescription should also be legibly written with details regarding dose, duration, mode and frequency of administration etc. and duly signed with date, time. The ward staff will procure these medicines from the pharmacy and keep it separately for each patient. These medicines should be administered according to the doctor's orders by the nursing staff to the inpatients.

### 7.3 **Verbal orders:**

- 7.3.1 In the case of in patients, in emergency situations if the doctor gives any verbal orders or telephonic orders regarding medicines to be administered to a particular patient.
- 7.3.2 The individual accepting the verbal order shall record and then read back the order in its entirety to the prescribing physician at the time the order is given, documenting that the order was "read back" (RB).
- 7.3.3 Nursing staff shall tag all verbal orders with a "SIGN HERE & DATE" tag to alert the physician of the need to sign the verbal order upon return to the unit.
- 7.3.4 Nursing staff are permitted to act upon verbal orders provided the orders contain the appropriate information.
- 7.3.5 Verbal and telephone orders shall be signed or initialed by the prescribing practitioner as soon as possible, not later than 24 hours.
- 7.3.6 When the ordering physician is unavailable, it is acceptable for another team member or the attending staff to authenticate the verbal order.
- 7.3.7 Whenever there is doubt regarding a particular prescription (such as illegible handwriting, wrongly written strength/dose or frequency, doubt regarding similar sounding medicines, duplication etc.) or when a prescription is incomplete ( without sign, date, etc), the pharmacist should promptly call the doctor and inform him and get it corrected without causing inconvenience for the patient.
- 7.3.8 The attending nurse shall remind the treating doctor about the patients known drug allergies as marked with red ink on the patients file so that the patient does not receive that drug.

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**7.4 High-risk medication:**

7.4.1 To identify potential high risk medications and to outline steps to prevent errors that may result from confusion of these medications.

**7.4.2 Circumstances Increasing Errors in High Risk Medications:**

7.4.2.1 Poorly handwritten medication orders.

**7.5 Verbal directions/orders.**

7.5.1.1 Similar product packaging.

7.5.1.2 Similar medication name.

7.5.1.3 Improper packaging leading to improper route of administration.

7.5.1.4 Storage of products with similar names in the same location.

7.5.1.5 Similar abbreviations. Improper storage of concentrated electrolytes

**7.5.2 Strategies to Avoid Errors Involving High Risk Medications:**

7.5.2.1 **Medication arrangement:** Avoid storing look-alike, sound-alike drugs next to each other (example: instead of storing by generic name (e.g. vincristine and vinblastine) store drugs by brand name (e.g. Oncovin and Velban). Limit high risk drug storage.

7.5.2.2 **Formulary selection:** Minimize look-alike, sound-alike formulary combinations.

7.5.2.3 **Prior verification:** As an additional precaution, high risk medication orders are verified prior to dispensing

**7.5.3 List of High risk medications:**

1.Inj.Heparin

2.Inj.Insulin


3.Inj.Propofol

4.Inj.Nitroglycerine

**8.0 HIGH RISK MEDICINES**

1.Ciplar 40

2.Ciplar 10

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3.Prolomet XL 25 mg

4.Calmpose 5 mg

5.Alprax 0.5 mg

6.Alprax 0.25 mg

7.Lonazep 0.5

8.Potassium Inj.

9.Lasix 40 mg

10.Zolpid 10 mg

11.Misoprost 200

12.Heparin 25K

13.Sodium Bicarbonate

8.1.1 The record in the register shall include the following details for each receipt and issue:

8.1.1.1 Date; name & address of person from whom medicines received or to whom supplied;

8.1.1.2 Quantity of medicines received or supplied;

8.1.1.3 Balance remaining;

8.1.1.4 Name of prescriber;

8.1.1.5 Signature of person making the entry;

8.1.1.6 Signature of person checking.


8.1.1.7 This record to be maintained by In-charge pharmacy and is responsible for any irregularity.

8.1.2 The Dangerous drugs Register entry must record the following details:

8.1.2.1 Date;

8.1.2.2 Time;

8.1.2.3 Patients name;

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- 8.1.2.4 Medical record number;
- 8.1.2.5 Amount administered;
- 8.1.2.6 Amount discarded (if part ampoule administered);
- 8.1.2.7 Balance remaining;
- 8.1.2.8 Signature of person making the entry;
- 8.1.2.9 Signature of person checking;
- 8.1.2.10 Name of the prescriber.

## 8.2 **Scope of the audit:**

8.2.1 The scope of the audit includes:

- 8.2.1.1 The appropriateness of the drug, dose, frequency and route of administration.
- 8.2.1.2 The presence of therapeutic duplication
- 8.2.1.3 The possibility of drug interaction and measures taken to avoid the same
- 8.2.1.4 The possibility of food – drug interaction and measures taken to avoid the same
- 8.2.1.5 The requirements to ensure completeness of prescription
- 8.2.1.6 The requirements to ensure completeness of entries in the medication charts.
- 8.2.1.7 The completeness of medications orders to ensure that they are clear, legible, dated, timed, named and signed.
- 8.2.1.8 The completeness of medications orders to ensure that they contain the name of the medicine, route of administration, dose to be administered and frequency / time of administration.



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## **MOM 4 - POLICY AND PROCEDURES TO GUIDE SAFE DISPENSING OF MEDICATION**

### **1.0 PURPOSE:**

- 1.1 To establish policies for drug dispensing in all Inpatient, Outpatient areas and guide lines for medication recall.

### **2.0 SCOPE:**

- 2.1 Pharmacy department

### **3.0 RESPONSIBILITY:**

- 3.1 Pharmacy In-Charge  
3.2 Pharmacists  
3.3 Pharmacy Staff

### **4.0 ABBREVIATION:**

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### **7.0 POLICY**

- 7.1 Dispensing of medication shall be conformed to applicable laws and regulations governing pharmacy practice in state of Tamilnadu and India.
- 7.2 The order shall be screened for appropriateness of drug, dose, and frequency, route of administration, therapeutic duplications, drug-drug interactions, allergies, and formulary status. Labelling requirements (at a minimum, labels must include the drug name, strength; frequency of

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administration (in a language the patient understands) shall be documented and implemented by the organization.

- 7.3 Expiry dates shall be checked prior to dispensing.
- 7.4 In case of contaminations, short expiry drugs, expired drugs etc., drugs shall be recalled as per the procedure. Drugs to be sent back to pharmacy and informed about this status in written to In-charge.
- 7.5 All medications shall be verified by the Departmental Head at the time of receipt of goods and the same shall be checked for damages and contaminations.
- 7.6 According to the feedback from patients or staff, the pharmacy should have a recall procedure if the medicine is contaminated or expired.
- 7.7 In case of any such incidence, same shall be returned back to the pharmacy along with the bill (batch and serial number).

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## **MOM 5 - POLICY AND PROCEDURES FOR MEDICATION ADMINISTRATION**

### **1.0 PURPOSE:**

- 1.1 To provide guidelines for safe medication management and administration to patients.

### **2.0 SCOPE:**

- 2.1 Hospital Wide

### **3.0 RESPONSIBILITY:**

- 3.1 Doctors / Consultants,  
3.2 Nursing staff

### **4.0 ABBREVIATION:**

- 4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers  
4.2 MOM : Management Of Medication

### **5.0 DEFINITION:**


### **6.0 REFERENCE:**

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2014

### **7.0 POLICY**

#### **7.1 Personnel for medication administration:**

- 7.1.1 The individual who administers the medication is responsible for ensuring that the right medicine with right dose is administered to the right patient through the right route at the right time.
- 7.1.2 All medications shall be administered as ordered by the physician, by an authorized health care professional.

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7.1.3 A registered nurse or licensed practical nurse is approved to administer medications to the patient as ordered by the physician. If the medical staff member authorized to administer the medication has questions concerning the physicians' order, he/she should consult the physician or pharmacist prior to administering the medication.

**7.2 Labeling of medication:**

7.2.1 Already prepared medications shall be labeled with the name of the drug, dosage, timing, start date & time, sign of the personnel prior to preparation of the second medication, applicable only for parenteral drugs.

**7.3 Patient identification prior to administration:**

7.3.1 The patient shall be verified by his / ID No and Name prior to administration of the drug.

**7.4 Medication verification:**

7.4.1 The medication shall be checked by the administering personnel with respect to:

7.4.1.1 Treatment orders

7.4.1.2 General appearance of the medicine

7.4.1.3 Medication name

7.4.1.4 Dosage

7.4.1.5 Frequency and time


7.4.2 In case of verbal orders, the verification shall be done by 'read back' method.

7.4.3 In case of high risk medications, the verifications shall be done independently by at least 2 staff, either a nurse-nurse or nurse-doctor and documented.

7.4.4 The documentation after administration shall be done in the medication chart.

**7.5 Dosage verification:**

7.5.1 The dose of the medication to be administered shall be double-checked by the nurse from the treatment orders and documented in the medication chart.

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**7.6 Route verification:**

7.6.1 The route of administering the medication shall be double-checked by the nurse from the treatment orders and documented in the medication chart.

**7.7 Timing verification:**

7.7.1 Standard medication administration times will be observed for administration of medications such as o/d, b/d, tds, hs, etc.

7.7.2 The timing / frequency of the medication to be administered shall be double-checked by the nurse from the treatment orders and documented in the medication chart

**7.8 Documentation of medication administration:**

7.8.1 There shall be a uniform location for documenting the medication administration, the medication chart to be used commonly for all IP areas ensuring continuity of medication given.

7.8.2 All the entries in the chart shall include the:

7.8.2.1 Date of entry

7.8.2.2 Name of medication

7.8.2.3 Dosage

7.8.2.4 Route of administration

7.8.2.5 Timing


7.8.2.6 Name and signature of the person who has administered the medication.

7.8.3 In case of infusions, it shall capture the start time, the rate of infusion and end time.

**7.9 Self-administration of medication:**

7.9.1 Self-administration of injectable drugs shall not be permitted in the Inpatient care areas.


7.9.2 Patients own oral medications brought in by the patients who are on chronic therapy (e.g. Conditions like Hypertension, Diabetes mellitus, Cancer, TB) shall be known to the treating physician and will be allowed to administer to the patient under the supervision and

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certification of treating physician, such medications shall also be recorded in patient's record.

**7.10 Medications brought from outside:**

- 7.10.1 Drugs bought from outside the organization are not allowed. In case of non-availability of some drugs, this may be allowed.
- 7.10.2 Bill, Label, Dose and Expiry date shall be verified before administering to patient.
- 7.10.3 Doctor or nurse shall educate the patients and the family members about safe and effective use of medication and about the food-drug interactions.

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## **MOM 6 - ADVERSE DRUG EVENTS MONITORING**

### **1.0 PURPOSE:**

- 1.1 To ensure patient safety after the administration of medication creating a system for monitoring, reporting and analyzing the medication errors and adverse drug reactions.

### **2.0 SCOPE:**

- 2.1 Hospital Wide – All Inpatient care areas

### **3.0 RESPONSIBILITY:**


- 3.1 Consultants, all Doctors,  
3.2 Nursing Staff &  
3.3 Pharmacy and Therapeutic Committee

### **4.0 ABBREVIATION:**

- 4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers  
4.2 MOM : Management Of Medication  
4.3 N.S : Nursing Superintendent  
4.4 M.S. : Medical Superintendent  
4.5 ICU : Intensive Care Unit  
4.6 RR : Recovery Room  
4.7 RMO : Resident Medical Officer

### **5.0 DEFINITION:**

- 5.1 **Adverse Drug Reactions:** Adverse drug reaction (ADR) is any noxious, unintended, undesirable, or unexpected response to a drug that occurs at doses used in humans for prophylaxis, diagnosis, therapy of disease, or for modification of psychological function. This definition is understood to exclude predictable, dose-related side effects due to drugs which result in little or no change in

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patient management, and in particular, mild extra pyramidal side effects due to neuroleptic drug therapy.

- 5.2 **Medication errors:** A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional. Such events may be related professional practice, procedures, and systems, including prescribing; communication; labeling, packaging, and nomenclature; dispensing; distribution; administration; education; monitoring and use.
- 5.3 **Types of errors: Order Error** – Types of ordering errors include: inappropriate medication selected, inappropriate dose, illegible order, duplicate order, order not dated/timed, wrong patient/chart selected, contraindications, verbal order misunderstood, verbal order not written in the drug chart, wrong frequency, route, illegible writing, therapy duration, alert information bypassed or use of nonstandard nomenclature or abbreviations.
- 5.4 **Transcription error** – Transcription involves both the orders that are manually transcribed onto manual record (e.g. Drug chart). **Types of transcription errors include:** wrong medication, time, dose, frequency, duration, rate patient/chart, verbal order misunderstanding, verbal orders not entered into patient case sheet.
- 5.5 **Preparation/Dispensing Error** – Types of preparation and dispensing errors include: Inaccurate Labeling, wrong quantity, medication, dose, diluents, formulation, expired medication, Pyxis refill error, and delay in medication delivery.
- 5.6 **Administration Error** – **Types of administration errors include:** Wrong patient, dose, time, Medication, route, rate, extravasation (may be an ADR) and unauthorized dose given


## 6.0 REFERENCE:

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2014

## 7.0 POLICY:

- 7.1 On notice of an unusual incident regarding a medication nursing staff shall immediately report to the consultant and the nursing staff.




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- 7.2 A report is submitted to Pharmacy and Therapeutic committee chairman for corrective actions.
- 7.3 If the patient has sustained serious illness as a result of the incident, Risk Management must be notified. The medication error report includes: 1. Patient demographics ( name, location, medical service); 2. Notation as to medical personnel who were notified of the incident (i.e. physician); 3. Severity rating of the incident; 4. Accurate description of incident.
- 7.4 All patients shall be monitored after medication administration by enquiring every patient or by documenting if the patient tells.
- 7.5 **Indications of adverse drug reactions:** Indications of an ADR include anaphylaxis, arrhythmia, convulsions, hallucinations, shortness of breath, rashes, itching, hypotension, dystonia, leukopenia, urinary retention, symptoms associated with neuroleptic malignant syndrome, initial report of tardive dyskinesia, EPS related to non-antipsychotic drugs and also includes true allergic (hypersensitivity) reactions and idiosyncratic reactions. All adverse drug reactions shall be reported to the consultant N.S. / M.S. / Dy. M.S. within 10- 15 minutes and the interventions observed will be documented in the patient case sheet. All adverse drug reactions will be reported to the pharmacy and therapeutic committee in a standardized format. All adverse drug reactions are intensively analyzed by Pharmacy and Therapeutic committee and the corrective actions are taken based on the discussion.


## 8.0 PROCEDURE:

- 8.1 **Procedure for the Identification and Review of any Medication Errors:** The inpatients who are administered different drugs need monitoring during their stay in the hospital. This is of paramount importance in the case of patients undergoing treatment in the ICU's. Certain drugs can produce serious immediate or delayed side effects. Patients with past history of drug allergies shall be identified. If drugs prone to produce allergic reactions, it should be done with caution. A small dose of the drug is given intra dermal and marked with time, if any drug allergy is noted the main dose administration is withheld and the doctor shall be informed. Drug reactions producing cardiac, neurological, pulmonary, skin etc. side effects shall be promptly identified and the concerned doctor should be promptly informed and remedial action is taken. All events and actions taken should be

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recorded by the concerned nurses in the patient's case sheet and signed with date. The medical superintendent and the nursing superintendent or the nursing supervisor shall be notified in cases where wrong medications are administered to a patient, or there has been negligence on the part of the nursing staff in following directions of drug administration and necessary investigations should be initiated. When Intra Venous (I.V) medications are given the nurse must be present along with the patient to monitor the progress or note any undue side effects. Starting and discontinuation of I.V medication shall be done by the treating nurse and the details should be noted in the case sheet with sign, date and time. The nurse should enquire about the patient's welfare from time to time after such treatment and make sure that everything has been running smoothly.

- 8.2 **Procedure for the Identification and Review of Adverse Drug Reactions (ADR):** Adverse drug events are defined and the staff nurse who has administered the drug will be reported to the doctor immediately and remedial actions will be taken, and before the shift, the concerned staff should fill the prescribed ADR forms available in all clinical areas. It should be given to the nursing superintendent through concerned nursing supervisor. Adverse drug events shall be collected and analyzed. Report and evaluate ADRs occurring in the concerned Pharmacy & therapeutic Committee meetings. These events shall then be analyzed by the committee to identify probable cause and suggest and implement measures to prevent the same in future. Policies are modified to reduce adverse drug events when unacceptable trends occur. Labels, vials, packets of medicine due to which adverse event occurred shall be secured by on duty staff nurse and given to committee. Inform healthcare providers about ADRs to improve patient care.

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## **MOM 7 - PROCEDURES FOR MEDICATION ADMINISTRATION**

### **1.0 PURPOSE:**

- 1.1 To ensure patient safety after the administration of medication by continuous monitoring, a system for monitoring the medication errors and adverse drug reactions.

### **2.0 SCOPE:**

- 2.1 Hospital Wide – All Inpatient care areas

### **3.0 RESPONSIBILITY:**

- 3.1 Consultants, all Doctors,  
3.2 Nursing Staff &  
3.3 Pharmacy and Therapeutic Committee

### **4.0 ABBREVIATION:**


- 4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers  
4.2 MOM : Management Of Medication  
4.3 ICU : Intensive Care Unit  
4.4 RR : Recovery Room  
4.5 RMO : Resident Medical Officer

### **5.0 REFERENCE:**

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2014

### **6.0 POLICY:**

- 6.1 All patients shall be monitored after medication administration to verify that the medication is having the intended effect and also to detect any near misses, medication errors and adverse drug reactions.

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6.2 Critical areas such as the ICU shall require close monitoring of the patient every hour or earlier as per the treatment requirements.

6.3 The monitoring shall be done through collaborative means involving the RMO and Nurses.

6.4 Medications, as well as dosages, shall be adjusted if required based on the observations.

## **7.0 PROCEDURE:**

### **7.1 Procedures to ensure appropriate patient monitoring after medication:**

7.1.1 The medication administered is noted in the medication chart by the nursing staff.

7.1.2 Thereafter, all the charts are maintained periodically to ensure that the medication is having the intended effect on the patient.

7.1.3 The different charts to be maintained are:

7.1.3.1 Medication

7.1.3.2 Temperature, pressure and heart rate (TPR)


7.1.3.3 Intake – Output

7.1.3.4 Nurses' notes

7.1.4 In the intensive care areas, the RMO and nurses are responsible to ensure that the patient condition is stable after medication administration.

7.1.5 In the wards, the RMOs are responsible to ensure that the patient condition is stable after medication administration.

7.1.6 Any variation in the patient condition during the monitoring is immediately notified to the concerned treating doctor either directly by the nursing staff or RMO whichever appropriate in the given setting.

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## **MOM 8 - POLICY AND PROCEDURES FOR USE OF NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES**

### **1.0 PURPOSE:**

- 1.1 To ensure safe and rational use of Narcotic and Psychotropic substances.

### **2.0 SCOPE:**

- 2.1 Pharmacy
- 2.2 Purchase
- 2.3 Hospital Wide – All Inpatient care areas

### **3.0 RESPONSIBILITY:**

- 3.1 Consultants / Doctors,
- 3.2 Nursing Staff
- 3.3 Pharmacy and Therapeutic Committee


### **4.0 ABBREVIATION:**

- 4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers
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### **5.0 DEFINITION:**

### **6.0 REFERENCE:**

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2014

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## 7.0 POLICY

- 7.1 Usage of narcotic drugs and psychotropic substances are in consonance with Narcotic drugs and psychotropic substances act.
- 7.2 Narcotic drugs and psychotropic substances shall be used as per Narcotic drugs and psychotropic substances Act.
- 7.3 A proper record of its uses, administration and disposal shall be maintained.
- 7.4 Only appropriate personnel shall handle these drugs in accordance with policies.
- 7.5 Narcotic and psychotropic medicines shall be issued only on registered medical practitioner's prescription.
- 7.6 The Narcotics shall be stored under double lock and key to ensure its rational usage throughout the hospital.
- 7.7 Other than narcotic drugs, no items are permitted to be stored in the narcotic drug cupboard including money.
- 7.8 Issues shall be under perpetual declining inventory and against prescription from the medical practitioner. The prescribing practitioner shall be responsible in case the prescription does not conform to statutory regulations. Nursing station shall ensure the entry of batch number in the prescription form while administering. Security clause for storage: All containers used for holding and storing narcotic drugs shall be properly labelled. Appropriate registers shall be maintained to have enough information on its usage.
- 7.9 Pharmacist shall be notified if any medicines or register is missing.
- 7.10 The narcotic drugs register must incorporate a record of all receipt and issue involving narcotic drugs.
- 7.11 The narcotic drugs register must be a bounded book with consecutively numbered pages.
- 7.12 A separate page must be used for; each narcotic drugs.
- 7.13 A proper record of its uses, administration and disposal shall be maintained at all the places wherever narcotic drugs are stored.
- 7.14 Weekly audits are conducted by Medical Superintendent and chief pharmacist.