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MOM

Chapter Book

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Annual Documents adequacy & Change Requirements Review

Sr. No	SOP /Doc No	Documents Name	Issue. No	Rev.No	Review Date	Change	Rev No	Revision Date	Reason for Change	Amendment
1	SDH/MOM/1.A	Pharmacy services and medication usage are implemented following written guidance	1	1	1-NOV-22	No Any change review completed	1	1-NOV-23	No Any change review completed	No Any Amendment History
2	SDH/MOM/1.D	There is a procedure to obtain medication when the pharmacy is closed	1	1	1-NOV-22		1	1-NOV-23		
3	SDH/MOM/2.E	The organisation adheres to the procedure for the acquisition of formulary medications	1	1	1-NOV-22		1	1-NOV-23		
4	SDH/MOM/2.F	The organisation adheres to the procedure to obtain medications not listed in the formulary	1	1	1-NOV-22		1	1-NOV-23		
5	SDH/MOM/3.C	The organization defines a list of high-risk medication(s).	1	1	1-NOV-22		1	1-NOV-23		
6	SDH/MOM/3.E	High-risk medications including look-alike, sound-alike medications and different concentrations of	1	1	1-NOV-22		1	1-NOV-23		

		the same medication are stored physically apart from each other								
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8	SDH/MOM/4.B	Medication prescription is in consonance with good practices/guidelines for the rational prescription of medications.	1	1	1-NOV-22		1	1-NOV-23		
9	SDH/MOM/4.E	Implementation of verbal orders ensures safe medication management practices	1	1	1-NOV-22		1	1-NOV-23		
10	SDH/MOM/5.A	The organization ensures that only authorized personnel write orders	1	1	1-NOV-22		1	1-NOV-23		
11	SDH/MOM/6.A	Dispensing of medications is done safely	1	1	1-NOV-22		1	1-NOV-23		
12	SDH/MOM/6.B	Medication recalls are handled effectively	1	1	1-NOV-22		1	1-NOV-23		
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17	SDH/MOM/7.J	Measures to govern patient's self-administration of medications are implemented	1	1	1-NOV-22		1	1-NOV-23		
18	SDH/MOM/8.A	Patients are monitored after medication administration	1	1	1-NOV-22		1	1-NOV-23		
19	SDH/MOM/8.C	The organization captures near miss, medication error and adverse drug reaction	1	1	1-NOV-22		1	1-NOV-23		
20	SDH/MOM/8.D	Near miss, medication error and adverse drug reaction are reported within a specified time frame	1	1	1-NOV-22		1	1-NOV-23		
21	SDH/MOM/9.A	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents are used safely	1	1	1-NOV-22		1	1-NOV-23		
22	SDH/MOM/10.A	Recall of implantable prosthesis and medical	1	1	1-NOV-22		1	1-NOV-23		

		devices are handled effectively								
23	SDH/MOM/10.B	The organization implements a mechanism for the usage of the implantable prosthesis and medical devices	**1**	**1**	1-NOV-22		1	1-NOV-23		
24	SDH/MOM/11.A	The organization adheres to the defined process for the acquisition of medical supplies and consumable	1	1	1-NOV-22		1	1-NOV-23		
		Original Date	**Effective Date**		**Next date of revision**		**Issue NO**			
		01 Nov 20	**20 November 2023**		**20 November 2024**		1			

Reviewed & Prepared By	**Recommended By**	**Approved By**
Mrs.Shraddha suryavanshi	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director

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Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director

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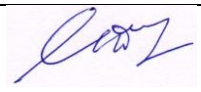
Mrs.Shraddha suryavanshi	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director

CHAPTER NAME – MOM 1. A

Pharmacy services and medication usage are implemented following written guidance

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

INTRODUCTION

This policy has been formulated to ensure as far as possible compliance to various standards pertaining to Management of Medications (MOM) as prescribed by the NABH Accreditation Standards.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the process of medication management at various units of the hospital to ensure patient safety and well being.

RESPONSIBILITIES

Medical Superintendent

The overall responsibility of implementing the policy rests with the MS of the hospital.

HODs / Unit Heads

They are responsible for implementing the various guidance in terms of ordering and administration of medications.

HOD - Pharmacy

Is responsible to ensure that the policies pertaining to pharmacy services are implemented.

POLICIES

A. Pharmacies

The hospital operates the following pharmacies;

- Following pharmacy outlets in the hospital.

1) The Main Pharmacy is located at the ground floor of the hospital which works 24x7.
2) Retail Pharmacy for Orthopedics and Neurology
3) General Pharmacy at Second Floor – 24 x 7 Operations
4) General Pharmacy for Third Scheme Patients
5) General Pharmacy in 4th Floor – Medicine Returns

The Chief Pharmacist is responsible to ensure that these pharmacies operate under updated and suitable licenses issued by the state drugs authority.

B. Drugs & Pharmacy Committee

The hospital has a Drugs & Therapeutic Committee which is multi-disciplinary in nature and the committee is empowered to establish and monitor an effective medication management system in the hospital.

The constitution and working system of the committee is described in the relevant section of the hospital manual.

C. Drug Formularies

The hospital formulary shall be made available in all wards and department for easy reference. The same shall be accessible through the Hospital network.

The same is approved and periodically reviewed by the Pharmacy & Therapeutics Committee (PTC) All updating / amendments of the formulary have to be approved by the PTC.

There are certain medications which are prepared in the hospital itself.

At times the hospital allow IP patients to procure medicines from outside, during situations like when the prescribed medicine is either out of stock or not included in the hospital's drug list.

D. Purchasing and Procurement

The method of purchase of a drug in the pharmacy is by inviting tenders from the manufactures/wholesalers.

The Central Pharmacy will be the only purchasing and procurement point for medicines in the Hospital. The detailed procedure governing the purchase of medications is specified in the Pharmacy Services SOP

The purchasing and procurement of drugs are controlled by the Drugs & Therapeutic Committee established by the hospital.

E. Policy for the Introduction of New Drugs

Introduction of a new drug in the hospital is based on the doctor's intend which, has to be approved by the drugs and therapeutic committee.

The procurement of a new drug is done by issuing purchase orders to the manufactures/wholesalers.

All patients of Lisie Hospital will be prescribed all the medicines they clinically require, based on their diagnosis from the hospital formulary.

To ensure the best use of resources there is a formal procedure for the introduction of new drugs. No new drug will be prescribed without prior authorization from the Drug and Pharmacy Committee.

For inclusion of the new drug in the formulary an application for the same would be sent to the Medical Superintendent. (Refer to the Bylaws of the Drugs & Pharmacy Committee)

F. Obtaining of Drugs not listed in formulary

The method adopted to get an emergency drug that is not there in the formulary is done by:

- Identifying the different brands and manufactures of the drug.
- Contacting the manufacture/wholesalers/other hospitals.
- Placing an emergency purchase order.

On specific request the pharmacy will make arrangements for procurement of the same. This shall be done only in cases where the same is ordered through a prescription by the Head of Departments / Senior Consultants.

All such instances will be reported to the Medical Superintendent by the pharmacy on a daily basis.

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment.
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and issuing the drugs explaining to the patient regarding the drug intake, do's and don'ts etc.

The medicines in the shelf of store, all retail areas, wards, critical care areas, OT etc. are checked once in every month for expiry date by the concerned staffs responsible, the medicines are returned to the dealers 3 months prior to expiry through pharmacy.

PROCEDURE (S)

The following policies have been established by the hospital to ensure an effective medication management system

- LSH/MOM/02 - Storage of Medication
- LSH/MOM/03 - Prescription of Medications
- LSH/MOM/04 - Verbal orders
- LSH/MOM/05 - High risk medication
- LSH/MOM/06 - Medication Dispensing and Labeling
- LSH/MOM/07 - Medication Administration
- LSH/MOM/08 - Medication- Patient ' s own medicine

- LSH/MOM/09 - Medication error
- LSH/MOM/10 - Adverse Medication Events
- LSH/MOM/11 - Narcotics &Psychotropic Substances Handling
- LSH/MOM/12- Medication - Implantable prosthesis
- LSH/MOM/13 - Policy on Medical supplies and consumables

Procedures have been established as a part of the Pharmacy Department Manual for defining and establishing a system for procurement, storage and dispensing of medications in the hospital;

- Procedure for Procurement of drugs
- Procedure for Central Pharmacy Operations
- Procedure for Retail Pharmacy Operations

The hospital has established separate policy and procedure for reporting and analysis of Adverse Drug Events.

MONITORING

The Drugs & Pharmacy Committee monitors the adherence to the medication management policy and processes across the hospital.

Individual Nursing Unit in-charges are responsible for monitoring of the implementation of the policies and procedures pertaining to medication management at the ground level on a day to day basis.

REFERENCES

Standards

MOM 1 & 2

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to the functioning of the Central Pharmacy of the hospital responsible for purchase and distribution of medications to retail pharmacies and other areas of the hospital
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

1. PURPOSE:

To define and describe the system of receipt, inspection, storage and issue of drugs at the central pharmacy.

2. SCOPE:

This procedure is applicable for all drugs and therapeutics purchased / supplied to the hospital.

3. DEFINITIONS

Drugs – For the purpose of this procedure and manual, drugs include prescription medications, samples, over-the-counter drugs, vaccines, sera, diagnostic and contrast agents administered to in-patients / out-patients to diagnose, treat or prevent diseases / conditions. These shall be inclusive of radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, intravenous solutions etc.

4. RESPONSIBILITY

The Pharmaco-Therapy Committee is responsible for the approving various types drugs and manufacturers to be procured for use in the hospital.

The Chief Pharmacist is responsible for overall management of the central pharmacy.

The Pharmacist – In-Charge Central Pharmacy is responsible for receipt, inspection, storage and issue of various drugs and therapeutics at the central pharmacy.

5. DESCRIPTION

The central pharmacy acts as point of procurement, receipt and storage of drugs to the hospital. It issues drugs to the retail pharmacies, surgical store, relevant sub-stores and units based on requisitions.

5.1 Purchase Functions

All purchasing of drugs and therapeutics shall be in accordance with the procedures for *Drugs and Therapeutic Committee.*

Central Pharmacy shall only purchase approved medications as per updated formulary of the hospital.

Vendors / Pharmaceutical Distributors for various approved medications are selected and rate contracts entered to them where possible. Efforts are made to make rate contracts / supplies from the approved company where possible. The list of vendors area maintained in the Hospital Management Information System (Mednet).

The reorder levels for all medications are set in the central pharmacy module of the Mednet software and purchase done at reaching the reorder level. Reorder levels are monitored based on seasonal variations in prescription for drugs and also based on various rate / discount offers from approved suppliers.

On reaching re-order level the Pharmacist assigned to manage purchase process inform the concerned supplier on phone the requirement on conformation of availability and time for delivery issues the purchase order generated from Mednet. The Purchase Order is mailed to the supplier.

Stock outs at vendor level and delays in supply are monitored for vendor evaluation and change of vendors where possible.

5.2 Receipt & Inspection of Items

All drugs and therapeutics supplied to the hospital shall be received by the central pharmacy after necessary security checks / clearance.

The Pharmacist shall inspect the materials (Refer to *Checklist for Inspection of Drugs & Therapeutics*).

The pharmacist shall enter the particulars of the Invoice in the computer and generate a Goods Receipts Note (GRN) and obtain printed copies of the same (1+2 Copies).

The Chief Pharmacist shall verify the GRN, attach it with Invoice, sign and send the whole set to the Chief Administrator. Upon approval by the Chief Administrator the original GRN and Invoice copies shall be forwarded to accounts department for payment. A dispatch Register shall be maintained for the same.

All material received by the Central Pharmacy shall be recorded in the Central Pharmacy Stock Register.

5.3 Rejected / Non-Conforming Items

All rejected / non-conforming items shall be identified and stored separately. All such items shall be sent back to the suppliers, as soon as possible.

5.4 Storage of Items

The items are stored company wise and in alphabetic order.

All shelves and racks shall be appropriately labeled and identified.

All items, which are of expensive nature, shall be maintained separately under lock and key.

The items shall be stored as per the storage instructions with regard to the temperature and light exposure. All items requiring refrigeration shall be maintained in the centralized refrigeration unit. The temperature conditions inside the refrigerated storage shall be monitored on a daily basis.

5.5 Controlled Drugs / Narcotics

The various drugs and therapeutics controlled by provisions of the Drugs and Cosmetics Act shall follow the norms laid down for the same.

The suppliers for these items shall be as specified by the relevant government agency.

5.5 Issues

The Central Pharmacy issues drugs & therapeutics to the retail pharmacy, Surgical Stores and sub-stores like Cath Lab Sub-store, Radiology Sub-Stores etc.

The issues to these stores shall follow the procedure specified for each of these areas. (Refer to the respective procedures).

5.6 Medications not listed in Pharmacy

a. Prescribing / Ordering of a Medication Not Listed in Formulary

The online ordering system for medications does not allow for ordering of medications not listed in the formulary.

Only consultants are allowed to prescribe / order a medication not listed in formulary. In such cases the ward nurses obtain the medication order / prescription on the hospital prescription pad with signature and credentials of the prescribing consultant and the same is sent to Central Pharmacy

b. Review and Approval of Request of Medication Not Listed in Formulary

The pharmacists from the central pharmacy will honor the prescription after approval of same by Chief Pharmacist who will countersign the medication requisition / prescription and procure the same as a local purchase. Any such local purchase of value more than Rs. 5000/- will be put up for the approval by Chief Medical Administrator who will countersign the medication order on approval.

c. Issue

The central pharmacy on procurement shall supply the medication directly to the ward.

d. Documentation and Evaluation of Local Purchases on Non-Formulary Medications

The details of procurement of medications not listed in formulary are noted in a separate register. The collated information of the same is reported to the Pharmacy & Therapeutics Committee monthly.

e. Future ratification and addition to Formulary

In case of repeated requirement of the same medications the Central Pharmacy and PTC will coordinate with the consultant to initiate a procedure for adding the medication to the hospital formulary.

The above procedure is applicable only for procurement of a unavailable medication or strength variations and forms of medications listed in formulary and not to obtain a brand of medication not approved by formulary

5.7 Statutory Records

All records as specified by the licensing and inspection authority (Office of the Drugs Controller) shall be maintained.

6. RECORDS

Record Code	Record	Format	Responsibility	Indexing	File No	Minimum Retention Period
R-MAT-22	Central Pharmacy Stock Register	Electronic	Pharmacist	Nil	Nil	Till Obsolete

7. Amendment History

Sl. No.	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 July 2021	Updated medication procurement process and process to procure medications not listed in formulary
2	01	01	20 Oct 2021	Further clarification on procedure to procure medications not listed in formulary
3	01	02	1Nov 21	General editing and renumbering

SUMMARY	This document provides instruction and guidance to the functioning of the Retail Pharmacies of the hospital located at various floors of the hospital
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

1. PURPOSE:

To define and describe the system of sales and issue of drugs and therapeutics through the retail pharmacy.

2. SCOPE:

This procedure is applicable for all issues and sales through the retail pharmacy covering outpatients, inpatients and to general public.

3. DEFINITIONS

Drugs – For the purpose of this procedure and manual, drugs include prescription medications, samples, over-the-counter drugs, vaccines, sera, diagnostic and contrast agents administered to in-patients / out-patients to diagnose, treat or prevent diseases / conditions. These shall be inclusive of radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, intravenous solutions etc.

4. RESPONSIBILITY

The Chief Pharmacist is responsible for overall management of the retail pharmacy.

The duty pharmacists are responsible for managing sales and issues to out patients and processing requisitions from the inpatient areas and units.

5. DESCRIPTION

The retail pharmacy is the point of sales and issue of drugs and therapeutics to outpatients, public and inpatient areas. It also acts as a point of supply of drugs and therapeutics to the various units of the hospital for replenishing their ward stocks / emergency stocks.

5.1 Requirements as per License

The pharmacy shall adhere to rules and regulations laid down by the relevant acts / rules governing its function and notifications issued from time to time by the office of the Controller of Drugs and Pharmaceuticals, Government of Maharashtra.

All statutory records that are required by the licensing authority shall be duly maintained.

5.2 Requisitions to Central Pharmacy

The Pharmacist shall make the Pharmacy Requisition whenever the Stocks at the Retail Outlet go below the re-order levels.

The Pharmacist shall verify the supply from the Central Pharmacy on receipt of the items and take them into retail pharmacy stock.

5.3 Issues to outpatients and outside customers

The drugs and therapeutics shall be issued against prescriptions only. The pharmacists shall verify the prescriptions carefully.

In case of the particular brand of drug being prescribed in not available, a substitute generic shall be issued after consultation with the prescribing physician or surgeon, and this is documented on the prescriptions.

All issues to outpatients and outside customers shall be made against payment only.

All sales / issues shall have a Cash Bill a copy of which shall be provided to the customer / outpatient. All such bills shall contain relevant details like patient identification number, patient name and prescribing physician / surgeon.

The issuing pharmacist shall verify the issued items against the cash bill. They shall also advice the patient on the dosage and frequency of medication as prescribed, contraindications, life style adjustments needed in view of effects of the particular medication etc.

5.4 Issues to In-patients

The issues to In-patients shall be made directly to the concerned nursing unit and directly billed online to the patient account on a credit/debit basis.

The concerned nursing staff shall send an In-patient Pharmacy Requisition based on the prescription / instruction of the concerned physician / surgeon. These requisitions shall ideally cover the required medications needed for a patient for a maximum of 24 hours.

5.5 Issues to Units

The user departments shall raise a Material Requisition –cum-Issue Slip detailing the required drugs and therapeutics to replace used / expired items in their ward stock / emergency carts.

All units shall maintain a Minimum Stock Level and re-order levels for all their ward stocks and emergency carts.

The retail pharmacy shall issue the required drugs and therapeutics as per the Material Requisition – cum – issue slip. The retail pharmacy shall maintain a record of overall stocks maintained issued to each unit.

All such issue of drugs and therapeutics, billed at Inpatient / Emergency shall be collated into the overall sales of retail pharmacy through the HIS.

6. RECORDS

Record Code	Record	Format	Responsibility	Indexing	File No	Minimum Retention Period
R-MAT-23	Pharmacy Requisition	Electronic	Pharmacist	Nil	NA	
R-MAT-24	In-patient Pharmacy Requisition	Electronic	Nursing in-charges	Chronological	NA	1 Year

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 1. D

There is a procedure to obtain medication when the pharmacy is closed

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to the functioning of the Retail Pharmacies of the hospital located at various floors of the hospital
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

1. PURPOSE:

To define and describe the system of sales and issue of drugs and therapeutics through the retail pharmacy.

2. SCOPE:

This procedure is applicable for all issues and sales through the retail pharmacy covering outpatients, inpatients and to general public.

3. DEFINITIONS

Drugs – For the purpose of this procedure and manual, drugs include prescription medications, samples, over-the-counter drugs, vaccines, sera, diagnostic and contrast agents administered to in-patients / out-patients to diagnose, treat or prevent diseases / conditions. These shall be inclusive of radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, intravenous solutions etc.

4. RESPONSIBILITY

The Chief Pharmacist is responsible for overall management of the retail pharmacy.

The duty pharmacists are responsible for managing sales and issues to out patients and processing requisitions from the inpatient areas and units.

5. DESCRIPTION

The retail pharmacy is the point of sales and issue of drugs and therapeutics to out patients, public and inpatient areas. It also acts as a point of supply of drugs and therapeutics to the various units of the hospital for replenishing their ward stocks / emergency stocks.

5.1 Requirements as per License

The pharmacy shall adhere to rules and regulations laid down by the relevant acts / rules governing its function and notifications issued from time to time by the office of the Controller of Drugs and Pharmaceuticals, Government of Maharashtra.

All statutory records that are required by the licensing authority shall be duly maintained.

5.2 Requisitions to Central Pharmacy

The Pharmacist shall make the Pharmacy Requisition whenever the Stocks at the Retail Outlet go below the re-order levels.

The Pharmacist shall verify the supply from the Central Pharmacy on receipt of the items and take them into retail pharmacy stock.

5.3 Issues to outpatients and outside customers

The drugs and therapeutics shall be issued against prescriptions only. The pharmacists shall verify the prescriptions carefully.

In case of the particular brand of drug being prescribed in not available, a substitute generic shall be issued after consultation with the prescribing physician or surgeon, and this is documented on the prescriptions.

All issues to outpatients and outside customers shall be made against payment only.

All sales / issues shall have a Cash Bill a copy of which shall be provided to the customer / outpatient. All such bills shall contain relevant details like patient identification number, patient name and prescribing physician / surgeon.

The issuing pharmacist shall verify the issued items against the cash bill. They shall also advice the patient on the dosage and frequency of medication as prescribed, contraindications, life style adjustments needed in view of effects of the particular medication etc.

5.4 Issues to In-patients

The issues to In-patients shall be made directly to the concerned nursing unit and directly billed online to the patient account on a credit/debit basis.

The concerned nursing staff shall send an In-patient Pharmacy Requisition based on the prescription / instruction of the concerned physician / surgeon. These requisitions shall ideally cover the required medications needed for a patient for a maximum of 24 hours.

5.4 Issues to Units

The user departments shall raise a Material Requisition –cum-Issue Slip detailing the required drugs and therapeutics to replace used / expired items in their ward stock / emergency carts.

All units shall maintain a Minimum Stock Level and re-order levels for all their ward stocks and emergency carts.

The retail pharmacy shall issue the required drugs and therapeutics as per the Material Requisition – cum – issue slip. The retail pharmacy shall maintain a record of overall stocks maintained issued to each unit.

All such issue of drugs and therapeutics, billed at Inpatient / Emergency shall be collated into the overall sales of retail pharmacy through the HIS.

6. RECORDS

Record Code	Record	Format	Responsibility	Indexing	File No	Minimum Retention Period
R-MAT-23	Pharmacy Requisition	Electronic	Pharmacist	Nil	NA	
R-MAT-24	In-patient Pharmacy Requisition	Electronic	Nursing in-charges	Chronological	NA	1 Year

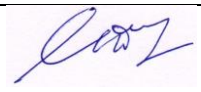
CHAPTER NAME – MOM 2.E

The organisation adheres to the procedure for the acquisition of formulary medications

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 2.F

The organisation adheres to the procedure to obtain medications not listed in the formulary

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to hospital staff on various issues related to pharmacy services and management of medication in the hospitals. The policy discusses the overall compliance to various standards pertaining to the Medication Management as per NABH standards; and links to further downstream policies and documentation established for compliance to standards specific to various issues like storage, ordering, administration, adverse reactions etc.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Usage Manual

INTRODUCTION

This policy has been formulated to ensure as far as possible compliance to various standards pertaining to Management of Medications (MOM) as prescribed by the NABH Accreditation Standards.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the process of medication management at various units of the hospital to ensure patient safety and wellbeing.

RESPONSIBILITIES

Chairman &Medical Director:
The overall responsibility of implementing the policy rests with the CMD of the hospital.

HODs / Unit Heads
They are responsible for implementing the various guidance in terms of ordering and administration of medications.

Director In-charge– Pharmacy
Is responsible to ensure that the policies pertaining to pharmacy services are implemented.

POLICIES

A. Pharmacies

The hospital operates the following pharmacies;

Central Pharmacy: Upper Basement

OPD Pharmacy: Upper Basement & Ground Floor

IPD Pharmacies: On Floors 2,3,4,56 and 9th.

The Chief Pharmacist is responsible to ensure that these pharmacies to operate under updated and suitable licenses issued by the state drugs authority.

B. Drugs & Pharmacy Committee

The hospital has a Drugs & Therapeutic Committee which is multi-disciplinary in nature and the committee is empowered to establish and monitor an effective medication management system in the hospital.

The constitution and working system of the committee is described in the relevant section of the hospital manual.

C. Drug Formulary

The hospital formulary shall be made available in all wards and department for easy reference. The same shall be accessible through the Hospital network.

The same is approved and periodically reviewed by the Drugs & Pharmacy Committee. All updating / amendments of the formulary have to be approved by the DPC.

There are certain medications which are prepared in the hospital itself.

At times the hospital allows IP patients to procure medicines from outside, during situations like when the prescribed medicine is either out of stock or not included in the hospital's drug list or the patient wishes to purchase medicines from outside.

D. Purchasing and Procurement

The method of purchase of a drug in the pharmacy is by inviting tenders from the manufactures/wholesalers.

The Central Pharmacy will be the only purchasing and procurement point for medicines in the Hospital. The detailed procedure governing the purchase of medications is specified in the Pharmacy Services SOP.

The purchasing and procurement of drugs are controlled by the Drugs & Therapeutic Committee established by the hospital.

E. Policy for the Introduction of New Drugs

Introduction of a new drug in the hospital is based on the doctor's indent which, has to be approved by the drugs and therapeutic committee.

The procurement of a new drug is done by issuing purchase orders to the manufacturers/wholesalers.

All patients of Saideep Hospital & Research Pvt Ltdwill be prescribed all the medicines they clinically require, based on their diagnosis from the hospital formulary.

To ensure the best use of resources there is a formal procedure for the introduction of new drugs. No new drug will be prescribed without prior authorization from the Drug and Pharmacy Committee.

For inclusion of the new drug in the formulary an application for the same would be sent to the Medical Superintendent. (Refer to the Bylaws of the Drugs & Pharmacy Committee)

F. Obtaining of Drugs not listed in formulary

The method adopted to get an emergency drug that is not there in the formulary is done by:

- Identifying the different brands and manufacturers of the drug.
- Contacting the manufacturers/wholesalers/other hospitals.
- Placing an emergency purchase order.

On specific request the pharmacy will make arrangements for procurement of the same. This shall be done only in cases where the same is ordered through a prescription by the Head of Departments / Senior Consultants.

All such instances will be reported to the Chief Pharmacist on a weekly basis and subsequently DTC by the him / her on a monthly basis

G. **Retail Pharmacy Operations**.

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment?

- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and issuing the drugs explaining to the patient regarding the drug intake, dos and don'ts etc.

H. General Policy on Expiry Checking

The medicines in the shelf of store, all retail areas, wards, critical care areas, OT etc. are checked once in every month for expiry date by the concerned staff responsible, the medicines are returned to the dealers 2 months prior to expiry datethrough pharmacy.

PROCEDURE (S)

The following policies have been established by the hospital to ensure an effective medication management system

- SDH/MOM/02 - Storage of Medications
- SDH/MOM/03 - Prescription of Medications
- SDH/MOM/06 - Medication Dispensing and Labeling
- SDH/MOM/08 - Medication Administration
- SDH/MOM/09 - Adverse Medication Events
- SDH/MOM/11 - Narcotics &Psychotropic Substances Handling
- SDH/MOM/05 - High risk medication
- SDH/MOM/12 - Chemotherapy Drugs
- SDH/MOM/13 - Radiotherapy drugs
- SDH/MOM/10 - Medication error
- SDH/MOM/04 - Verbal orders

Procedures have been established as a part of the Pharmacy Department Manual for defining and establishing a system for procurement, storage and dispensing of medications in the hospital;

- Procedure for Procurement of drugs
- Procedure for Central Pharmacy Operations
- Procedure for Retail Pharmacy Operations

The hospital has established separate policy and procedure for reporting and analysis of Adverse Drug Events.

MONITORING

The Drugs & Pharmacy Committee monitors the adherence to the medication management policy and processes across the hospital.

Individual Nursing Unit in-charges are responsible for monitoring of the implementation of the policies and procedures pertaining to medication management at the ground level on a day-to-day basis.

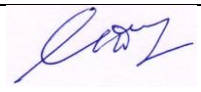
REFERENCES

Standards

MOM 1 – a, b
MOM 2 – a, b, c, d, e, f

CHAPTER NAME – MOM 3.C

The organization defines a list of high-risk medication(s).

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 3.E

High-risk medications including look-alike, sound-alike medications and different concentrations of the same medication are stored physically apart from each other

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on handling the high risk drugs and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Pharmacy & Medication Use Manual

INTRODUCTION

High Risk / A high Alert Medications carry a heightened risk for adverse out

PURPOSE AND SCOPE

The purpose and scope of this policy are:

1. To ensure that patients are administered prescribed medications safely.
2. To ensure that appropriate records are maintained.
3. To increase staff knowledge and understanding of medication management process and as far as possible, develop an institutionalized approach to medicines' administration.

RESPONSIBILITIES

Chairman & Managing Director

The overall responsibility for implementing the policy rests with CMD of the hospital.

Nursing Staff

The nurses are responsible for implementing the provisions of this policy.

Policies of hospital for administering high risk medicines are:

- High risk medication orders are verified with regards to patient name, diagnosis, ordering doctors, dose and route, frequency of administration.

- Patients are instructed regarding the likely adverse events in a manner which doesn't produce apprehension.
- Patient are observed for a specified period of time for adverse events and hemodynamic responses.

The high risk medications used in our hospital are listed, updated and published by the Drugs & Therapeutics Committee and displayed prominently in all the patient acre areas. All staff are trained on the listed medications as a part of Medication Management in services training

While administering these drugs the following has to be done;

1. A second check by a second person will be required for all 'High Risk' medications and things to be checked are,

a) Medication chart for the order
b) Correct product
c) Dose
d) Calculation
e) The initial set up of the infusion device
f) Chamber shall be clearly labeled with medication infusing

If there is a question or doubt regarding the drug, dosage, concentration, or calculation, consults the doctor.

2. Assistance in calculations, including dosage charts, weight charts, and preprogrammed infusion pumps, and clear labeling on the dispensed dose will promote medication safety.

3. A double check of all doses and calculations is needed prior to administration of the above high risk medications.

4. Two individuals should independently check calculations of high-risk drugs.

5. The double check should include the chart order, the calculated dose and the pump infusion.

6. Double check that the correct product is selected (and the correct concentration) and double check the dose drawn up. (In case of IV injections)

7. For infusions via controlled infusion devices (example: IV potassium, heparin, dopamine, etc.):

- Double check that the correct product is selected (and the correct concentration)
- Double check the initial set up of the infusion device
- A double check is needed if there is an addition/deletion of one of the additives

- A change in concentration/strength (double/quad)

8. The chamber shall be clearly labeled with medication infusing.

WHO CAN PERFORM A DOUBLE CHECK?

- Registered nurses

- Paramedics

- Pharmacist

For high risk medications at least two nurses should verify all administration related parameters and checks before administrations. In an emergency situations like resuscitation the administrating clinician or nurse will call out the name, dose and mode for the benefit of the other members of the code team and the team leader will verbally confirm to avoid any errors.

STANDARD REFERENCE

MOM-4 c. d, e

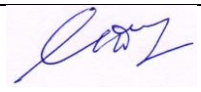
HIGH RISK MEDICINE UPDATED

	TAB TRIGLUCORED FORTE
Glipizide	TAB GLYNASE ,XL-10
Glipizide + Metformin	TAB GLYNASE-MF
Gliclazide	TAB DIAMICRON MR , XR -60
	TAB RECLIDE-40, 80
	TAB RECLIDE-XR 60
	TAB RECLIDE MR 30
	TAB CYBLEX 30 XR
Gliclazide + Metformin	TAB GLIZID-M
	TAB GLYCHEK-M
	TAB GLYCHEK-M FORTE
	TAB MCLAZIDE M
	TAB RECLIMET
	TAB RECLIMET OD 30 ,60
	TAB RECLIMET XR FORTE
	TAB CYBLEX M 60 XR
Gliclazide + Pioglitazone + Metformin	TAB GLYCINORM TOTAL 60
Voglibose + Metformin + Gliclazide	TAB CYBLEX MV 40.2
Magnesium Sulphate	INJ MAGNESIUM SULPHATE 2ML
Methotrexate	TAB FOLITRAX 2.5,5,7.5,15
Potassium Chloride	INJ FOLITRAX 50MG
	INJ KESOL 10ML
Promethazine	SYP KESOL 200ML
	TAB AVOMINE
	TAB PHENERGAN 10,25 MG
	SYP PHENERGAN 100ML
	INJ PHENERGAN 2ML
Vasopressin	INJ VPRESS 1ML

PHARMACO THERAPEUTICS COMMITTEE
SHRL

CHAPTER NAME – MOM 3.F

The list of emergency medications is defined and is stored uniformly

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	**SAIDEEP HOSPITAL** **PHARMACY / MEDICATION USAGE MANUAL**	Doc No	SDH/MOM/4.1
		Issue No	01
		Rev No.	01
		Date	1 Nov 21
		Pages	6
	Document Title : General Policies Pharmacy Services &Medication Management		

SUMMARY	This document provides instruction and guidance to hospital staff on various issues related to pharmacy services and management of medication in the hospitals. The policy discusses the overall compliance to various standards pertaining to the Medication Management as per NABH standards; and links to further downstream policies and documentation established for compliance to standards specific to various issues like storage, ordering, administration, adverse reactions etc.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Usage Manual

INTRODUCTION

This policy has been formulated to ensure as far as possible compliance to various standards pertaining to Management of Medications (MOM) as prescribed by the NABH Accreditation Standards.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the process of medication management at various units of the hospital to ensure patient safety and wellbeing.

RESPONSIBILITIES

Chairman &Medical Director:
The overall responsibility of implementing the policy rests with the CMD of the hospital.

HODs / Unit Heads
They are responsible for implementing the various guidance in terms of ordering and administration of medications.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Director In-charge– Pharmacy

Is responsible to ensure that the policies pertaining to pharmacy services are implemented.

POLICIES

A. Pharmacies

The hospital operates the following pharmacies;

Central Pharmacy: Upper Basement

OPD Pharmacy: Upper Basement & Ground Floor

IPD Pharmacies: On Floors 2,3,4,56 and 9th.

The Chief Pharmacist is responsible to ensure that these pharmacies to operate under updated and suitable licenses issued by the state drugs authority.

B. Drugs & Pharmacy Committee

The hospital has a Drugs & Therapeutic Committee which is multi-disciplinary in nature and the committee is empowered to establish and monitor an effective medication management system in the hospital.

The constitution and working system of the committee is described in the relevant section of the hospital manual.

C. Drug Formulary

The hospital formulary shall be made available in all wards and department for easy reference. The same shall be accessible through the Hospital network.

The same is approved and periodically reviewed by the Drugs & Pharmacy Committee. All updating / amendments of the formulary have to be approved by the DPC.

There are certain medications which are prepared in the hospital itself.

At times the hospital allows IP patients to procure medicines from outside, during situations like when the prescribed medicine is either out of stock or not included in the hospital's drug list or the patient wishes to purchase medicines from outside.

D. Purchasing and Procurement

The method of purchase of a drug in the pharmacy is by inviting tenders from the manufactures/wholesalers.

The Central Pharmacy will be the only purchasing and procurement point for medicines in the Hospital. The detailed procedure governing the purchase of medications is specified in the Pharmacy Services SOP.

The purchasing and procurement of drugs are controlled by the Drugs & Therapeutic Committee established by the hospital.

E. Policy for the Introduction of New Drugs

Introduction of a new drug in the hospital is based on the doctor's indent which, has to be approved by the drugs and therapeutic committee.

The procurement of a new drug is done by issuing purchase orders to the manufacturers/wholesalers.

All patients of Saideep Hospital & Research Pvt Ltdwill be prescribed all the medicines they clinically require, based on their diagnosis from the hospital formulary.

To ensure the best use of resources there is a formal procedure for the introduction of new drugs. No new drug will be prescribed without prior authorization from the Drug and Pharmacy Committee.

For inclusion of the new drug in the formulary an application for the same would be sent to the Medical Superintendent. (Refer to the Bylaws of the Drugs & Pharmacy Committee)

F. Obtaining of Drugs not listed in formulary

The method adopted to get an emergency drug that is not there in the formulary is done by:

- Identifying the different brands and manufacturers of the drug.
- Contacting the manufacturers/wholesalers/other hospitals.
- Placing an emergency purchase order.

On specific request the pharmacy will make arrangements for procurement of the same. This shall be done only in cases where the same is ordered through a prescription by the Head of Departments / Senior Consultants.

All such instances will be reported to the Chief Pharmacist on a weekly basis and subsequently DTC by the him / her on a monthly basis

G. **Retail Pharmacy Operations**.

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment?
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and issuing the drugs explaining to the patient regarding the drug intake, dos and don'ts etc.

H. General Policy on Expiry Checking

The medicines in the shelf of store, all retail areas, wards, critical care areas, OT etc. are checked once in every month for expiry date by the concerned staff responsible, the medicines are returned to the dealers 2 months prior to expiry datethrough pharmacy.

PROCEDURE (S)

The following policies have been established by the hospital to ensure an effective medication management system

- SDH/MOM/02 - Storage of Medications
- SDH/MOM/03 - Prescription of Medications
- SDH/MOM/06 - Medication Dispensing and Labeling
- SDH/MOM/08 - Medication Administration
- SDH/MOM/09 - Adverse Medication Events
- SDH/MOM/11 - Narcotics &Psychotropic Substances Handling
- SDH/MOM/05 - High risk medication
- SDH/MOM/12 - Chemotherapy Drugs
- SDH/MOM/13 - Radiotherapy drugs
- SDH/MOM/10 - Medication error
- SDH/MOM/04 - Verbal orders

Procedures have been established as a part of the Pharmacy Department Manual for defining and establishing a system for procurement, storage and dispensing of medications in the hospital;

- Procedure for Procurement of drugs
- Procedure for Central Pharmacy Operations
- Procedure for Retail Pharmacy Operations

The hospital has established separate policy and procedure for reporting and analysis of Adverse Drug Events.

MONITORING

The Drugs & Pharmacy Committee monitors the adherence to the medication management policy and processes across the hospital.

Individual Nursing Unit in-charges are responsible for monitoring of the implementation of the policies and procedures pertaining to medication management at the ground level on a day-to-day basis.

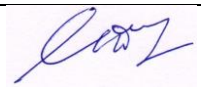
REFERENCES

Standards

MOM 1 – a, b
MOM 2 – a, b, c, d, e, f

CHAPTER NAME – MOM 4.B

Medication prescription is in consonance with good practices/guidelines for the rational prescription of medications.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on prescription and ordering of drugs and its protocols. All HODs throughout the hospital are required to initiate actions to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

INTRODUCTION

Effective system of medication ordering which is legible, standardized and followed universally within a hospital; reduces chances of medication errors and contributes to patient safety.

The NABH standards extensively cover the various aspects of prescription of medications and provide a baseline for the formulation of this policy.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in matters relating to prescriptions and medication ordering.

RESPONSIBILITIES

Chairman & Managing Director
The overall responsibility for implementing the policy rests with CMD of the hospital.

Clinicians
The clinicians are responsible for adhering to the prescription guidelines of the hospital.

Nurses
The nurses are responsible to ensure that they adhere to the guidelines provided by verbal and telephonic medication orders.

POLICIES

A.Prescribing

All medicines (including medical gases) must be prescribed by a Duty Medical Officer/ Resident Medical Officer or above in the approved prescription area of the patient's medical record.

The people authorized to write a prescription include all the registered medical practitioners working in our hospital. Prescriptions are generally written on a typical format which is usually kept as pads in the respective departments.

The prescription must be written legibly (BLOCK CAPITAL LETTERS PREFERRED) and signed and dated by the authorized prescriber.

The generic drug name should preferably be used as far as possible, do not use any abbreviation and the prescription shall include the following:

- Hospital number.
- Date.
- Name, age and sex.
- Inscription.
  - **The approved name of the preparation**
  - **The dose**
  - **The frequency**
  - **The route of administration**
  - **Any other special instruction e.g. length of supply for courses**
  - **For children under 16 years – weight of the patient**
- Signature and designation of the prescriber.
- Error prone abbreviations shall not be used
- Errors / changes must be cut off with a single strike through, initialed and rewritten
- Drug allergies and previous drug reactions must be ascertained in each instance in point of care and prominently noted in prescription and medication order sheets

All prescriptions shall be made from the approved hospital formulary only.

All prescribing doctors must ensure that the prescription / medication orders are in consonance with good practices / guidelines for rational prescription of medications

Electronic Prescription

Hospital has enabled electronic prescription / medication orders in both OP and IP modules of its HMIS. While it is not mandatory for physicians to use them currently, the hospital strongly encourages use of the same as it supports identification of drug reactions, food-drug intercations, therapeutic duplication, dose adjustment etc.

B. Doubts about Prescriptions

In accordance with professional responsibilities, any nurse or pharmacist who has **any doubt** about the prescription's legibility, accuracy or meaning **must not administer or dispense** the medicine and must notify the nurse in-charge immediately for verification with the prescriber.

Any alterations to a prescription must be in the form of a cancellation of the original instruction; the revised instructions being in the form of a new prescription. The cancellation should be clear and unambiguous, be signed and dated by the prescriber.

C. Verbal / telephonic Orders

Refer to Policy on Verbal Orders

D. Prescription Audit

The same is done on a sample sized and results analyzed on a monthly basis by a Clinical Pharmacist.

The findings of the audit is shared with the Drugs and Therapeutic Committee of ther hospital.

Corrective / Preventive Actions are taken based on audit findings and are based on root cause analysis done where applicable.

Reconciliation of Medications at Transition Points

The reconciliation of medications are done by the nurses and RMO in the following manner

- Patient's existing medications are reviewed, documented and reconciled as a part of initial assessment process and a reviewed plan is implemented as per treatment plan by the primary / admitting physician
- The primary / admitting physician reviews and reconciles medications at the time of receiving cross consultation referral inputs from physicians from other specialties.
- A medication reconciliation is documented as a part of patient hand over sheet from one ward / department to another
- The Primary Physicians with assistance of RMOs reconciles the medication prior to discharge to provide a comprehensive medication plan as a part of discharge advice and same is prescribed through the discharge summary

PROCEDURE (S)

The procedures / guidelines for Prescription of Medication are provided as an appendix to this policy.

MONITORING

The CMA is responsible for monitoring the adherence to the policy.

References

A. Standards

MOM 4 – a, b, c, d, e, f, g, h

Appendix 1. Guidance for Prescription & Medication Order Writing

In general all prescriptions must:

- be legible and indelible
- state the patient's full name, age, address and ward number / name
- state the treatment in block letters using the approved (generic) drug name
- state the form of the drug
- state the route of administration
- state the dose in the metric system
- state precisely the frequency and times of administration
- State the weight for children under 16 years.
- be signed with the prescriber's full signature
- be dated

These general requirements for prescriptions are expanded to more specific elements below:

ALLERGY

The allergy box on the inpatient drug chart / file must be completed before **ANY** medication can be prescribed.

DRUG NAME –

Approved drug must be written as the approved generic name (preferably) **without using abbreviations. When using brand names kindly ensure that only brands approved as per formulary are used.**

DOSE –

- Specified dose is written appropriately on the prescription or in the appropriate box of the Drug Chart.

- Units must be written using acceptable abbreviations i.e.ml, g, and mg. The words units and micrograms must be written in full.

- Dosages should be legible and unambiguous with no possible confusion over intended strength.

- Dose is written correctly, dose quantity must be written in words or Western Hindu Arabic numerals, using the minimum number of decimal places. Microgram doses should be used when appropriate.

- There should be no evidence of striking out or alteration of the dose.

ROUTE

- The intended route must be specified.
- The route must be legible and unambiguous.
- Use only acceptable abbreviations:

IV - intravenous	IM - intramuscular
SC - subcutaneous	PR - per rectum
TOP - topical	INH - inhalation
SL - sublingual	PV - per vagina

- Oral and other routes should be written in full.
- Only one route should be specified (e.g. IM/ORAL, meaning intramuscular or oral, is unacceptable.)
- There should be no evidence of striking out or alteration of the route.

VALID PERIOD

Specified number of days for a course should be stated. Indication that the prescription is to be continued indefinitely is not acceptable.

FREQUENCY

- Legible and unambiguous:the frequency must be clearly defined. On ward drug charts this is done by entering specific times.
- The frequency must not be increased or reduced, without the entry being rewritten.
- Time of administration: the indicated time of administration has to be clearly stated. This applies to 'once only' prescriptions as well.

SIGNATURE

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

The prescription / medication drug prescription must be signed by the prescriber in full signature with name.

DISCONTINUATION

Cancellation: to cancel a prescription, a line must be drawn through the prescribing section of the ward drug chart and the instruction signed and dated by the prescriber.

Alteration: if a drug is altered in any way, a line must be drawn through that section signed and dated by the doctor, and the drug rewritten with the alteration.

CHAPTER NAME – MOM 4.E

Implementation of verbal orders ensures safe medication management practices

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on the policies of verbal orders and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

INTRODUCTION

Verbal orders are commonly used in the hospital scenario but can be a major source for medication related errors unless streamlined and standard processes for error reductions are not followed . Hence rightchecks and balances in this process level result in reduction of potential medication errors.

PURPOSE AND SCOPE

The purpose and scope of this policy are:

1. To ensure safety of medications when prescribed / ordered verbally by physicians
2. To ensure that any appropriate records are maintained when verbal orders are used.
3. To increase staff knowledge and understanding of verbal order process and as far as possible, develop an institutionalized approach to verbal orders.

POLICIES

Policies on Verbal / telephonic Orders

Instruction by telephone from a prescriber to a nurse to administer a medicine previously not prescribed is **unacceptable in normal circumstances**.

In exceptional circumstances where patient care could be compromised and where the medication has been previously prescribed and the authorized prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, a verbal order will be made to the duty medical officer manning the area.

This shall be recorded in the patient medical record. This shall be validated and countersigned by the prescriber within 24 hours.

In case of verbal orders the following process shall be adhered to;

A verbal order shall be issued only by anybody who is aConsultant or above that and none other than that. A seal is made available in the wards which shall be stamped and the verbal order given by the doctor shall be written down by the duty medical officer /duty nurse with the date, time, andwhose order andthe nurse signs it and then carries out the order.

The order once written down by the nurse shall follow this step of action also;

- The order shall be written and before closing the conversation (telephone or person) the **duty medical officer or duty nurse shall read back the order to the doctor** and confirm if the written down order is correct, in case of drugs she/he shall even spell the drug to recheck with the consultant and then close it.

- Doctor who issued the verbal order within 24 hrs should counter sign that verbal order, which was brought forward to the medication sheet by the Duty Medical Officer.

Verbal order – Not permitted

- Chemotherapy drugs are **high risk drugs**,Hence **Verbal orders are not permitted**
- Radioactive drugs are '**high risk drugs'**, Hence**verbal orders are not permitted**
- Narcotics **– Legally not allowed**
- **High Alert Medications**

While administering these drugs verbal orders are not permitted. These drugs have to undergo the routine protocol of second check by a second person as according to high risk drug. (Details – chemotherapy and radiotherapy protocols)

STANDARD REFERENCE

MOM- 4 e

CHAPTER NAME – MOM 5.A

The organization ensures that only authorized personnel write orders

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on prescription and ordering of drugs and its protocols. All HODs throughout the hospital are required to initiate actions to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

INTRODUCTION

Effective system of medication ordering which is legible, standardized and followed universally within a hospital; reduces chances of medication errors and contributes to patient safety.

The NABH standards extensively cover the various aspects of prescription of medications and provide a baseline for the formulation of this policy.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in matters relating to prescriptions and medication ordering.

RESPONSIBILITIES

Chairman & Managing Director
The overall responsibility for implementing the policy rests with CMD of the hospital.

Clinicians
The clinicians are responsible for adhering to the prescription guidelines of the hospital.

Nurses
The nurses are responsible to ensure that they adhere to the guidelines provided by verbal and telephonic medication orders.

POLICIES

A. Prescribing

All medicines (including medical gases) must be prescribed by a Duty Medical Officer/ Resident Medical Officer or above in the approved prescription area of the patient's medical record.

The people authorized to write a prescription include all the registered medical practitioners working in our hospital. Prescriptions are generally written on a typical format which is usually kept as pads in the respective departments.

The prescription must be written legibly (BLOCK CAPITAL LETTERS PREFERRED) and signed and dated by the authorized prescriber.

The generic drug name should preferably be used as far as possible, do not use any abbreviation and the prescription shall include the following:

- Hospital number.
- Date.
- Name, age and sex.
- Inscription.
  - **The approved name of the preparation**
  - **The dose**
  - **The frequency**
  - **The route of administration**
  - **Any other special instruction e.g. length of supply for courses**
  - **For children under 16 years – weight of the patient**
- Signature and designation of the prescriber.
- Error prone abbreviations shall not be used
- Errors / changes must be cut off with a single strike through, initialed and rewritten
- Drug allergies and previous drug reactions must be ascertained in each instance in point of care and prominently noted in prescription and medication order sheets

All prescriptions shall be made from the approved hospital formulary only.

All prescribing doctors must ensure that the prescription / medication orders are in consonance with good practices / guidelines for rational prescription of medications

Electronic Prescription

Hospital has enabled electronic prescription / medication orders in both OP and IP modules of its HMIS. While it is not mandatory for physicians to use them currently, the hospital strongly encourages use of the same as it supports identification of drug reactions, food-drug intercations, therapeutic duplication, dose adjustment etc.

B. Doubts about Prescriptions

In accordance with professional responsibilities, any nurse or pharmacist who has **any doubt** about the prescription's legibility, accuracy or meaning **must not administer or dispense** the medicine and must notify the nurse in-charge immediately for verification with the prescriber.

Any alterations to a prescription must be in the form of a cancellation of the original instruction; the revised instructions being in the form of a new prescription. The cancellation should be clear and unambiguous, be signed and dated by the prescriber.

C. Verbal / telephonic Orders

Refer to Policy on Verbal Orders

D. Prescription Audit

The same is done on a sample sized and results analyzed on a monthly basis by a Clinical Pharmacist.

The findings of the audit is shared with the Drugs and Therapeutic Committee of ther hospital.

Corrective / Preventive Actions are taken based on audit findings and are based on root cause analysis done where applicable.

Reconciliation of Medications at Transition Points

The reconciliation of medications are done by the nurses and RMO in the following manner

- Patient's existing medications are reviewed, documented and reconciled as a part of initial assessment process and a reviewed plan is implemented as per treatment plan by the primary / admitting physician

- The primary / admitting physician reviews and reconciles medications at the time of receiving cross consultation referral inputs from physicians from other specialties.
- A medication reconciliation is documented as a part of patient hand over sheet from one ward / department to another
- The Primary Physicians with assistance of RMOs reconciles the medication prior to discharge to provide a comprehensive medication plan as a part of discharge advice and same is prescribed through the discharge summary

PROCEDURE (S)

The procedures / guidelines for Prescription of Medication are provided as an appendix to this policy.

MONITORING

The CMA is responsible for monitoring the adherence to the policy.

References

A. Standards

MOM 4 – a, b, c,d,e,f,g,h

Appendix 1. Guidance for Prescription & Medication Order Writing

In general all prescriptions must:

- be legible and indelible
- state the patient's full name, age, address and ward number / name
- state the treatment in block letters using the approved (generic) drug name
- state the form of the drug
- state the route of administration
- state the dose in the metric system
- state precisely the frequency and times of administration
- State the weight for children under 16 years.
- be signed with the prescriber's full signature
- be dated

These general requirements for prescriptions are expanded to more specific elements below:

ALLERGY

The allergy box on the inpatient drug chart / file must be completed before **ANY** medication can be prescribed.

DRUG NAME –

Approved drug must be written as the approved generic name (preferably) **without using abbreviations. When using brand names kindly ensure that only brands approved as per formulary areused.**

DOSE –

- Specified doseis written appropriately on the prescription or in the appropriate box of the Drug Chart.

- Units must be written using acceptable abbreviations i.e.ml, g, and mg. The words units and micrograms must be written in full.

- Dosages should be legible and unambiguous with no possible confusion over intended strength.

- Doseis written correctly, dose quantity must be written in words or Western HinduArabic numerals, using the minimum number of decimal places. Microgram doses should be used when appropriate.

  - There should be no evidence of striking out or alteration of the dose.

ROUTE

- The intended route must be specified.
- The route must be legible and unambiguous.
- Use only acceptable abbreviations:

IV - intravenous	IM - intramuscular
SC - subcutaneous	PR - per rectum
TOP - topical	INH - inhalation
SL - sublingual	PV - per vagina

  - Oral and other routes should be written in full.
- Only one route should be specified (e.g. IM/ORAL, meaning intramuscular or oral, is unacceptable.)
  - There should be no evidence of striking out or alteration of the route.

VALID PERIOD

Specifiednumber of days for a course should be stated. Indication that the prescription is to be continued indefinitely is not acceptable.

FREQUENCY

- Legible and unambiguous:the frequency must be clearly defined. On ward drug charts this is done by entering specific times.
- The frequency must not be increased or reduced, without the entry being rewritten.
- Time of administration: the indicated time of administration has to be clearly stated. This applies to 'once only' prescriptions as well.

SIGNATURE

The prescription / medication drug prescription must be signed by the prescriber in full signature with name.

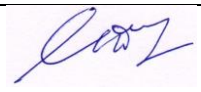
DISCONTINUATION

Cancellation: to cancel a prescription, a line must be drawn through the prescribing section of the ward drug chart and the instruction signed and dated by the prescriber.

Alteration: if a drug is altered in any way, a line must be drawn through that section signed and dated by the doctor, and the drug rewritten with the alteration.

CHAPTER NAME – MOM 6.A

Dispensing of medications is done safely

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on medication dispensing issues and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Pharmacy & Medication Use Manual

INTRODUCTION

Safe and Sound dispensing practice include requisite verifications and check of dispensed medications in terms of routes, strengths , expiry etc. ; coupled with dispensing advice from the health service providers.

PURPOSE AND SCOPE

- The policy document discusses the requirements of the NABH standards pertaining to dispensing and labelling of medications and its application and implementation in the Hospital.
- The policy is applicable to all units of the hospital.

RESPONSIBILITIES

Medical Director.

The overall responsibility for implementing the policy rests with Chief Medical Administrator of the hospital.

Pharmacists & Nurses

The dispensing pharmacists and nurses in the wards are responsible to ensure that dispensing and labeling standards are followed.

POLICIES

A. Dispensing to Out Patients

The dispensing of medicines for outpatients through retail pharmacy is detailed in the Pharmacy Services Procedure

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment.
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and
- issuing the drugs
- Explaining to the patient regarding the drug intake, dos and don'ts etc.

B. Indent from Wards

C. Indent for Inpatients

The bystanders shall purchase the medicines based on the prescription given.
The purchased medicines are given to the nurse of the ward who shall administer it
To the patient. Patient self-medication is not allowed.

D. Drug replacement and inpatient

Medicines for inpatient in wards and for the drug replacement in places like critical care areas are supplied by the pharmacy.
The requirement of such medicines requires the following information.

- Hospital, Ward and unit Name
- Date & Time
- Patient name and hospital number
- Name of medicine including dose, strength and quantity
- Name and signature of the doctor

E. Delivery and Receipt

Medicines are transported to Wards and Departments in sealed tamper-evident packages/boxes/PTS by approved messengers. The sealed package must be signed for in the delivery record book by a registered nurse upon receipt in the ward /department.
In case where the ward nursing staff are collecting the weekly issues for replenishment of ward stock the collecting nurse will sign for the issue in the issue register maintained at the issue counter in the central pharmacy.
Failure to receive medicines ordered or discrepancies in medicines received must be notified to the Central Pharmacy Immediately.

F. Documents and Records

Prescription forms, Requisition Books, Narcotics Order Books and Record Books must be kept in a secure place with access only todesignated personnel.

G. Labeling Requirements

- All labelling of items removed from their original container/package occurs at the time the medication is being prepared, even if there is only one medication being prepared. Use of pre-labelled packaging from the manufacturer is unacceptable.
- Any unlabelled or partially labelled medication or solution is discarded immediately.
- Label one medication at a time (e.g., Get the first medication and label per guidelines, then get the second medication and label per guidelines, etc.
- All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.
- Upon a shift change or break relief (change in personnel involved with labelled medications, such as in the operating room or procedural areas), all medications/solutions and their labels are reviewed by entering and exiting persons.
- Attaching the original container (vial/amp, etc.) to the final container is unacceptable.

PROCEDURE (S)

The dispensing procedures are also described in the Pharmacy Services procedure.

MONITORING

The medical superintendentis responsible for monitoring of the process.

REFERENCES

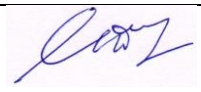
A.

B. Standards

MOM 6 - a,b,c,d,e,f

CHAPTER NAME – MOM 6.B

Medication recalls are handled effectively

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance for recall of non-confirming medications from all locations of the hospital
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

1. PURPOSE:

To establish an effective process for medication recall in the hospital.

2. SCOPE:

This procedure is applicable to all situations of medication recalls including drugs issued to patients.

3. DEFINITIONS

Nil

4. RESPONSIBILITY

The Chief Pharmacist is responsible for leading and coordinating an effective drug recall effort across the hospital.

The Chief Medical Administrator along with the Chair of Drugs and Therapeutics Committee is responsible for ordering a medication recall

The Drugs and Therapeutics Committee is responsible for overall evaluation of the drug recall process and suggest on improvements to process.

5. DESCRIPTION

5.1 Approval and Planning for a Medication Recall

The decision for recall shall be based on following scenarios.

- Based on communication from state and central drug authorities
- Information received from manufacturers / suppliers
- Based on internal review of medication related incidents like damage, impurities, possible breakage of cold chain conditions etc
- Based on internal review of adverse drug events related to same medication or particular batches of a medication

The requirement for a medication recall based on above scenarios is discussed by Chairperson of DTC, Medical Superintendent and Chief Pharmacist. On decision the official circular approving the medication recall is issued by Medical Superintendent and shall contain the details like generic name, trade / brand name, manufacturer name, batch detail, expiry dates etc are relevant.

The Chief Pharmacist along with the central pharmacy would plan for the medication recall by preparing a list of issue of the medication / selected batches and their issues to retail pharmacies, wards / units stocks, emergency drug carts / crash carts and patients based on data from the systems.

5.2 Procedure for Identification, Collection and Return Recalled Medications

a. Identification and Removal from Units / Wards / Emergency Medication Trolleys

- The same is coordinated with all units by various pharmacists with the aid of the issue lists and the recalled medication units.
- Medication units collected from each area / unit are stored separately in paper bag / carton and labelled with the unit / area name from which it was collected

b. Identification and Removal from Retail Pharmacy Stocks

- The same is lead by the respective retail unit pharmacists.
- The medications removed from stock will be tallied and labelled and returned to pharmacy. Same is updated in the HMIS as stock returns.

c. Recall of medication issued to patients

- For the IP patients, the remaining units are tracked using the issue list and same collected from the patients. Alternate medication (substitute brands or unaffected batch) shall be provided as replacement to avoid any disruption in medical care.
- Medications collected from each patient is stored in separate paper bag / pouch and labelled with patient name and UHID.
- For discharged patients and OP patients the pharmacists shall list them out and make an effort to reach out to them on telephones based on contact number available in HMIS. A warning SMS would be send to all such patients warning them about the recall. The patients shall be advised to return and replace the recalled batches at the hospital pharmacy or dispose the recalled medications

d. Tallying of the recalled medications shall be done by the Central Pharmacy team and a report on same shall be provided quantifying the quantity of recall medication originally procured and issued, numbers recalled and collected, no of patients possibly affected etc.

5.3 Review, analysis and Further Actions on Medication Recall

The recalled medications may be returned to supplied or disposed of as biomedical waste (after ensuring that they can't be scavenged for reuse).

Efforts shall be undertaken by the DTC and hospital quality team to identify and document any possible ADE related to the medications involved in the recall by retrospective review process combining medical records review and survey of the patients involved.

The DTC shall discuss in detail during monthly meetings any recalls that happened during the period evaluation circumstances leading to the medication recall and the effectives of the recall process based on report of same provided by the Central Pharmacy team.

The DTC shall inform the regulatory authorities about the recall and / or the possible ADEs that resulted in the recall based on circumstances of the each of the medication recall.

6. RECORDS

- Medication Recall Circulars
- Medication Recall Process Reports
- Minutes of Meeting of DTC

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 6.C

Near-expiry medications are handled effectively

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to hospital staff on various issues related to pharmacy services and management of medication in the hospitals. The policy discusses the overall compliance to various standards pertaining to the Medication Management as per NABH standards; and links to further downstream policies and documentation established for compliance to standards specific to various issues like storage, ordering, administration, adverse reactions etc.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Usage Manual

INTRODUCTION

This policy has been formulated to ensure as far as possible compliance to various standards pertaining to Management of Medications (MOM) as prescribed by the NABH Accreditation Standards.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the process of medication management at various units of the hospital to ensure patient safety and wellbeing.

RESPONSIBILITIES

Chairman &Medical Director:
The overall responsibility of implementing the policy rests with the CMD of the hospital.

HODs / Unit Heads
They are responsible for implementing the various guidance in terms of ordering and administration of medications.

Director In-charge– Pharmacy

Is responsible to ensure that the policies pertaining to pharmacy services are implemented.

POLICIES

A. Pharmacies

The hospital operates the following pharmacies;

Central Pharmacy: Upper Basement

OPD Pharmacy: Upper Basement & Ground Floor

IPD Pharmacies: On Floors 2, 3, 4, 5, 6 and 9th.

The Chief Pharmacist is responsible to ensure that these pharmacies to operate under updated and suitable licenses issued by the state drugs authority.

B. Drugs & Pharmacy Committee

The hospital has a Drugs & Therapeutic Committee which is multi-disciplinary in nature and the committee is empowered to establish and monitor an effective medication management system in the hospital.

The constitution and working system of the committee is described in the relevant section of the hospital manual.

C. Drug Formulary

The hospital formulary shall be made available in all wards and department for easy reference. The same shall be accessible through the Hospital network.

The same is approved and periodically reviewed by the Drugs & Pharmacy Committee. All updating / amendments of the formulary have to be approved by the DPC.

There are certain medications which are prepared in the hospital itself.

At times the hospital allows IP patients to procure medicines from outside, during situations like when the prescribed medicine is either out of stock or not included in the hospital's drug list or the patient wishes to purchase medicines from outside.

D. Purchasing and Procurement

The method of purchase of a drug in the pharmacy is by inviting tenders from the manufactures/wholesalers.

The Central Pharmacy will be the only purchasing and procurement point for medicines in the Hospital. The detailed procedure governing the purchase of medications is specified in the Pharmacy Services SOP.

The purchasing and procurement of drugs are controlled by the Drugs & Therapeutic Committee established by the hospital.

E. Policy for the Introduction of New Drugs

Introduction of a new drug in the hospital is based on the doctor's indent which, has to be approved by the drugs and therapeutic committee.

The procurement of a new drug is done by issuing purchase orders to the manufacturers/wholesalers.

All patients of Saideep Hospital & Research Pvt Ltd will be prescribed all the medicines they clinically require, based on their diagnosis from the hospital formulary.

To ensure the best use of resources there is a formal procedure for the introduction of new drugs. No new drug will be prescribed without prior authorization from the Drug and Pharmacy Committee.

For inclusion of the new drug in the formulary an application for the same would be sent to the Medical Superintendent. (Refer to the Bylaws of the Drugs & Pharmacy Committee)

F. Obtaining of Drugs not listed in formulary

The method adopted to get an emergency drug that is not there in the formulary is done by:

- Identifying the different brands and manufacturers of the drug.
- Contacting the manufacturers/wholesalers/other hospitals.
- Placing an emergency purchase order.

On specific request the pharmacy will make arrangements for procurement of the same. This shall be done only in cases where the same is ordered through a prescription by the Head of Departments / Senior Consultants.

All such instances will be reported to the Chief Pharmacist on a weekly basis and subsequently DTC by the him / her on a monthly basis

G. **Retail Pharmacy Operations**.

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment?
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and issuing the drugs explaining to the patient regarding the drug intake, dos and don'ts etc.

H. General Policy on Expiry Checking

The medicines in the shelf of store, all retail areas, wards, critical care areas, OT etc. are checked once in every month for expiry date by the concerned staff responsible, the medicines are returned to the dealers 2 months prior to expiry date through pharmacy.

PROCEDURE (S)

The following policies have been established by the hospital to ensure an effective medication management system

- SDH/MOM/02 - Storage of Medications
- SDH/MOM/03 - Prescription of Medications
- SDH/MOM/06 - Medication Dispensing and Labeling
- SDH/MOM/08 - Medication Administration
- SDH/MOM/09 - Adverse Medication Events
- SDH/MOM/11 - Narcotics &Psychotropic Substances Handling
- SDH/MOM/05 - High risk medication
- SDH/MOM/12 - Chemotherapy Drugs
- SDH/MOM/13 - Radiotherapy drugs
- SDH/MOM/10 - Medication error
- SDH/MOM/04 - Verbal orders

Procedures have been established as a part of the Pharmacy Department Manual for defining and establishing a system for procurement, storage and dispensing of medications in the hospital;

- Procedure for Procurement of drugs
- Procedure for Central Pharmacy Operations
- Procedure for Retail Pharmacy Operations

The hospital has established separate policy and procedure for reporting and analysis of Adverse Drug Events.

MONITORING

The Drugs & Pharmacy Committee monitors the adherence to the medication management policy and processes across the hospital.

Individual Nursing Unit in-charges are responsible for monitoring of the implementation of the policies and procedures pertaining to medication management at the ground level on a day-to-day basis.

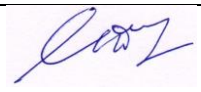
REFERENCES

Standards

MOM 1 – a, b
MOM 2 – a, b, c, d, e, f

CHAPTER NAME – MOM 6.D

Dispensed medications are labeled

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on medication dispensing issues and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Pharmacy & Medication Use Manual

INTRODUCTION

Safe and Sound dispensing practice include requisite verifications and check of dispensed medications in terms of routes, strengths , expiry etc. ; coupled with dispensing advice from the health service providers.

PURPOSE AND SCOPE

- The policy document discusses the requirements of the NABH standards pertaining to dispensing and labelling of medications and its application and implementation in the Hospital.
- The policy is applicable to all units of the hospital.

RESPONSIBILITIES

Medical Director.
The overall responsibility for implementing the policy rests with Chief Medical Administrator of the hospital.

Pharmacists & Nurses
The dispensing pharmacists and nurses in the wards are responsible to ensure that dispensing and labeling standards are followed.

POLICIES

A. Dispensing to Out Patients

The dispensing of medicines for outpatients through retail pharmacy is detailed in the Pharmacy Services Procedure

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment.
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and
- issuing the drugs
- Explaining to the patient regarding the drug intake, dos and don'ts etc.

B. Indent from Wards

The nurse in charge of the Ward is responsible for the indent of medicines for that Ward or Department from the Central Pharmacy.

Medicines for ward or departmental stock are supplied by pharmacy staff operating the Issue Counter at the Central Pharmacy.

The indent of medicines for the wards requires the following information:

- Hospital, Ward name
- Date
- Code number of the indenting material with details of existing stock and quantity required
- Name of medicine including dose, strength and quantity
- Name of the Ward Supervisor who is indenting

Issue of the drugs from the pharmacy store to the wards, critical care areas, OT etc. is done twice, every month based on the corresponding indent.

The entry can be done by a staff nurse and the approval is done by the ward supervisor after verification.

This information goes directly to the pharmacy and the drugs are issued.

C. Indent for Inpatients

The bystanders shall purchase the medicines based on the prescription given.
The purchased medicines are given to the nurse of the ward who shall administer it
To the patient. Patient self-medication is not allowed.

D. Drug replacement and inpatient

Medicines for inpatient in wards and for the drug replacement in places like critical care areas are supplied by the pharmacy.
The requirement of such medicines requires the following information.

- Hospital, Ward and unit Name
- Date & Time
- Patient name and hospital number
- Name of medicine including dose, strength and quantity
- Name and signature of the doctor

E. Delivery and Receipt

Medicines are transported to Wards and Departments in sealed tamper-evident packages/boxes/PTS by approved messengers. The sealed package must be signed for in the delivery record book by a registered nurse upon receipt in the ward /department.
In case where the ward nursing staff are collecting the weekly issues for replenishment of ward stock the collecting nurse will sign for the issue in the issue register maintained at the issue counter in the central pharmacy.
Failure to receive medicines ordered or discrepancies in medicines received must be notified to the Central Pharmacy Immediately.

F. Documents and Records

Prescription forms, Requisition Books, Narcotics Order Books and Record Books must be kept in a secure place with access only to designated personnel.

G. Labeling Requirements

- All labelling of items removed from their original container/package occurs at the time the medication is being prepared, even if there is only one medication being prepared. Use of pre-labelled packaging from the manufacturer is unacceptable.
- Any unlabelled or partially labelled medication or solution is discarded immediately.
- Label one medication at a time (e.g., Get the first medication and label per guidelines, then get the second medication and label per guidelines, etc.
- All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.
- Upon a shift change or break relief (change in personnel involved with labelled medications, such as in the operating room or procedural areas), all medications/solutions and their labels are reviewed by entering and exiting persons.
- Attaching the original container (vial/amp, etc.) to the final container is unacceptable.

PROCEDURE (S)

The dispensing procedures are also described in the Pharmacy Services procedure.

MONITORING

The medical superintendent is responsible for monitoring of the process.

REFERENCES

A.

B. Standards

MOM 6 - a, b, c, d, e, f

CHAPTER NAME – MOM 6.F

Return of medications to the pharmacy is addressed

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to hospital staff on various issues related to pharmacy services and management of medication in the hospitals. The policy discusses the overall compliance to various standards pertaining to the Medication Management as per NABH standards; and links to further downstream policies and documentation established for compliance to standards specific to various issues like storage, ordering, administration, adverse reactions etc.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Usage Manual

INTRODUCTION

This policy has been formulated to ensure as far as possible compliance to various standards pertaining to Management of Medications (MOM) as prescribed by the NABH Accreditation Standards.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the process of medication management at various units of the hospital to ensure patient safety and wellbeing.

RESPONSIBILITIES

Chairman &Medical Director:
The overall responsibility of implementing the policy rests with the CMD of the hospital.

HODs / Unit Heads
They are responsible for implementing the various guidance in terms of ordering and administration of medications.

Director In-charge– Pharmacy
Is responsible to ensure that the policies pertaining to pharmacy services are implemented.

POLICIES

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

A. Pharmacies

The hospital operates the following pharmacies;

Central Pharmacy: Upper Basement

OPD Pharmacy: Upper Basement & Ground Floor

IPD Pharmacies: On Floors 2,3,4,56 and 9th.

The Chief Pharmacist is responsible to ensure that these pharmacies to operate under updated and suitable licenses issued by the state drugs authority.

B. Drugs & Pharmacy Committee

The hospital has a Drugs & Therapeutic Committee which is multi-disciplinary in nature and the committee is empowered to establish and monitor an effective medication management system in the hospital.

The constitution and working system of the committee is described in the relevant section of the hospital manual.

C. Drug Formulary

The hospital formulary shall be made available in all wards and department for easy reference. The same shall be accessible through the Hospital network.

The same is approved and periodically reviewed by the Drugs & Pharmacy Committee. All updating / amendments of the formulary have to be approved by the DPC.

There are certain medications which are prepared in the hospital itself.

At times the hospital allows IP patients to procure medicines from outside, during situations like when the prescribed medicine is either out of stock or not included in the hospital's drug list or the patient wishes to purchase medicines from outside.

D. Purchasing and Procurement

The method of purchase of a drug in the pharmacy is by inviting tenders from the manufactures/wholesalers.

The Central Pharmacy will be the only purchasing and procurement point for medicines in the Hospital. The detailed procedure governing the purchase of medications is specified in the Pharmacy Services SOP.

The purchasing and procurement of drugs are controlled by the Drugs & Therapeutic Committee established by the hospital.

E. Policy for the Introduction of New Drugs

Introduction of a new drug in the hospital is based on the doctor's indent which, has to be approved by the drugs and therapeutic committee.

The procurement of a new drug is done by issuing purchase orders to the manufacturers/wholesalers.

All patients of Saideep Hospital & Research Pvt Ltd will be prescribed all the medicines they clinically require, based on their diagnosis from the hospital formulary.

To ensure the best use of resources there is a formal procedure for the introduction of new drugs. No new drug will be prescribed without prior authorization from the Drug and Pharmacy Committee.

For inclusion of the new drug in the formulary an application for the same would be sent to the Medical Superintendent. (Refer to the Bylaws of the Drugs & Pharmacy Committee)

F. Obtaining of Drugs not listed in formulary

The method adopted to get an emergency drug that is not there in the formulary is done by:

- Identifying the different brands and manufacturers of the drug.
- Contacting the manufacturers/wholesalers/other hospitals.
- Placing an emergency purchase order.

On specific request the pharmacy will make arrangements for procurement of the same. This shall be done only in cases where the same is ordered through a prescription by the Head of Departments / Senior Consultants.

All such instances will be reported to the Chief Pharmacist on a weekly basis and subsequently DTC by the him / her on a monthly basis

G. **Retail Pharmacy Operations**.

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment?
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and issuing the drugs explaining to the patient regarding the drug intake, dos and don'ts etc.

H. General Policy on Expiry Checking

The medicines in the shelf of store, all retail areas, wards, critical care areas, OT etc. are checked once in every month for expiry date by the concerned staff responsible, the medicines are returned to the dealers 2 months prior to expiry date through pharmacy.

PROCEDURE (S)

The following policies have been established by the hospital to ensure an effective medication management system

- SDH/MOM/02 - Storage of Medications
- SDH/MOM/03 - Prescription of Medications
- SDH/MOM/06 - Medication Dispensing and Labeling
- SDH/MOM/08 - Medication Administration
- SDH/MOM/09 - Adverse Medication Events
- SDH/MOM/11 - Narcotics &Psychotropic Substances Handling
- SDH/MOM/05 - High risk medication
- SDH/MOM/12 - Chemotherapy Drugs

- SDH/MOM/13 - Radiotherapy drugs
- SDH/MOM/10 - Medication error
- SDH/MOM/04 - Verbal orders

Procedures have been established as a part of the Pharmacy Department Manual for defining and establishing a system for procurement, storage and dispensing of medications in the hospital;

- Procedure for Procurement of drugs
- Procedure for Central Pharmacy Operations
- Procedure for Retail Pharmacy Operations

The hospital has established separate policy and procedure for reporting and analysis of Adverse Drug Events.

MONITORING

The Drugs & Pharmacy Committee monitors the adherence to the medication management policy and processes across the hospital.

Individual Nursing Unit in-charges are responsible for monitoring of the implementation of the policies and procedures pertaining to medication management at the ground level on a day-to-day basis.

REFERENCES

Standards

MOM 1 – a, b
MOM 2 – a, b, c, d, e, f

CHAPTER NAME – MOM 7. H

Measures to avoid catheter and tubing mis-connections during medication administration are implemented

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance for to establish measures to avoid catheter and tubing misconnections during administration of medications
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Management Manual

1. PURPOSE:

To prevent catheter and tubing mis-connections during medication administration.

2. SCOPE:

This procedure is applicable to medication administrations at all locations and settings with in the hospital.

3. DEFINITIONS

Nil

4. RESPONSIBILITY

The Nursing Superintendent is overall responsible for ensuring compliance to this procedure.

The nurses involved in medication administration is responsible for ensuring the prevention measured are implemented.

5. DESCRIPTION

1. Saideep has systems and procedures in place which:

a) Emphasize to non-clinical staff, patients, and families that devices should never be connected or disconnected by them. Help should always be requested from clinical staff.

b) Require the labeling of high-risk catheters (e.g. arterial, epidural, intrathecal). Use of catheters with injection ports for these applications is to be avoided.

c) Require that caregivers trace all lines from their origin to the connection port to verify attachments before making any connections or reconnections, or administering medications, solutions, or other products.

d) Include a standardized line reconciliation process as part of handover communications. This should involve rechecking tubing connections and tracing all patient tubes and catheters to their sources upon the patient's arrival in a new setting or service and at staff shift changes.

e) Bar the use of standard Luer-connection syringes to administer oral medications or enteric feedings and preferring Using only oral/enteral syringes to administer oral/enteral medications and avoiding the use of adapters and three-way taps.

2. Saideep gives training on the hazards of misconnecting tubing and devices into the orientation and continuing professional development of practitioners and healthcare workers.

3. Saideep prefers purchasing of tubes and catheters that are designed to enhance safety and to prevent misconnections with other devices or tubes.

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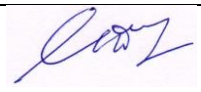
6. RECORDS

Nil

CHAPTER NAME – MOM 7. J

Measures to govern patient's self-administration of medications are implemented

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL PHARMACY / MEDICATION USAGE MANUAL	Doc No	SDH/MOM/4.1
		Issue No	01
		Rev No.	01
		Date	1 Nov 21
		Pages	6
	Document Title : General Policies Pharmacy Services &Medication Management		

SUMMARY	This document provides instruction and guidance to hospital staff on various issues related to pharmacy services and management of medication in the hospitals. The policy discusses the overall compliance to various standards pertaining to the Medication Management as per NABH standards; and links to further downstream policies and documentation established for compliance to standards specific to various issues like storage, ordering, administration, adverse reactions etc.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Usage Manual

INTRODUCTION

This policy has been formulated to ensure as far as possible compliance to various standards pertaining to Management of Medications (MOM) as prescribed by the NABH Accreditation Standards.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the process of medication management at various units of the hospital to ensure patient safety and wellbeing.

RESPONSIBILITIES

Chairman &Medical Director:
The overall responsibility of implementing the policy rests with the CMD of the hospital.

HODs / Unit Heads

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

They are responsible for implementing the various guidance in terms of ordering and administration of medications.

Director In-charge– Pharmacy
Is responsible to ensure that the policies pertaining to pharmacy services are implemented.

POLICIES

A. Pharmacies

The hospital operates the following pharmacies;

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B. Drugs & Pharmacy Committee

The hospital has a Drugs & Therapeutic Committee which is multi-disciplinary in nature and the committee is empowered to establish and monitor an effective medication management system in the hospital.

The constitution and working system of the committee is described in the relevant section of the hospital manual.

C. Drug Formulary

The hospital formulary shall be made available in all wards and department for easy reference. The same shall be accessible through the Hospital network.

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At times the hospital allows IP patients to procure medicines from outside, during situations like when the prescribed medicine is either out of stock or not included in the hospital's drug list or the patient wishes to purchase medicines from outside.

D. Purchasing and Procurement

The method of purchase of a drug in the pharmacy is by inviting tenders from the manufactures/wholesalers.

The Central Pharmacy will be the only purchasing and procurement point for medicines in the Hospital. The detailed procedure governing the purchase of medications is specified in the Pharmacy Services SOP.

The purchasing and procurement of drugs are controlled by the Drugs & Therapeutic Committee established by the hospital.

E. Policy for the Introduction of New Drugs

Introduction of a new drug in the hospital is based on the doctor's indent which, has to be approved by the drugs and therapeutic committee.

The procurement of a new drug is done by issuing purchase orders to the manufacturers/wholesalers.

All patients of Saideep Hospital & Research Pvt Ltdwill be prescribed all the medicines they clinically require, based on their diagnosis from the hospital formulary.

To ensure the best use of resources there is a formal procedure for the introduction of new drugs. No new drug will be prescribed without prior authorization from the Drug and Pharmacy Committee.

For inclusion of the new drug in the formulary an application for the same would be sent to the Medical Superintendent. (Refer to the Bylaws of the Drugs & Pharmacy Committee)

F. Obtaining of Drugs not listed in formulary

The method adopted to get an emergency drug that is not there in the formulary is done by:

- Identifying the different brands and manufacturers of the drug.
- Contacting the manufacturers/wholesalers/other hospitals.
- Placing an emergency purchase order.

On specific request the pharmacy will make arrangements for procurement of the same. This shall be done only in cases where the same is ordered through a prescription by the Head of Departments / Senior Consultants.

All such instances will be reported to the Chief Pharmacist on a weekly basis and subsequently DTC by the him / her on a monthly basis

G. **Retail Pharmacy Operations**.

The method adopted by the retail pharmacy outlets in dispensing the drugs includes:

- Receiving the prescription on the basis of the queue.
- Billing the prescription.
- Issue of token on cash payment?
- Retrieving the medicine on the basis of the bill.
- Checking the medications retrieved on the basis of the prescription.
- Calling the token and issuing the drugs explaining to the patient regarding the drug intake, dos and don'ts etc.

H. General Policy on Expiry Checking

The medicines in the shelf of store, all retail areas, wards, critical care areas, OT etc. are checked once in every month for expiry date by the concerned staff responsible, the medicines are returned to the dealers 2 months prior to expiry date through pharmacy.

PROCEDURE (S)

The following policies have been established by the hospital to ensure an effective medication management system

- SDH/MOM/02 - Storage of Medications
- SDH/MOM/03 - Prescription of Medications
- SDH/MOM/06 - Medication Dispensing and Labeling
- SDH/MOM/08 - Medication Administration
- SDH/MOM/09 - Adverse Medication Events
- SDH/MOM/11 - Narcotics &Psychotropic Substances Handling
- SDH/MOM/05 - High risk medication
- SDH/MOM/12 - Chemotherapy Drugs
- SDH/MOM/13 - Radiotherapy drugs
- SDH/MOM/10 - Medication error
- SDH/MOM/04 - Verbal orders

Procedures have been established as a part of the Pharmacy Department Manual for defining and establishing a system for procurement, storage and dispensing of medications in the hospital;

- Procedure for Procurement of drugs
- Procedure for Central Pharmacy Operations
- Procedure for Retail Pharmacy Operations

The hospital has established separate policy and procedure for reporting and analysis of Adverse Drug Events.

MONITORING

The Drugs & Pharmacy Committee monitors the adherence to the medication management policy and processes across the hospital.

Individual Nursing Unit in-charges are responsible for monitoring of the implementation of the policies and procedures pertaining to medication management at the ground level on a day-to-day basis.

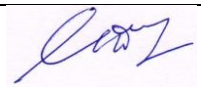
REFERENCES

Standards

MOM 1 – a, b
MOM 2 – a, b, c, d, e, f

CHAPTER NAME – MOM 8.A

Patients are monitored after medication administration

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on medication administration and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Use Manual

INTRODUCTION

Medication administration processes are the key stone to reducing medication errors in the hospitals. Actual administration of medication is the terminal event in a process chain of the medication management cycle. Hence right checks and balances in this process level result in reduction of potential medication errors.

PURPOSE AND SCOPE

The purpose and scope of this policy are to:

1. To ensure that patients are administered prescribed medications safely.
2. To ensure that any appropriate records are maintained.
3. To increase staff knowledge and understanding of medication management process and as far as possible, develop an institutionalized approach to medicines administration.

RESPONSIBILITIES

Medical Director.

The overall responsibility for implementing the policy rests with Medical Director of the hospital.

Nursing Staff
The nurses are responsible for implementing the provisions of this policy.

POLICIES

A. Administration of Medicines
Only qualified medical and nursing staff are allowed to administer medication to patients. Whereas during special situation the designated person shall administer the following:

- Chemotherapeutic agents - Doctors/Chemotherapy Nurses
- Injectable - Senior staff nurses.
- Oral Medicines – Staff nurses / ANMs (In General Wards)
- Blood transfusion – Doctors / Nurses
- Implants by the concerned surgeons after proper informed consent by the patient or relatives

Nursing trainees involved in medication administration will perform the same under supervision of staff nurses.

Medicines shall only be administered in accordance with a prescription or agreed protocols.

Doctors will explain tothe patient regarding the type of food intake and food to be avoided during a particular drug intake. Consultant while taking rounds shall explain the risks involved in the particular drug, on his/her absence another doctor deputed by him/her shall do the same.

Self Administration of Medication

The hospital does not allow self-administration medications by the patients including self-administered insulin.

PROCEDURE (S)

Procedure for Administration of Medicines

A. Responsibilities of Administration

The administration of medicines, including medical gases and intravenous fluids will be undertaken by either:
I) A qualified nurse posted in the ward / department.

II) A duty medical officer and registrar posted in the ward / department

B. Second Person Reviews

It is recognized that there are situations where a second person may be required and this need should be assessed by the nurse who is responsible for the administration. Such situations may be due to the status of the patient or where a drug dose needs calculation. The following specific situations require a second person whatever the circumstances.

1. Narcotics
2. Where a calculation of dose is required
3. Administration to children under 12 years of age
4. Where a drug dose is weight related
5. Intravenous drugs

Drugs must be prepared by the person who is to administer them and they must be given immediately after preparation. In case of multi-dose vials, the remaining dose should be stored in appropriate conditions approved by the DTC. The nurse is responsible for ensuring that the form of the drug is appropriate for the route of administration.

C. Safeguards in Medication Administration

The following points must be checked by the administering nurse:

- Patient's name on prescription sheet
- Prescription sheet is clearly written and signed by the prescriber.
- The prescribed time, date and method of administration
- The drug name on the container is the same as that on the prescription / order sheet.
- Check allergy box is completed and patient is not allergic to the medication prescribed.
- The dose has not already been given
- The correct dose of the drug is prepared
- The identity of the patient, with reference to the MRN (in wards where it is used)

IF THERE IS ANY DOUBT REGARDING THE ABOVE, THE NURSE MUST REFER THE MATTER BACK TO THE PRESCRIBER

ALWAYS ENSURE	
RIGHT	**Patient**

	Medication **Dosage** **Route** **Timing**

D. High Risk Medications
(Details – refer to high risk medication policy)

Each nursing unit will list and prominently display the list of high risk medications.
The list of high risk medications will be approved by the Drugs & Therapeutic Committee and reviewed on a yearly basis.

For high risk medications at least two nurses should verify all administration related parameters and checks before administrations. In emergency situations like resuscitation the administrating clinician or nurse will call out the name, dose and mode for the benefit of the other members of the code team and the team leader will verbally confirm to avoid any errors.

E. Self Administration of Medication

The hospital does not allow self administration of medications. All medications including insulin have to be ADMINISTERED by a nurse.

F. Recording

The administration of the drug must be recorded on the drug chart after administration has occurred and been observed.

If a prescribed drug is not given, the reasons for omission must be recorded on the case sheet.

MONITORING
The respective nursing in-charges of each ward are responsible to monitor the adherence to the policy by nurses.

REFERENCES

Standards

MOM 7 – a, b, c, d, e, f, g, I, j

	SAIDEEP HOSPITAL **PHARMACY& MEDICATION MANAGEMENTMANUAL**	Doc No	SDH/MOM/4.8
		Issue No	01
		Rev No.	01
		Date	1 Nov 21
		Pages	1of 5
	Document Title : Policies on Medication administration		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 8.C

The organisation captures near miss, medication error and adverse drug reaction

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 8.D

Near miss, medication error and adverse drug reaction are reported within a specified time frame

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on Medication errors and its protocols. All HODs throughout the hospital are required to instigate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Pharmacy & Medication Management Manual

PURPOSE

The purpose is to identify and report the medication error in patients. To provide for documentation of such in the incident form, preventing reoccurrence of the same and to identify training needed if any.

SCOPE

Pharmacy and all patient care units

DEFINITIONS

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, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Types of Medication Errors

1. Wrong Prescription i.e. incorrect dose, route, frequency, drug name, and illegible order
2. Indent error i.e. wrong drug, strength, dose, route, frequency
3. Dispensing delay of >2 hours, wrong drug, strength
4. Administration errors:

a. Wrong time
b. Wrong patient
c. Wrong medication
d. Wrong dose

e. Wrong route
f. Wrong documentation

Major medication error is one which results in either permanent harm or transfer to the intensive care units or death.

POLICY

1. When an error is identified, it shall be reported on an "incident form" to nurse in charge and the doctor on duty immediately.
2. Reporting an error must be part of the ordinary routine, and simple to do. It must also be non-punitive so that staff does not have to be afraid of repercussions.
3. An error shall be reported to the concerned consultant immediately.
4. Continuous monitoring and frequent assessments shall be done for the patient
5. An incident form shall be filled up with signatures of both the doctor and nurse. The Nursing Supervisor shall send this to QM Office.
6. The QCO shall maintain the incident database. The database shall be forwarded to the Quality Team on a monthly basis. The data shall be reviewed by the Drug Committee on a quarterly basis.
7. A Root Cause Analysis (RCA) shall be done for all major medication errors.

MONITORING

The QM will be responsible for monitoring all medication errors, ADR / ADE and conduct Root Cause Analysis.

REFERENCES

Standards

MOM 8 -c, d, e, f

INTRODUCTION

Incident reporting is a key tool of quality improvement and risk management and it is essential to learn from experience. The process enables any person to report an incident which has given, or may give rise to, actual or possible personal injury, or resulted in or could have resulted in a loss to the hospital, either financial or by way of reputation. This would include incidents such as staff injuries through manual handling, theft of hospital assets, improper patient care, e.g. misdiagnosis, equipment malfunction/failure, patient accidents, etc.

The hospital has a duty to communicate effectively with patients and/or their relatives as part of the process should errors or problem with their treatment arise.

The hospital is in the process of developing a database for the purpose of recoding and analyzing incident data. This will allow trends and common types of incidents to be identified and action plans developed to address the most commonly occurring incidents.

The healthcare industry in the country in general is going through increases consumer activism and increased litigation under the CPA. Litigation can be both very damaging personally, financially and from a publicity standpoint, for the hospital and staff involved. Reporting incidents promptly can lead to the avoidance of litigation through good communication with the injured party, and/or out of court settlement (as appropriate). Where an incident is defensible, prompt and thorough investigation will allow the hospital to effectively defend its position.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the risks through better system of reporting incidents and near misses; and analyzing them through classification and severity ratings.

The policy and accompanying procedures apply to hospital staff (permanent and temporary) including those working on contracts or service agreements with outsourced agencies.

RESPONSIBILITIES

Quality Coordinator

The QC is responsible for ensuring incident reporting and investigation processes are in place and acts as the co-coordinating officer for investigations into Sentinel Events and Grade III incidents. He/she shall be responsible for proving regular updates to the associate director and top management as per requirement from time to time.

Nursing Superintendent

The Nursing Superintend

ent is responsible for ensuring that investigations into incidents, including those involving doctors are undertaken in accordance with this policy and liaising with Chief Medical Administrator and Quality Coordinator to ensure that investigations are co-ordinated and comprehensive and action is taken to minimize the risk of recurrence.

Security Officer

The security officer is responsible ensuring incidents impacting on the protection of people, property and assets, maternity and pediatric units, drugs and hazardous materials are reported to the Medical Administrator, QC and Medical Superintendent.

Head of the Departments

Responsibility for ensuring that this Policy is notified to all staff rests with Head of the Departments, who are responsible for monitoring its compliance. They are also responsible for ensuring that any remedial action required is planned and implemented liaising with Associate director / QCO and other staff as necessary.

Person In-charge at the time of Incident

He / She shall be responsible for initiating the incident reporting procedure. This person should ensure that, where appropriate, remedial action is taken to ensure the safety of anyone involved and any evidence is preserved and co-ordinate the provision of any prompt appropriate information or apology to the patient and or relatives They should also ensure that the Ward In-charge /Nursing Superintendent / HOD is suitably informed of incidents.

DEFINITIONS

Near Miss:

It is more of an error. It is the most common type of error. The error can lead to an incident but has not happened so in a "near miss", as it is intercepted prior to the completion as an incident and thereby has not harmed the patient. This has to be reported.

Incident:

Incident if that has "caused harm to a patient or visitor", the list of areas and incidents are in the incident reporting form which has to be checked for the entire day and filled every day that evening and signed by the corresponding ward supervisor and sent to the Quality control Office by the next day.

Adverse Event:

An adverse event is any adverse change in health or side effect that occurs in a patient while he is receiving the treatment or within a previously specified period of time after the treatment has been completed.

The incidents like

- Adverse Drug Reaction (ADR),
- Adverse transfusion reaction and
- Adverse anesthesia events are adverse events looked at present.

The root cause analysis shall be done by the Pharmacovigilance Committee and Transfusion Committee and submitted to the Management Committee Every month.

Sentinel Events:

These are rare events but can be more serious and need to be investigated immediately.

These are that involves both patient care and health care delivery system and process deficiencies hence the patient can be harmed.

POLICIES

5.1 All incidents relating to patient and personnel safety occurring in hospital shall be reported using appropriate forms to designated officers as per this policy and supporting procedures. This shall include near misses.

5.2 Various categories of incident reporting forms and guidance materials / posters on incident categorization and reporting shall be made available in all nursing stations / units to actively encourage compliance to incident reporting.

5.3 No punitive actions will be undertaken by the hospital administration on self reported incidents.

5.4 The designated officers for each category of incident shall undertake root cause analysis for each incident reported to them and suggest positive corrective and preventive actions.

5.5 The QCO shall prepare trend analysis for all incidents reports on a quarterly basis.

5.6 The reported incidents and trend analysis shall be a standing agenda for all Hospital Management Committee meetings.

PROCEDURE (S)

The following procedures have been established for implementation of this policy.

- Procedure for Categorization and Flow of Reporting for Incidents
- Procedure for Sentinel Event Reporting & Analysis
- Procedure for Adverse Drug Event Reporting & Analysis

MONITORING

The Quality Management Office will review and assess classification of incidents; analysis and follow up actions undertaken. An analysis will be undertaken of the distribution, location, type, and population involved in incidents to identify any trends, system, or procedural failure.

Quarterly reports are to be provided to the Quality controller based on the analysis of incidents and the trends. Reviews of incidents and trends should form a standing agenda item for review meetings of the Hospital Management Committee.

STANDARD REFERENCES

CQI-3C,3J,3K,4F, 4H,4I,7A,CQI 8A-8D

APPENDICES

Appendix 1: Procedure for Adverse Drug Event Reporting & Analysis
Appendix 2: Procedure for Categorization and Flow of Reporting for Incidents
Appendix 3: Procedure for Sentinel Event Reporting & Analysis

atient Name:	MRD No:

Appendix 1: Procedure for Adverse Drug Event Reporting & Analysis

1. Notification:

Suspected adverse drug reactions are reported immediately to the registered nurse in charge of the patient to physician and the drug reaction form filled and sent to pharmacology department.

2. Monitoring

The Qualified nurse in charge of the patient observes closely for the adverse reaction. The patient's vital signs are frequently monitored and nurses are to be ready with all emergency measures.

3. Documentation

All suspected adverse drug reactions are properly documented in the patient's record including time of reaction, patient's response to drug therapy including signs and symptoms and measures instituted, the name of physician and time notified and the patient general condition.

Appendix 3: Procedure for Sentinel/Incident Event Reporting & Analysis

1.The sentinel/incident event reporting proforma will be available at the nursing station. The reporting shall be done by the ward staff. In the case of events involving doctors, the reporting shall be done by the immediate senior doctor.

2. The proforma signed and completed shall be sent to the quality management office on the same day.

3. The QC shall inform the concerned unit chief and the HOD of the incident on the same day of the reporting.

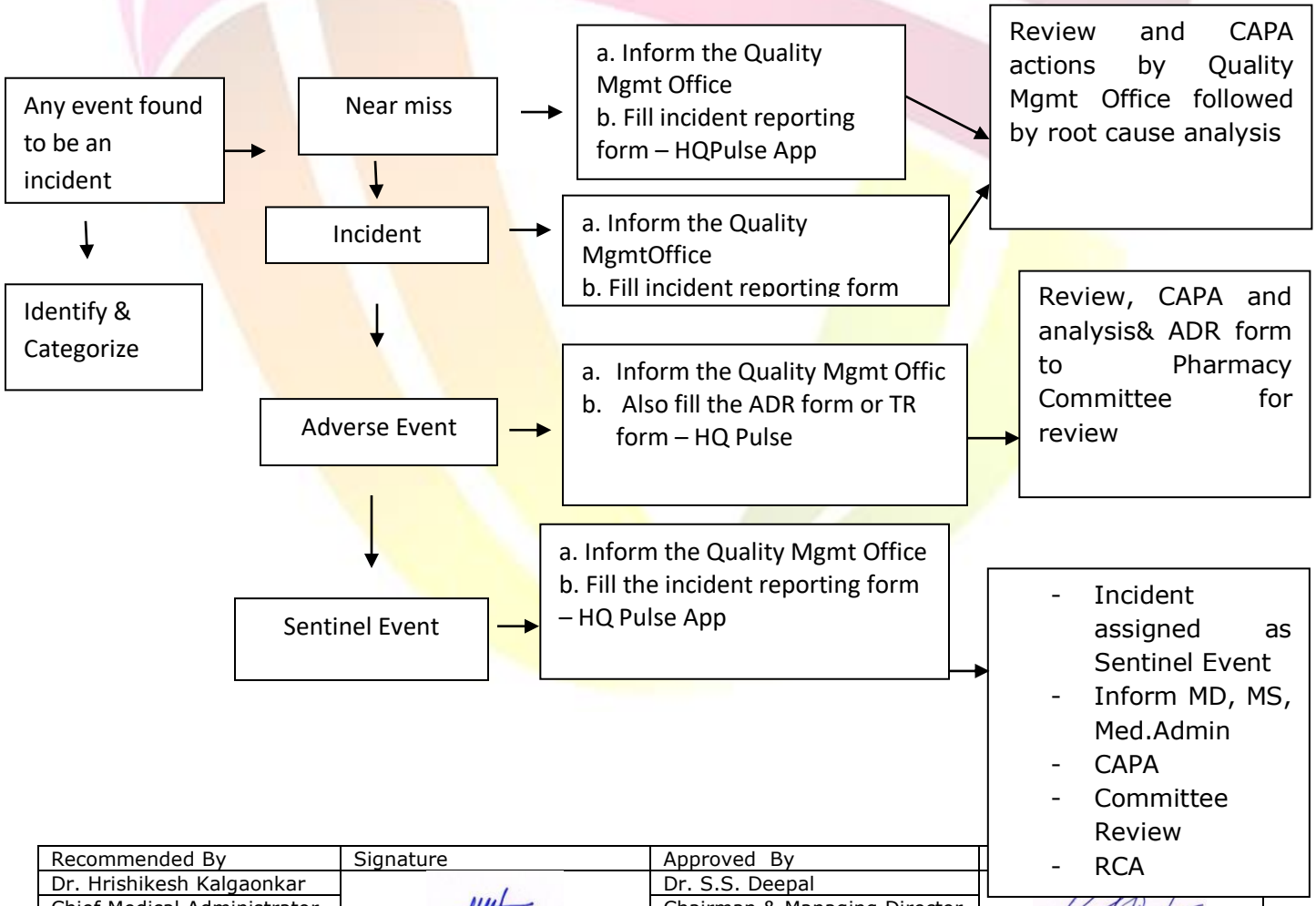
4. In case of any major illness to the patient, as a result of the event, the HOD discuss the treatment aspect and the costs involved with the Medical Superintendent

5. A committee shall be formed based on the nature of the incident. The employee shall be called for an enquiry by the committee, and the required action shall be taken depending upon on the severity of the incident.

6. The outcome of the meeting shall be decided by the committee on that day and the appropriate action shall be taken.

7. The minutes and the outcome of the meeting shall be sent to the hospital management committee within three days of the meeting.

Appendix 2 - Incident Reporting / Root Cause Analysis – FLOW CHART



Appendix 3 : Procedure for Sentinel/Incident Event Reporting & Analysis

1. The incident / event reporting is done through HQ Pulse Application (Mobile or Computer) using access made available at the nursing station. The reporting shall be done by the ward staff. In the case of events involving doctors, the reporting shall be done by the immediate senior doctor.
2. The Quality Coordinator is altered by HQ Pulse system (email / sms) and will log on and review the incident. Any incident qualifying criteria for sentinel event as per NABH guidelines is designated as Sentinel Event in the system by QC
3. On marking an event as sentinel event alerts (sms/email) will be sent to Managing Director, Medical Directors, Medical Superintendent, Medical Administrator and Nursing Superintendent.
4. The QC shall inform the concerned HOD of the incident on the same day of the reporting.
5. In case of any major illness to the patient, as a result of the event, the HOD discuss the treatment aspect and the costs involved with the Medical Superintendent
6. A committee shall be formed based on the nature of the incident. The key stakeholders shall be called for an enquiry by the committee, and the required action shall be taken depending upon on the severity of the incident.
7. The outcome of the meeting shall be decided by the committee on that day and the appropriate action shall be taken. A copy of the proceedings is filed with the QM office and reviewed in the next quality committee meeting
8. The QC shall ensure a RCA and report of same will be appended in the HQ Pulse Incident management system for reference.

CHAPTER NAME – MOM 9.A

Narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents are used safely

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on handling the narcotic drugs and its protocols. All HODs throughout the hospital are required to instigate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Pharmacy and Medication Management Manual

INTRODUCTION

Narcotics and Psychotropic Substances Act covers the use of some vital drugs like Pethidine, Morphine and Fentanyl etc. which are regularly used in a tertiary care center involving large number of surgical and critical care patients.

However due to high potential of abuse of these substances; government has established strict licensing terms for their use by the approved medical institutions. Violations of these licensing can lead to criminal proceeding against the licensee in case of violations both by commission or omission.

PURPOSE AND SCOPE

The purpose and scope of this policy are to:

1. To ensure that terms of license awarded to the hospital under the Narcotics and Psychotropic Substances Act are adhered.
2. To define the roles and responsibilities of persons to whom the rights to issues, administer and monitor such medications are assigned.
3. To increase staff knowledge and understanding of the rules and processes governing this class of medications.

RESPONSIBILITIES

Chairman & Managing Director

The overall responsibility for implementing the policy rests with CMD of the hospital.

Pharmacy & Nursing Staff

The assigned pharmacists and nurses are responsible for implementing the provisions of this policy.

POLICIES

Narcotics must be handled in accordance with the Narcotics and Pyschotropic Substances Act, Rules and Regulation of the license.

PROCEDURE

Procedure for Management Narcotics

a. Storage

All Narcotics must be stored in separate cupboard under lock and key maintained by persons approved by the Medical Superintendent.

The current locations in the hospital approved for stocking with list of approved personnel for handling and stock level to be maintained are as follows;

Narcotic drugs permitted in our hospital are:
Inj. Morphine
Inj. Fentanyl
Inj. Pentazocin

No.	LOCATIONS	DRUGS	NUMBER PERMITTED	INCHARGE	DESIGNATION
1.	Pharmacy	Morphine, Fentanyl, Pentazocin	100 each	Head Pharmacist	Pharmacist
2.	Casualty	Pentazocin	5		
3.	ICU	Morphine, Fentanyl, Pentazocin	5 each	RMO	RMO
4.	OT	Morphine, Fentanyl, Pentazocin	5 each	Anaesthetist	Anaesthetist
5.	Wards	Not allowed	None		
6.	Labour room	Morphine	5	Anaesthetist	Anaesthetist

B.Accountability and Responsibility

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

A pharmacist or Nursing Staff is nominated as authorized personnel at all location of Narcotics stocking. The authorized personnel can delegate control of access (i.e. key-holding) to the Narcotic Locker / cupboard to another registered nurse / pharmacist of the same unit (for ensuring access through the various shifts). However, legal responsibility remains with the authorized person. Whilst the task can be delegated, the responsibility cannot. The keys of the Narcotic cupboard shall be kept separately from other keys.

c. Ordering

Only medical personnel attached and privileged with hospital are permitted to order Narcotics. Narcotics must only be ordered in the ward drug / prescription chart only. A separate page must be used for each drug. Each order must be in indelible ink and state:

- Hospital, Ward or Unit name
- Date
- Name and form of the preparation
- Strength and quantity required
- The printed name and qualifications of the signatory

Narcotics can be requisitioned from the main stock at the pharmacy by the sub stock units through a separate requisition slip signed by the authorized personnel for that stock unit and the HOD of the department. Requisition for Narcotics will not be mixed with requisition of other drugs.

The sub-stock book maintained will be sent to the pharmacy for verification of the stock.

Used vials of consumed stock will be returned along with the requisition for new stock.

d. Delivery and Receipt

Narcotics are delivered to wards by an approved messenger in a sealed tamper-evident package/PTS. The package will be accompanied by a Narcotic Delivery record sheet, which must be signed on receipt in the ward by an authorized person and returned to the HOD Pharmacy. On no account should Narcotics or its used vials be left unattended.

Receipt of a Narcotic should only be by the authorized person of that ward/ department.

When the contents do not match the expected amount stated on the pack, the authorized (person) in charge should contact the chief pharmacist. Appropriate records should be made in the Narcotic register and all necessary action taken to resolve the discrepancy. The Medical

superintendent/associate director will be informed immediately in writing and a separate incident form filed to the Quality Coordinator.

Under **no** circumstances can entries in the Main or Ward Narcotic Stock Register be altered, erased or obliterated. Any entry made in error in the Main or Ward Narcotics Stock Register is to be annotated as "entered in error" and signed by both the authorized personnel for the ward and HOD of that Department. In case of the main stock register the changes should be countersigned by the Medical Superintendent.

e. Control and Checking

Narcotics must be checked at least weekly. This should be organized by and is the responsibility of the authorized persons in charge of the ward /department.

The Ward Narcotics Stock Register shall be kept in a locked cupboard.

Pharmacy staff (approved personnel) shall be given access to all storage facilities and shall inspect these every month. A record of inspections will be documented with a note of any actions taken.

f. Records and Documents

It is unlawful to obliterate or erase an entry in the Narcotic related Registers because it must remain legible, even if made in error.

Each page is numbered and **must not be removed.**

Narcotic Order Books and Registers must be kept in a secure place with access only TO designated personnel (ideally inside the stored cupboards).

All documents and records must be retained in the relevant ward / department for a period of two years from the date of the last entry. Then, the records must be destroyed by shredding.

g. Prescribing

As per guidance for prescription

h. Administration

In hospital the administration of Narcotics must be carried out by qualified nurse or Duty Medical Officer. Students and trainees shall not administer Narcotics.

The following guidelines should be followed at the time of administration

When removing the Narcotic from the cupboard:

- Two persons must check the label against the prescription.
- Two persons must check the amount left in stock against the balance in the Ward Narcotic Stock Register.
- **If the prescribed dose is only part of an ampoule, the unused part must be discarded immediately, by one of the persons in the presence of the other. The amounts given and wasted must be entered in the register and signed by BOTH persons.**
- The entire process, from removal of the drug from the cupboard to its administration to the patient must be carried out by **two persons.**
- Individual doses of Narcotic which have been prepared but not administered should be destroyed in the ward/department by a registered nurse in the presence of a witness. The reason should be documented in the Narcotic Stock Register.
- If a mistake is made in the register it should be bracketed in such a way that the original entry is still clearly legible. This should be signed, dated and witnessed by HOD (for ward stock)

i. Incidents involving Narcotics

When a Narcotic discrepancy is found on a ward /department, in the first instance the following should be carefully checked-

- All requisitions received have been entered onto the correct page of the register
- All Narcotics administered have been entered into the register
- Items have not been put in the wrong place in the cupboard
- Arithmetic to ensure that balances have been calculated correctly

If the error is traced, the authorized person in charge should make an entry in the register clearly stating the reason and the corrected balance. This should be validated by HOD in case of wards and Medical superintendent for the main stock at Pharmacy.

If the error cannot be detected then the Medical superintendent/associate director would be intimated immediately in writing and an '**incident reporting form'** initiated and sent to QCO.

All Narcotic incidents are automatically categorized "Moderate", "Major" or "Catastrophic" and so there will be an investigation and a root cause analysis by a multidisciplinary team

j. Returning Narcotics to the Pharmacy

Narcotics that are time –expired or unfit for use should be returned to pharmacy for disposal.

Narcotics are returned by the approved person for the ward who will make the entry in the relevant page of the Narcotics Stock register and have this validated by the HOD. A record of any drugs returned (and any further transactions e.g. disposal or return to authorized supplier) is kept in the central pharmacy.

MONITORING

The Chief Pharmacist and Medical superintendent/associate director are responsible for monitoring the implementation of this policy.

REFERENCES

Standards

MOM 9 – a, b, c, e

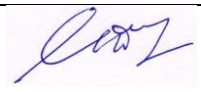
CHAPTER NAME – MOM 10. A

Recall of implantable prosthesis and medical devices are handled effectively

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – MOM 10. B

The organisation implements a mechanism for the usage of the implantable prosthesis and medical devices

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on handling the implantable prosthesis and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

INTRODUCTION

Several of the super specialty departments like Orthopedics and Cardiology uses implantable prosthesis and devices like joints, pace makers etc.

It is important to maintain the systematic records of these devices for the benefit of the patients and to ensure continuity of care and also to tackle future issues of malfunctions.

POLICIES

1. Hospital uses various manufacturers of implants as approved by the purchase In-charge in consultation with respective HODs. These implants are 8-9 varieties, manufactured by different companies. The implants to be used in particular patient are selected by the concerned unit head / surgeon / physician in discussion with the patients and family after explaining the benefits and side effects of the same. Two methods are adopted. One, the implants are directly ordered from the OT by the OT staff. Two, an order is placed to the purchase department after the consent of the HOD through the Purchase In-charge. In patients with poor economic condition, to reduce the cost of surgery, locally manufactured implants are used after explaining to the patient.

2. All purchases of the implants and devices follow the purchase policies of the hospital.

The commonly used implants can be kept in hospital pharmacy after following the quotation system as used for the medications. The doctors concerned can give the list of implants required and those with best rates (to patient and to Saideep Hospital & Research Pvt. Ltd. may be selected as being done for antibiotics and other medications.

Orders can be placed through the pharmacy for commonly used prosthesis, and a few of them may be kept in the OT / procedure room as is being done for drains/surgical/VP shunts etc.

3. All the implants are held in hospital operation theater medical stores and replacement order is placed with the same company supplying the implants.

4. Selection of specific type of implant depends on:

a. Patients' decision based on economic condition.
b. The deformity, its type and severity, a patient has.
c. Type and pattern and extent of fracture.
d. Surgeons' choice

This policy will work in tandem with the policy and procedures for consignment items in the hospital purchase manual.

The departments where prosthesis is used are Orthopedic, Urology, Oncology, Neurology, Cardiology and ENT.

The method of procuring prosthesis for different departments includes:

- Orthopedic/Neurology - Order directly placed to the stockist instantly based on the operations posted.
- Urology/Oncology - Through pharmacy.
- Cardiology - Order directly placed to the stockist instantly based on the operations posted.
- ENT - Through the central store of the hospital.

5. The billing to the patient is done according to the type of implant used.

6. Similarly for all trauma / orthopedic cases needing plating, wiring and fixation by screws, indigenous and foreign material is used based on patients; or surgeons; choice and type of injury sustained by the patient

7. Almost all types of implants used in trauma cases are readily available in the hospital medical store; some specific implants need to be ordered before surgery.

8. Most of them are supplied in pre-sterile packs and those supplied otherwise are autoclaved in the hospital CSSD.

9. The identification and traceability of each implants used is maintained by pasting the respective bar coded identification stickers in the OT / Cath Lab register and respective patient case sheets. **It is important to write both the serial number and stick the bar code stickers in the register and case sheet so that the serial numbers are available even if the barcode stickers become illegible in future.**

10. The respective clinical departments are responsible for counseling for the usage of implantable prosthesis and medical devices. This includes the benefits and precautions and precautions to be taken while living with devices like pacemakers. They are also counseled on do and don'ts related with the implant / device including contraindicated medications where applicable. They are also counseled on situations where immediate hospitalization may be required.

11. The clinical departments, DTC, Biomedical Engineering and Purchase department monitors communications from regulatory authorities, manufacturers and patient feedback on devices. Recalls are implemented when recommended by manufacturer or regulatory authorities

12. A device recall is always done under the supervision of Chief Medical Administrator by a team consisting of him / her, Biomedical Engineer, Material Management In-charge and representative from medical specialty where applicable.

13. All patients who are affected are informed and recall / replacement arranged based on parameters of such recall program.

14. Legal opinions are sought when hospital patients are involved in such recall incidents and hospitals legal liabilities are reviewed before recall is instituted and patients informed.

15. The hospital shall document and maintain details all such recalls.

16. Unused implants and devices from hospital stock of falling under the recall parameters are identified and quarantined in central stores under lock and key till clarity of their handling is received from manufacturer and or regulatory authority

STANDARDS REFERENCE

MOM 10 – a, b, c, d, e

CHAPTER NAME – MOM 11. A

The organisation adheres to the defined process for the acquisition of medical supplies and consumables

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on handling the implantable prosthesis and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

INTRODUCTION

Several of the super specialty departments like Orthopedics and Cardiology uses implantable prosthesis and devices like joints, pace makers etc.

It is important to maintain the systematic records of these devices for the benefit of the patients and to ensure continuity of care and also to tackle future issues of malfunctions.

POLICIES

1. Hospital uses various manufacturers of implants as approved by the purchase In-chargein consultation with respective HODs. These implants are 8-9 varieties, manufactured by different companies. The implants to be used in particular patient are selected by the concerned unit head / surgeon / physician in discussion with the patients and family after explaining the benefits and side effects of the same. Two methods are adopted. One, the implants are directly ordered from the OT by the OT staff. Two, an order is placed to the purchase department after the consent of the HOD through the Purchase In-charge. In patients with poor economic condition, to reduce the cost of surgery, locally manufactured implants are used after explaining to the patient.

2. All purchases of the implants and devices follow the purchase policies of the hospital.

The commonly used implants can be kept in hospital pharmacy after following the quotation system as used for the medications. The doctors concerned can give the list of implants required and those with best rates (to patient and to Saideep Hospital & Research Pvt. Ltd. may be selected as being done for antibiotics and other medications.

Orders can be placed through the pharmacy for commonly used prosthesis, and a few of them may be kept in the OT / procedure room as is being done for drains/surgical/VP shunts etc.

3. All the implants are held in hospital operation theater medical stores and replacement order is placed with the same company supplying the implants.

4. Selection of specific type of implant depends on:

a. Patients' decision based on economic condition.
b. The deformity, its type and severity, a patient has.
c. Type and pattern and extent of fracture.
d. Surgeons' choice

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The departments where prosthesis is used are Orthopedic, Urology, Oncology, Neurology, Cardiology and ENT.

The method of procuring prosthesis for different departments includes:

- Orthopedic/Neurology - Order directly placed to the stockist instantly based on the operations posted.
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- ENT - Through the central store of the hospital.

5. The billing to the patient is done according to the type of implant used.

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12. A device recall is always done under the supervision of Chief Medical Administrator by a team consisting of him / her, Biomedical Engineer, Material Management In-charge and representative from medical specialty where applicable.

13. All patients who are affected are informed and recall / replacement arranged based on parameters of such recall program.

14. Legal opinions are sought when hospital patients are involved in such recall incidents and hospitals legal liabilities are reviewed before recall is instituted and patients informed.

15. The hospital shall document and maintain details all such recalls.

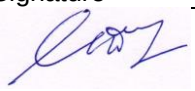
16. Unused implants and devices from hospital stock of falling under the recall parameters are identified and quarantined in central stores under lock and key till clarity of their handling is received from manufacturer and or regulatory authority

STANDARDS REFERENCE

MOM 10 – a, b, c, d, e

CHAPTER NAME – MOM 7.K

Measures to govern patient's medications brought from outside the organization are implemented

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance to Hospital staff on intake of patient's own medications and its protocols. All HODs throughout the hospital are required to initiate action to ensure the successful implementation of the policy within their area(s) of control.
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

INTRODUCTION

These medications have potential to react with medication prescribed by the hospital or cause adverse physiological events detrimental to treatment lines undertaken in the hospital. Hence processes have to be established as a part of medication management system to address the issues.

PURPOSE AND SCOPE

The purpose and scope of this policy are to:

1. To ensure that existing medications taken by the patient is accounted for as part of the patients assessment.
2. To ensure that no unauthorized drugs are brought to the hospital from outside sources; so that the hospital can ensure the quality of all medications.

RESPONSIBILITIES

Chairman and Managing Director

The overall responsibility for implementing the policy rests with Medical Director of the hospital.

Nursing Staff

The nurses are responsible for implementing the provisions of this policy.

POLICIES

A. Medicines Brought into Hospital by Patients (Patients' Own Medication)

- Hospital inpatients shall be advised of the need to inform staff of medicines they are currently taking and have brought into hospital.
- This statement shall be included in the patients' rights & responsibility / patients' information booklets.
- All medicines brought in by patients are their property and the patient's consent (verbal) for their removal or use must be obtained.
- Inpatient - Self administration not permitted.
- Patients who have been on regular medicine for some other diseases/ailments are continued. These medicines are written on order-sheet by doctors and dispensed to the patient by staff.
- It is the hospital's policy to ask patients to bring their current medication with them on admission. This enables staff to see what treatment the patient is having and allows accurate medication history taking.
- The residents serving in their units will decide on continuation of the current medications. The list of current medication to be continued will be written on the patient chart as a medication order with appropriate details.

- The nursing staff will then include the patient's current medications as a part of the medication administration plan.

- Drugs which are no longer needed or which may be detrimental to the patient's treatment should, with the patient's consent, disposed of or sent back with the patient attendants. In no case the unwanted medication should be allowed to mix with the patient's medication increasing chances of medication errors.

MONITORING

The respective nursing in-charges of each ward are responsible to monitor the adherence to the policy by nurses.

REFERENCES

A. Standards
MOM 7-k