SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

Pharmacy & Medication Management Manual

SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

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/Pharma/01	Contents	1	2	01-Jan-25	No Any Change Review Completed	2	01-Jan-26	No Any Change Review Completed	No Any Amendment History
2	SDH/Pharma/02	Organization chart	1	2	01-Jan-25		2	01-Jan-26		
3	SDH/Pharma/03	Roles and Responsibilities	1	2	01-Jan-25		2	01-Jan-26		
4	SDH/Pharma/4.1	Medication Mgmt Policy-General	1	2	01-Jan-25		2	01-Jan-26		
5	SDH/Pharma/ 4.2	Medication storage	1	2	01-Jan-25		2	01-Jan-26		
6	SDH/Pharma/ 4.3	Medication - Prescription and Ordering	1	2	01-Jan-25		2	01-Jan-26		
7	SDH/Pharma/ 4.5	High risk Medication Policy	1	2	01-Jan-25	No Any Change Review Completed	2	01-Jan-26	No Any Change Review Completed	No Any Amendment History
8	SDH/Pharma/ 4.6	Medication Dispensing issue	1	2	01-Jan-25		2	01-Jan-26		
9	SDH/Pharma/ 4.7	Medication- Patients Own Medicine	1	2	01-Jan-25		2	01-Jan-26		
10	SDH/Pharma/ 4.8	Medication Administration	1	2	01-Jan-25		2	01-Jan-26		
11	SDH/Pharma/ 4.9	Medication- Adverse drug Reaction	1	2	01-Jan-25		2	01-Jan-26		
12	SDH/Pharma/ 4.10	Medication Error	1	2	01-Jan-25		2	01-Jan-26		
13	SDH/Pharma/ 4.11	Medication- Narcotics	1	2	01-Jan-25		2	01-Jan-26		
14	SDH/Pharma/ 4. 12	Medication Chemotherapy	1	2	01-Jan-25		2	01-Jan-26		
15	SDH/Pharma/ 4.13	Medication- Implantable Prosthesis	1	2	01-Jan-25		2	01-Jan-26		
16	SDH/Pharma/ 4.14	Central Pharmacy	1	2	01-Jan-25		2	01-Jan-26		
17	SDH/Pharma/ 4.15	Retail Pharmacy	1	2	01-Jan-25		2	01-Jan-26		
18	SDH/Pharma/4.16	QA for Pharmacy	1	2	01-Jan-25		2	01-Jan-26		

19	SDH/Pharma	Pharmacy Department	1	2	01-Jan-25		2	01-Jan-26		

		Original Date	Effective Date	Next date of revision	Issue NO		
		01 November 2021	**01 JANUARY 2026**	**01 JANUARY 2027**	1		

Reviewed & Prepared By		Recommended By	Approved By
Mr. Deepak Kale	Mrs. Renuka Sonwane	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Pharmacy HOD	Quality Co-ordinator	Quality Head	Chairman & Managing Director
			

SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

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/Pharma/01	Contents	1	1	20-Nov-22	No Any Change Review Completed	1	20-Nov-23	No Any Change Review Completed	No Any Amendment History
2	SDH/Pharma/02	Organization chart	1	1	20-Nov-22		1	20-Nov-23		
3	SDH/Pharma/03	Roles and Responsibilities	1	1	20-Nov-22		1	20-Nov-23		
4	SDH/Pharma/4.1	Medication Mgmt Policy-General	1	1	20-Nov-22		1	20-Nov-23		
5	SDH/Pharma/ 4.2	Medication storage	1	1	20-Nov-22		1	20-Nov-23		
6	SDH/Pharma/ 4.3	Medication - Prescription and Ordering	1	1	20-Nov-22		1	20-Nov-23		
7	SDH/Pharma/ 4.4	Medication- Verbal orders	1	1	27-Jun-22	Policy updates	1	20-Nov-23	As per NABH NC	Policy updates
8	SDH/Pharma/ 4.5	High risk Medication Policy	1	1	20-Nov-22	No Any Change Review Completed	1	20-Nov-23	No Any Change Review Completed	No Any Amendment History
9	SDH/Pharma/ 4.6	Medication Dispensing issue	1	1	20-Nov-22		1	20-Nov-23		
10	SDH/Pharma/ 4.7	Medication- Patients Own Medicine	1	1	20-Nov-22		1	20-Nov-23		
11	SDH/Pharma/ 4.8	Medication Administration	1	1	20-Nov-22		1	20-Nov-23		
12	SDH/Pharma/ 4.9	Medication- Adverse drug Reaction	1	1	20-Nov-22		1	20-Nov-23		

13	SDH/Pharma/4.10	Medication Error	1	1	20-Nov-22		1	20-Nov-23		
14	SDH/Pharma/ 4.11	Medication- Narcotics	1	1	20-Nov-22		1	20-Nov-23		
15	SDH/Pharma/ 4. 12	Medication Chemotherapy	1	1	20-Nov-22		1	20-Nov-23		
16	SDH/Pharma/ 4.13	Medication- Implantable Prosthesis	1	1			1	20-Nov-23		
17	SDH/Pharma/ 4.14	Central Pharmacy	1	2	20-Nov-22		1	20-Nov-23		
18	SDH/Pharma/ 4.15	Retail Pharmacy	1	1	20-Nov-22		1	20-Nov-23		
19	SDH/Pharma/ 4. 16	QA for Pharmacy	1	1	20-Nov-22		1	20-Nov-23		
20	SDH/Pharma/ 4.17	Medication Recall	1	0	27-Jun-22	Medicine return to the pharmacy	1	20-Nov-23	As per NABH NC	Medicine return to the pharmacy
21	SDH/Pharma/ 4.18	Measure to prevent catheter and tubing misconnection during medication administrations	1	0	27-Jun-22	Catheter & tubing miss connection	1	20-Nov-23	As per NABH NC	Catheter & tubing miss connection
22	SDH/Pharma/ 5.2	Purchase system Policy	1	1	27-Jun-22	Vendor selection vendor evaluation	1	20-Nov-23	As per NABH NC	Vendor selection vendor evaluation
23	SDH/Pharma	Pharmacy Department Incharge	1	1	27-Jun-22	No Any Change Review Completed	1	20-Nov-23	No Any Change Review Completed	No Any Amendment History
24	SDH/Pharma	Pharmacy Department	1	1	27-Jun-22		1	20-Nov-23		

		Original Date	Effective Date	Next date of revision	Issue NO		
		01 November 2021	**20 November 2023**	**20 November 2024**	1		

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

SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

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/Pharma/01	Contents	1	1	01-Jan-23	No Any Change Review Completed	1	01-Jan-24	No Any Change Review Completed	No Any Amendment History
2	SDH/Pharma/02	Organization chart	1	1	01-Jan-23		1	01-Jan-24		
3	SDH/Pharma/03	Roles and Responsibilities	1	1	01-Jan-23		1	01-Jan-24		
4	SDH/Pharma/4.1	Medication Mgmt Policy-General	1	1	01-Jan-23		1	01-Jan-24		
5	SDH/Pharma/ 4.2	Medication storage	1	1	01-Jan-23		1	01-Jan-24		
6	SDH/Pharma/ 4.3	Medication - Prescription and Ordering	1	1	01-Jan-23		1	01-Jan-24		
7	SDH/Pharma/ 4.5	High risk Medication Policy	1	1	01-Jan-23	No Any Change Review Completed	1	01-Jan-24	No Any Change Review Completed	No Any Amendment History
8	SDH/Pharma/ 4.6	Medication Dispensing issue	1	1	01-Jan-23		1	01-Jan-24		
9	SDH/Pharma/ 4.7	Medication- Patients Own Medicine	1	1	01-Jan-23		1	01-Jan-24		
10	SDH/Pharma/ 4.8	Medication Administration	1	1	01-Jan-23		1	01-Jan-24		
11	SDH/Pharma/ 4.9	Medication- Adverse drug Reaction	1	1	01-Jan-23		1	01-Jan-24		
12	SDH/Pharma/ 4.10	Medication Error	1	1	01-Jan-23		1	01-Jan-24		
13	SDH/Pharma/ 4.11	Medication- Narcotics	1	1	01-Jan-23		1	01-Jan-24		
14	SDH/Pharma/ 4. 12	Medication Chemotherapy	1	1	01-Jan-23		1	01-Jan-24		
15	SDH/Pharma/ 4.13	Medication- Implantable Prosthesis	1	1	01-Jan-23		1	01-Jan-24		
16	SDH/Pharma/ 4.14	Central Pharmacy	1	2	01-Jan-23		1	01-Jan-24		
17	SDH/Pharma/ 4.15	Retail Pharmacy	1	1	01-Jan-23		1	01-Jan-24		
18	SDH/Pharma/ 4. 16	QA for Pharmacy	1	1	01-Jan-23		1	01-Jan-24		

19	SDH/Pharma	Pharmacy Department	1	1	01-Jan-23		1	01-Jan-24		

		Original Date	Effective Date	Next date of revision	Issue NO		
		01 November 2021	**01 JANUARY 2024**	**01 JANUARY 2025**	1		

Reviewed & Prepared By		Recommended By	Approved By
Mr. Deepak Kale	Mrs. Shraddha Suryavanshi	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Pharmacy HOD	Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director
			

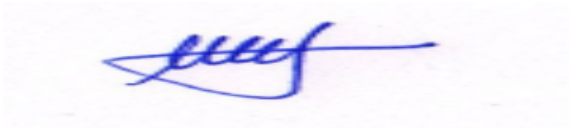
SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

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/Pharma/01	Contents	1	1	05-Mar-21	No Any Change Review Completed	1	20-Nov-22	No Any Change Review Completed	No Any Amendment History
2	SDH/Pharma/02	Organization chart	1	1	01-Nov-21		1	20-Nov-22		
3	SDH/Pharma/03	Roles and Responsibilities	1	1	01-Nov-21		1	20-Nov-22		
4	SDH/Pharma/4.1	Medication Mgmt Policy-General	1	1	01-Nov-21		1	20-Nov-22		
5	SDH/Pharma/4.2	Medication storage	1	1	01-Nov-21		1	20-Nov-22		
6	SDH/Pharma/4.3	Medication - Prescription and Ordering	1	1	01-Nov-21		1	20-Nov-22		
7	SDH/Pharma/4.5	High risk Medication Policy	1	1	01-Nov-21	No Any Change Review Completed	1	20-Nov-22	No Any Change Review Completed	No Any Amendment History
8	SDH/Pharma/4.6	Medication Dispensing issue	1	1	01-Nov-21		1	20-Nov-22		
9	SDH/Pharma/4.7	Medication- Patients Own Medicine	1	1	01-Nov-21		1	20-Nov-22		
10	SDH/Pharma/4.8	Medication Administration	1	1	01-Nov-21		1	20-Nov-22		
11	SDH/Pharma/4.9	Medication- Adverse drug Reaction	1	1	01-Nov-21		1	20-Nov-22		
12	SDH/Pharma/4.10	Medication Error	1	1	01-Nov-21		1	20-Nov-22		
13	SDH/Pharma/4.11	Medication- Narcotics	1	1	01-Nov-21		1	20-Nov-22		
14	SDH/Pharma/ 4.	Medication Chemotherapy	1	1	01-Nov-21		1	20-Nov-22		

	12									
15	SDH/Pharma/ 4.13	Medication- Implantable Prosthesis	1	1			1	20-Nov-22		
16	SDH/Pharma/ 4.14	Central Pharmacy	1	2	01-Nov-21		1	20-Nov-22		
17	SDH/Pharma/ 4.15	Retail Pharmacy	1	1	01-Nov-21		1	20-Nov-22		
18	SDH/Pharma/ 4. 16	QA for Pharmacy	1	1	01-Nov-21		1	20-Nov-22		
19	SDH/Pharma	Pharmacy Department	1	1	01-Nov-21		1	20-Nov-22		

		Original Date	Effective Date	Next date of revision	Issue NO		
		01 November 2021	**20 November 2022**	**20 November 2023**	1		

Reviewed & Prepared By		Recommended By	Approved By
Mr.Deepak Kale	Mrs.Shraddha Suryavanshi	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Pharmacy HOD	Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director
			

	SAIDEEP HOSPITAL PHARMACY & MEDICATION MANAGEMENT MANUAL	Doc No	SDH/MOM/01
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Page	1
	Amendment Sheet		

Sr. No	Page No	Clause No	Date of Amendment	Amendment Made	Reasons	Signature of Approval Authority

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S. S. Deepak	
Quality Head		Chairman & Managing Director	

	SAIDEEP HOSPITAL PHARMACY & MEDICATION MANAGEMENT MANUAL	Doc No	SDH/MOM/02
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	Organisational Chart – Pharmacy Services		

Pharmacy Dept.

I/C Pharmacy Services

Central Pharmacy I/C

- Central Pharmacist
  - Computer Operator
    - Helper
- Retail Pharmacist
  - Computer Operator
    - Helper Pharmacist

Retail Pharmacy

- Pharmacist (Ground Floor)
- Pharmacist (2nd Floor)
- Pharmacist (3rd Floor)
- Pharmacist (5th Floor)
- Pharmacist (9th Floor)

Operations, Quality & HR

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Quality Head		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

SUMMARY	This document provides instruction and guidance to hospital staff on the medication storage in pharmacy and wards and other areas within the hospital 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 Use Manual

INTRODUCTION

An effective system of medication storage promotes patient safety. This is achieved through effective storage which ensures the quality and potency of medication. Effective storage also prevents the misuse of medication through defining effective security and access control measures to medications stored at the ward / unit level.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in the matter of storage of medication in their respective wards / units.

RESPONSIBILITIES

Chairman & Managing Director

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

Chief Pharmacist

The Chief Pharmacist is responsible for ensuring the proper storage of medications at the pharmacies.

Nursing Superintendents and Ward Nurse In-Charges

They are responsible to ensure that the storage guidelines are followed at the unit level and periodically inspecting all medication storage (cupboards, crash carts etc.) to ensure compliance.

POLICIES

Pharmacy Storage

The conditions and guidelines for medication storage in the various pharmacies are discussed in detail in the Pharmacy Services Manual. However the main points are discussed here too:

All drugs are arranged based on the alphabetical index of their brand names. Separate sections are allotted for different formulations like tablets/capsules, injections, suspensions and emulsions, ointments, pastes, jellies and creams, powders, suppositories and surgical sutures and ligatures.

Medications are stored in the racks of pharmacy based on their storage conditions mentioned in their label. Normal medicines are stored at room temperature.

Medications whose label suggest “store in cold condition” (2-8 degree Celsius) are stored in a refrigerator of which the temperature is maintained thermostatically between 2-8 degree Celsius.

Medications whose labels suggest “store in a cool place” (8-25 degree Celsius) are stored in pharmacy at the desired statutory temperature.

Vaccines where applicable shall be stored in Ice-Lined-Refrigerators.

Inventory Control

All narcotic drugs are stored in alocked locker whose key and stock is maintained by the person authorized by the head pharmacist.

All medications are protected from the free access of the public and secured with in various pharmacies. The medications are billed and dispensed based on the issue of valued prescription from a registered medical practitioner practicing in our hospital through counters.

All pharmacies follow a fist in first out methods and separate batches are identified using a color coded labeling system to ensure FIFO

Chief pharmacist is responsible for the inventory control.

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 staffresponsible, the medicines are returned to the dealers 3 months prior to expiry through pharmacy.

Physician Samples

Physician Samples are not allowed to be stored in pharmacies or in any in-patient clinical areas of the pharmacies. Physician samples received by the doctors in their OPD chambers are required to be taken home by them or donated for use by the charity wing of the hospital for free distribution in various medical camps and other such activities

Pest Control in Pharmacy

Medicines are arranged in steelslotted shelves andglass racks in plastic containers little above the flooring. Medicines are stored in dry and well ventilated areas.

Cold Chain Storage Breakdown Policy

1. Temperature reading of the refrigerator is monitored twicedailyfrom the electronic device attached to the unit and noted.
2. If any variations in the temperature exceeds lower or higher limit, it is to inform to the engineering department for necessary action.
3. If the problem exceeds more than 4 hours, the items are shifted to the adjustment refrigerator or alternate spare refrigerator called for from the engineering department.
4. Calibration periods are promptly reviewed and necessary updates are done.

Ward / Unit Storage

All medicines, and other substances issued by the Pharmacy department, shall be stored in the Wards and Departments in appropriate locked cupboards, with the

exception of approved emergency crash trolleys for use in emergency situations. Approved emergency crash trolleys shall be clearly marked and be tamper-evident.

There should be separate storage for:

- Narcotics (only as per list of approved locations)
- Normal Medications (as per requirements of storage temperature including air conditioning)
- Medicines requiring Refrigeration

Patients' own medications will be stored at bedside trolley.

Each ward / department will maintain and display a list of medications to be stored in refrigerated storage. The guidelines for storage and handling ofmedications that need to be stored in a refrigerator are provided in pharmacy service manual.

Security

1. The custody of all drugs held in wards and pharmacy is the overall responsibility of the nurse in charge of that ward and the pharmacist.

2. The nurse in charge of a ward is responsible for controlling access to medicine cupboards, medicine refrigerators and emergency crash carts.

3. The keys of the medicines cupboard(s), crash cart(s) and drug refrigerator(s) are the responsibility of the nurse in charge of the ward and shall be held and passed on to shift in-charges assigned by the nurse in charge.

4. In any department / unit where staff does not include a nurse, the responsibility for the safe handling and storage of drugs shall be with the Unit In-Charge.

5. Medicines stored in wards and departments are for use in the treatment of patients in that ward or department and must not be given to patients to take away or be used by staff.

Control and Checking

1. It is the responsibility of nurse in charge to monitor the stock of medicines held in cupboards, refrigerators and emergency crash carts.

2. Medication Bottles / Containers / Packs with illegible or damaged labels must be returned to the Central Pharmacy for re-labeling or disposal.

3. Containers designated for multiple use (e.g. bottles of syrups / expectorants) etc. shall be labeled with date of opening. The same principle is applied for multi- use vials for injections (e.g. XYLOCAINE injections on dressing trolleys)

4. Pharmacy staff shall be given access to all medicinestorage facilities and shall audit these once a month. A record of audit will be kept (both in the ward / department and in the pharmacy) with a note of any actions to be taken.

5. If a discrepancy in medicine stock is found, the procedure in an Incident Report must be initiated by the nurse in-charge aswell as an “incident form” being completed and forwarded to the Quality Management Office.

Emergency Crash Carts, Emergency Trays

1. A range of medicines is kept in Emergency / Crash Carts at each ward / identified units department for handling emergency situations / cardiac arrests / resuscitations.

2. The emergency crash cartis provided on all floors,provided in all ICUs and other locationsand will be maintained as per the checklist approved.

3. Emergency crash carts in the ICUs will be checked in the beginning of each nursing shift by the shift in-charge and initialed with time of checking in the check list which is hung on the side of each cart. In cases of units / departments where a nurse is not posted the technician in-charge will perform this check.

4. Emergency crash cart in the wards / non-ICU areas will be checked in the beginning of every month and sealed. They are replenished, checked and sealed after every use .

5. A list of locations / departments maintaining emergency crash carts will be available with Nursing Superintendent.

Sound Alike and Look Alike Drugs

1. As far as the look-alike &sound-alike drugs are concerned it is reported by the pharmacist whenever a new drug is added to the formulary to the chief pharmacist
2. The list is approved by the chief pharmacist, the display list is updated as and when the drug is included in the pharmacy formulary; it is displayed in all the pharmacies.

3. All units will maintain a list of Sound Alike and Look Alike Drugs which is maintained in their respective wards.

4. Look Alike and Sound Alike drugs are color separately color coded for their easy identification at all points of storage in the hospital

5. Such drugs are stored with clear separation from each other to avoid potential mix ups.

PROCEDURE (S)

The Pharmacy procedure addresses the following issues pertaining to this policy; environmental conditions of storage, inventory control practices, prevention of loss and theft etc.

MONITORING

The Chief Pharmacist will conduct periodic inspections / audits of the ward stocks. The audit process will cover both the stock positions and adherence to storage guidelines. Reports of these audits will be forwarded to the MD.

REFERENCES

Standards

MOM 3 – a,b,,e,f,g

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 –

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.

NABH Standard: MOM 4

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 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:

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 a Consultant 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, and whose order and the 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 f

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 / Ahigh Alert Medications carry a heightened risk for adverse ou

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 CMDof 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 areinstructed 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 administeringthese drugs the following has to be done;

1. A second check by a second person will be required for all 'HighRisk' 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- 3 c

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

Safe Identification, Segregation and Labelling of LASA Medicines in Pharmacy

1. PURPOSE

The purpose of this policy is to establish a standardised, NABH-compliant framework for the safe identification, labelling, physical segregation, and storage of Look-Alike Sound-Alike (LASA) drugs within all pharmacy and drug-storage areas of this hospital. The specific objectives are:

- To define what constitutes a LASA drug pair within the hospital formulary and to maintain a current, PTC-approved LASA Drug List.
- To mandate physical separation of LASA drug pairs at all storage locations — main pharmacy, satellite pharmacies, and ward drug rooms — eliminating the risk of inadvertent selection errors.
- To specify standardised alerting strategies including Tall-Man lettering, LASA alert stickers, and physical barrier systems.
- To establish clear responsibilities for pharmacists, pharmacy technicians, nurses, and physicians in relation to LASA drug management.
- To ensure that all LASA-related processes are auditable and demonstrably compliant with NABH 6th Edition standard MOM.3.e.
- To reduce adverse drug events, medication errors, and near misses arising from confusion between LASA drug pairs.

2. SCOPE

This policy applies to all clinical and pharmacy staff who handle, store, or dispense medications. It covers the following storage locations:

Storage Location / Area	Applicability
Main Pharmacy (In-Patient and Out-Patient sections)	Full application — all LASA storage, labelling, and dispensing requirements apply
Satellite / Floor Pharmacies	Full application — LASA stocks must mirror main pharmacy segregation standards
Emergency / Crash Carts	Applicable — LASA drugs in crash carts must be clearly differentiated and individually labelled
Refrigerators (insulin, biologics, vaccines, oxytocin)	Applicable — LASA refrigerated items must occupy separate shelves with clear dividers and labels
Controlled / Schedule H1 / Narcotic Drug Storage	Applicable — LASA scheduled drugs stored in separate locked compartments with dual-check at dispensing

3. DEFINITIONS

Term	Definition
Look-Alike Drug	Two or more drugs whose names, packaging, labels, or physical appearance are sufficiently similar that they may be confused with each other during storage, retrieval, or administration.
Sound-Alike Drug	Two or more drugs whose names, when spoken aloud or written in shorthand, are phonetically similar and may cause confusion (e.g., Dopamine / Dobutamine; Metformin / Metronidazole).
LASA Drug Pair	A pair or group of drugs identified as both look-alike and/or sound-alike. All such pairs on the hospital formulary must appear on the LASA Drug List.
Tall-Man Lettering (TML)	A risk-reduction technique that capitalises the distinctive portion of a drug name to highlight differences between LASA drugs — e.g., DOPamine vs DOBUTamine.
Physical Segregation	Storing LASA drug pairs in clearly separate locations — on different shelves, in different bins, or with a physical divider — so they cannot be accidentally co-selected.
LASA Alert Label	A visually distinctive label affixed to the drug shelf, bin, or container warning staff that a LASA drug is present and caution is required.
LASA Drug List	The hospital-specific, PTC-approved list of all LASA drug pairs on the formulary, reviewed and updated at least annually.
High-Alert Medication	Medications that bear heightened risk of causing significant patient harm when used in error. Many LASA drugs are also high-alert medications.

4. NABH STANDARD REFERENCE — MOM.3.e

NABH STANDARD: *MOM.3.e (NABH 6th Edition — Commitment): "Look-alike sound-alike drugs are stored separately." Interpretation: The organisation shall identify look-alike sound-alike drugs from its formulary and ensure that these are stored separately. The organisation may use strategies like Tall-Man lettering and physical separation to alert the user about look-alike sound-alike drugs.*

The following NABH MOM elements provide broader context for this policy:

NABH Element	Requirement	Relationship to This Policy
MOM.3.e	LASA drugs stored separately	Primary standard — directly addressed by this entire

NABH Element	Requirement	Relationship to This Policy
	(Commitment)	policy
MOM.3.a	Medications are stored safely and securely	LASA storage is a core sub-component of safe storage
MOM.3.b	High-alert medications stored separately with precautions (Core)	Many LASA drugs are also HAMs; dual compliance required
MOM.3.c	Expired or damaged medications are removed	LASA stock checks conducted during routine expiry checks
MOM.7	Medications are administered safely	LASA labelling at ward level directly supports safe administration
MOM.8.c	Near misses and medication errors captured (Core)	LASA-related errors to be reported via incident reporting system
MOM.8.d	Errors reported within a specified timeframe (Commitment)	Reporting timelines apply to LASA-related incidents

5. POLICY STATEMENT

- **5.1 LASA Drug List:** This hospital shall maintain an up-to-date, PTC-approved LASA Drug List for all drugs on the hospital formulary. This list shall be reviewed at minimum annually and whenever a new drug is added to or removed from the formulary.

- **5.2 Physical Separation:** All LASA drug pairs shall be stored with a minimum physical separation of at least one complete bin or shelf slot between them — or in entirely separate shelving bays — at every pharmacy and drug storage location in the hospital. Alphabetical proximity shall not override this requirement.

- **5.3 LASA Alert Labelling:** Every LASA drug storage location shall be prominently marked with a standardised LASA Alert Label. The label shall be affixed to the shelf edge, storage bin, and outer drug packaging where feasible.

- **5.4 Tall-Man Lettering:** Tall-Man lettering shall be applied on shelf-edge labels, bin labels, and within the pharmacy dispensing software for all identified LASA pairs where this technique meaningfully differentiates the drug names.

- **5.5 LASA + High-Alert Medications:** LASA drugs that are also High-Alert Medications shall comply with both this policy and the hospital's High-Alert Medication policy (MOM.3.b). No LASA high-alert medication shall be stored in a general open-access area.

- **5.6 Verbal Communication:** When communicating a LASA drug name verbally (telephone order, handover), staff shall use the full generic name plus strength and route. Verbal orders for LASA drugs require read-back confirmation before action.

- **5.7 Staff Training:** All pharmacists, pharmacy technicians, and nursing staff shall receive training on LASA drug identification, this policy's requirements, and the current LASA Drug List upon joining and annually thereafter.

- **5.8 Incident Reporting:** Any near miss, dispensing error, or administration error involving a LASA drug shall be reported through the hospital's Incident Reporting System within the defined timeframes per MOM.8.d.

6. PROCEDURE

6.1 Identification and Maintenance of the LASA Drug List

1. The In-charge Pharmacist shall compile the hospital's LASA Drug List based on the current formulary, cross-referencing ISMP's published LASA lists, CDSCO safety alerts, and pharmacist professional judgement.
2. The list shall be reviewed and approved by the Pharmacy and Therapeutics Committee (PTC) at minimum once a year, or immediately upon any formulary change that introduces or removes a LASA drug.
3. New LASA pairs identified through incident reports or near-miss events shall be added to the list between annual reviews following formal PTC approval.
4. The approved LASA Drug List shall be displayed prominently in the main pharmacy, all satellite pharmacies, and ward drug rooms, and stored in the hospital's Quality Management System (QMS).
5. Each entry shall record: generic name, brand name(s), strength/concentration, its LASA pair, LASA type (look-alike / sound-alike / both), and the applicable storage and labelling safeguards.

6.2 Physical Storage Segregation

The following physical separation standards shall be implemented at all storage locations:

Storage Location	Segregation Requirement	Minimum Standard
Main Pharmacy Shelves	LASA pair drugs shall NEVER be placed on adjacent shelves or in adjoining bins	Minimum 1 empty bin/slot gap OR placement in a separate bay
Satellite / Floor Pharmacies	Same principle as main pharmacy; pharmacist-in-charge is responsible for verifying layout	Separate labelled shelf section for each LASA drug
Refrigerators	LASA refrigerated items on separate, clearly labelled shelves	Shelf-edge label in Tall-Man lettering; do not stack side-by-side
Emergency / Crash Carts	LASA drugs in separate, labelled pockets or trays; avoid adjacent placement	Bold drug-name label on each pocket; checked at every crash-cart audit
Controlled / Schedule H1 Drug Storage	LASA scheduled drugs in separate locked compartments with additional warning label	Two-person check required at dispensing

IMPORTANT: *Drugs shall NOT be stored in alphabetical proximity if doing so places a LASA pair adjacent to each other. Therapeutic-class or risk-based shelving arrangements are preferred for LASA-prone drug categories (e.g., sympathomimetics, insulins, anticoagulants).*

6.3 LASA Labelling and Visual Alerting System

The following labelling elements shall be standardised across all pharmacy and drug storage locations:

Alert Element	Description	Where Applied
LASA Alert Sticker	Bold text reading 'LASA DRUG — CHECK CAREFULLY'. Black text on white or yellow sticker in hospital-standard format.	Shelf edge, drug bin, and outer drug packaging where feasible
Tall-Man Lettering Label	Shelf-edge and bin labels display the drug name using approved Tall-Man lettering to highlight name differences.	Main pharmacy, satellite pharmacies, ward cupboards
Concentration Warning Label	For drugs differing only in concentration (e.g., Heparin 5,000 vs 25,000 IU/mL), a bold concentration sticker is applied in addition to the LASA sticker.	Ampoule / vial label and shelf edge
Route-of-Administration Alert	For drugs available in multiple routes (e.g., oral vs injectable Methotrexate), a bold route label is applied: 'FOR ORAL USE ONLY' or 'INJECTABLE ONLY'.	Outer box and individual unit label
Verbal Caution Protocol	Full generic name + strength + route must be stated. Telephone orders for LASA drugs require read-back confirmation.	All verbal and telephone communications involving LASA drugs

6.4 Approved Tall-Man Lettering List

The hospital adopts the ISMP-recommended Tall-Man lettering convention. The following approved pairs shall be used on all labels, shelf edges, and computer systems:

Drug Name (Standard)	Tall-Man Lettering	LASA Pair
Dopamine	DOPamine	DOBUTamine
Dobutamine	DOBUTamine	DOPamine
Hydralazine	hydrALAZINE	hydrOXYzine
Hydroxyzine	hydrOXYzine	hydrALAZINE
Metformin	metFORMIN	metroNIDAZOLE
Metronidazole	metroNIDAZOLE	metFORMIN
Carbamazepine	carBAMazepine	carBImazole
Carbimazole	carBImazole	carBAMazepine
Vincristine	vinCRIStine	vinBLAStine
Vinblastine	vinBLAStine	vinCRIStine
Cyclophosphamide	cycloSPHOSPHAmide	cycloSPORINE
Cyclosporine	cycloSPORINE	cycloSPHOSPHAmide

Drug Name (Standard)	Tall-Man Lettering	LASA Pair
Tramadol	traMAdol	traZODone
Trazodone	traZODone	traMAdol
Azathioprine	azaTHIOprine	azithroMYCIN
Azithromycin	azithroMYCIN	azaTHIOprine

NOTE: *The above list is not exhaustive. The full Tall-Man lettering list is maintained in the current LASA Drug List (Appendix A). New pairs are added following PTC approval.*

6.5 Dispensing Verification Procedure for LASA Drugs

6. The dispensing pharmacist shall verify the drug name, strength, concentration, and route against the prescription before retrieving the drug from the shelf.
7. For all LASA drugs, a second independent verification by another pharmacist or trained pharmacy technician is required before the drug is dispensed to the ward or patient. This second check shall be documented.
8. For LASA drugs that are also high-alert medications (e.g., concentrated electrolytes, insulin, anticoagulants), the double-check is mandatory regardless of workload or staffing level.
9. The dispensing staff member shall verbally state the full drug name, strength, and route aloud (self-check) as the drug is retrieved from storage.
10. Dispensing labels shall include the Tall-Man lettered drug name where applicable.
11. The pharmacist shall counsel the ward nurse at the point of dispensing for high-risk LASA drugs, confirming the drug, dose, and any special monitoring requirements.

6.6 Ward-Level Handling of LASA Drugs

12. Nursing staff receiving LASA drugs from pharmacy shall verify the drug name, strength, and route against the medication order at the point of receipt.
13. LASA drugs shall be stored in designated, labelled compartments in the ward drug trolley or cupboard, separate from their LASA counterparts.
14. When preparing LASA drug doses at the ward level, the nurse shall perform an independent double-check with a second nurse or the doctor-in-charge before administration.
15. LASA drugs shall never be removed from their labelled compartments and placed loose on trolleys or worktops without immediate administration.
16. Partially used LASA drug vials/ampoules shall be clearly re-labelled with drug name, concentration, and date opened before being returned to storage.

6.7 LASA Drug Management in Specific High-Risk Areas

- **ICU / Critical Care:** All high-alert LASA drugs (vasopressors, concentrated electrolytes, opioids, insulin) shall be stored in a dedicated locked compartment or smart-pump drug library. Infusion bags and syringes must be clearly labelled with drug name, concentration, rate, and date prepared. Ready-to-use infusions of LASA drugs shall not be prepared in advance beyond the shift requirement.

- **Emergency Department:** Emergency drug trays and crash-cart trays shall be audited at every shift to ensure LASA drugs are in their correct, designated positions. Adrenaline and Noradrenaline ampoules shall be stored in separate pockets with a bold name label on each. Oxytocin and Vasopressin shall never be in the same tray compartment.

- **Operation Theatre (OT) / Anaesthesia:** The anaesthesia drug tray shall organise LASA drugs in a standardised layout agreed by the anaesthesia department. Suxamethonium and Atracurium (neuromuscular blockers) shall be stored separately from each other and from other injectables. All drawn-up syringes shall be labelled immediately with drug name, concentration, and time of preparation. Unlabelled syringes shall never be left on the anaesthesia trolley.

- **NICU / Paediatrics:** All NICU medications shall undergo a weight-based dose double-check. Concentration-based LASA pairs (e.g., varying morphine concentrations) shall be stored in separate labelled compartments. Dilution charts shall be posted at the preparation area. A second nurse must independently verify all neonatal LASA drug preparations before administration.

- **Oncology / Chemotherapy:** Vincristine and Vinblastine (and any other cytotoxic LASA pairs) shall be stored in separately labelled compartments within the bio safety cabinet. Dispensing requires dual pharmacist sign-off. Chemotherapy drug labels shall include the regimen name, cycle number, day, and patient-specific dose.

- **Dialysis Unit:** Heparin concentrations (5,000 IU/mL vs 25,000 IU/mL) shall be stored in separate clearly labelled compartments. The required dilution shall be prepared only after confirming the correct concentration. A bold concentration sticker shall be affixed to each heparin vial on storage and at the point of use

7. ROLES AND RESPONSIBILITIES

Designation	Key Responsibilities under MOM.3.e
In-charge Pharmacist	Compile and maintain the LASA Drug List; enforce storage segregation standards in main and satellite pharmacies; lead annual LASA audit; report LASA-related incidents to Quality Team.
Dispensing Pharmacist	Perform double-check verification at dispensing for all LASA drugs; apply Tall-Man lettering labels; counsel ward nurses on LASA drug risks; document dispensing verification.
Pharmacy Technician	Ensure physical segregation is maintained during stock replenishment; affix LASA alert stickers on storage bins; report any observed LASA storage non-compliance to the In-charge Pharmacist.
Nursing Staff (Ward/ICU/OT)	Verify LASA drugs at receipt from pharmacy; perform bedside double-check before administration; store LASA drugs in designated compartments in ward drug trolleys; report near misses via IRF.
Head of Nursing	Ensure all nursing staff is trained on LASA policy requirements; conduct periodic ward-level LASA storage audits; escalate non-compliance to Quality Department.
Treating Physician / RMO	Use full generic drug name + strength + route in all prescriptions and verbal orders; avoid abbreviations for LASA drugs; respond promptly to pharmacist LASA-related queries.
Pharmacy & Therapeutics Committee (PTC)	Review and approve the LASA Drug List annually; approve additions or removals; review LASA incident trends; recommend formulary changes to reduce LASA risk.
Quality Manager	Monitor LASA compliance through audits; collate and analyse LASA-related incident data; report LASA quality indicators to the Quality Council; track CAPA completion.

Designation	Key Responsibilities under MOM.3.e
Medical Superintendent / CMO	Overall policy owner; ensure adequate pharmacy staffing for double-check compliance; review serious LASA incidents; approve major CAPA arising from LASA events.

9. STAFF TRAINING AND COMPETENCY

- All pharmacists and pharmacy technicians shall complete orientation training on this policy and the LASA Drug List within 14 days of joining the pharmacy department.
- All nursing staff shall complete orientation training on LASA drug handling, ward-level storage requirements, and the double-check procedure within 30 days of joining.
- Annual refresher training shall be mandatory for all pharmacy and nursing staff. Training content shall include updates to the LASA Drug List, any new LASA incidents from the previous year, and reinforcement of Tall-Man lettering and alert sticker standards.
- Competency assessment shall be conducted annually for pharmacists and nurses covering: LASA drug identification, correct storage segregation, labelling application, and the double-check dispensing procedure.
- Training records shall be maintained by the HR / Training Department and produced during NABH assessment.

10. AUDIT AND MONITORING

Audit / Indicator	Frequency	Responsible	Target
Physical LASA storage segregation compliance audit (main and satellite pharmacy)	Monthly	In-charge Pharmacist	100% compliance
Ward drug trolley / cupboard LASA storage audit	Monthly (sample of 5 wards)	Quality Team + Head of Nursing	100% compliance
LASA alert sticker and Tall-Man label presence audit	Monthly	In-charge Pharmacist	100% all LASA bins labelled
Double-check documentation compliance for LASA drugs	Monthly (random dispensing record sample)	Quality Team	>95% documented
% LASA-related incidents reported within timeframe	Monthly	Quality Manager	100%
LASA Drug List reviewed and PTC-	Annually (or after	In-charge Pharmacist +	Done within 30 days

Audit / Indicator	Frequency	Responsible	Target
approved	each formulary change)	PTC	of formulary change
Staff training completion — LASA orientation (new joiners)	Within 30 days of joining	HR / Training + Dept. Head	100%
Annual LASA competency assessment completion	Annually	HR / Training	100% of pharmacy and nursing staff
Crash-cart LASA drug positioning verification	Each crash-cart audit	In-charge Nurse + Pharmacist	100%

Audit findings shall be compiled quarterly by the Quality Department and presented to the PTC and Quality Council. Non-compliances shall trigger immediate corrective action with a defined timeline for resolution.

11. INCIDENT REPORTING FOR LASA-RELATED EVENTS

All LASA-related medication errors, near misses, and adverse drug events shall be reported in accordance with MOM.8.c and MOM.8.d:

Event Type	Reporting Timeline	Reported To
LASA error resulting in patient harm (moderate / severe)	Within 1 hour	Treating Doctor + Department Head + Medical Superintendent + Quality Manager
LASA error reaching patient — no harm	Within 24 hours	In-charge Pharmacist + Quality Department
LASA near miss (intercepted before reaching patient)	Within 48 hours	Quality Department via Incident Reporting Form / EIRS
LASA storage non-compliance identified during audit	Within 24 hours	In-charge Pharmacist + Quality Manager for immediate CAPA

Corrective and preventive actions (CAPAs) arising from LASA incidents shall be tracked through the Quality Department and reviewed at the monthly PTC meeting.

12. REFERENCES

17. National Accreditation Board for Hospitals & Healthcare Providers (NABH). Standards for Hospitals, 6th Edition. New Delhi: Quality Council of India; 2023. [MOM.3.e]
18. NABH Programme on Implementation — 6th Edition Course Notes (September 2025).
19. Institute for Safe Medication Practices (ISMP). ISMP's List of Confused Drug Names. Horsham, PA: ISMP; current edition.
20. Institute for Safe Medication Practices (ISMP). Tall Man Lettering List. Horsham, PA: ISMP; current edition.
21. Central Drugs Standard Control Organisation (CDSCO). Drug Safety Alerts and Communications. New Delhi: Ministry of Health & Family Welfare, Government of India.
22. World Health Organization (WHO). Medication Without Harm — WHO Global Patient Safety Challenge. Geneva: WHO; 2017.
23. Maharashtra Medical Council — Clinical Establishment Act and applicable state regulations on pharmacy practice and hospital records.

AMENDMENT HISTORY

SR 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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 toall 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 superintendentis responsible for monitoring of the process.

REFERENCES : NABH standards : MOM 6

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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

Patients' own medication is a key issue that can lead to medication errors. Most patients especially senior citizens are likely to be under regular medications for chronic conditions like diabetes, blood pressure related conditions, cardiac problems etc.

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

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

SUMMARY	This document provides instruction and guidance to Hospital staff on handling the adverse drug reaction 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 Services Manual

PURPOSE

To readily identify patients with known food, drug and environmental allergies/adverse drug reactions and to provide for documentation of such on the Patient Assessment, in order to prevent the possibility of reactions.

DEFINITIONS

1. Allergy - a disease or reaction caused by an immune response to a drug, resulting in tissue inflammation and/or organ dysfunction usually, but not always, characterized by angioedema, rash or anaphylaxis.
2. Adverse Drug Reaction (ADR) - any response to a drug which is noxious and unintended and which occurs at doses normally used in humans for prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.

POLICY

1. A history of any allergies/ADRs shall be obtained during the admission nursing assessment before any medications are administered, except in emergencies. This history is documented in the space provided on the Patient History/Assessment and Discharge Record.

2. Suspected Adverse Drug Reactions shall be identified and reported on the **Patient Incident Form**, which is available at all Nursing Units. The filled up forms should reach the Quality Manager on the same day for analysis. The physician must also document the ADR in the Progress Notes of the patient's medical record.
3. The Drugs & Therapeutic Committee will be responsible for monitoring of reported adverse reactions. All severity level 5 and 6 reports shall be forwarded to the QPS office for Root Cause Analysis.

Allergic Idiosyncratic Irritant Pharmacologic Severity Scale

Level 1 – ADR occurred but required no change in treatment with suspected drug
Level 2 – Drug held, discontinued or changed but no antidote or additional treatment needed.
Level 3 – Drug held, discontinued or changed AND/OR antidote or other treatment required.
Level 4 – ADR required patient transfer to an intensive care setting
Level 5 – ADR caused permanent harm to the patient
Level 6 – ADR either directly or indirectly led to the patient's death

The reaction will be reported to the manufacturer or the Drug Controller of India if:

1. The ADR is classified probable or definite and is a severe reaction.
2. The ADR is probable or definite and is not listed in the manufacturer's package insert.
3. The ADR involved is a new drug (released in the last three years) and exhibits a temporal relationship to the administration of the new drug.

Root Cause Analysis is done where applicable and records of same maintained.

The DTC ensures appropriate Corrective and Preventive Actions are taken based on the analysis and records of same are maintained.

MONITORING

The Pharmacy & Therapeutic Committee will be responsible for monitoring all ADR / ADE and conduct analysis. The Severity V and VI reactions are monitored by CMA / CMD directly on an immediate basis.

REFERENCES

STANDARDS

MOM 8

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 labelling, 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

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

1. PURPOSE

To establish a standardised procedure for the identification, segregation, monitoring, and controlled use or return of near-expiry medications and consumables across all storage areas of Saideep Pharmacy, in order to minimise financial loss, prevent inadvertent dispensing of near-expiry or expired products, and ensure patient safety — in accordance with NABH 6th Edition Standard MOM 6C.

2. SCOPE

This policy applies to all areas within Saideep Pharmacy where medications and consumables are stored or dispensed, including:

- Main pharmacy dispensing area and stock room
- All satellite / sub-store locations
- Nursing units, ICUs, OTs, and Emergency drug trolleys supplied by the pharmacy
- All consumables procured and stocked alongside medications

3. DEFINITIONS

Term	Definition
Expiry Date	The date printed on the container, label, or wrapper up to which the product is expected to retain potency of not less than labelled amount, as defined under the Drugs & Cosmetics Act, 1940. Where only month and year are stated, the product is valid until the last day of that month.
Near-Expiry Medication / Consumable	Any medication or consumable with ≤ 2 months remaining before its printed expiry date. Such items are subject to mandatory withdrawal and action under this policy at Saideep Pharmacy.
Expired Medication	Any medication or consumable that has crossed its printed expiry date. Expired items must NOT be dispensed or used and must be immediately segregated and disposed of as per the Biomedical Waste Management Policy.
FEFO	First Expiry First Out — inventory rotation principle ensuring items with earlier expiry dates are dispensed or used before those with later expiry dates.
DTC / PTC	Drug / Pharmacy & Therapeutics Committee — the body responsible for policy oversight, trend review, and corrective action related to medication management.

4. POLICY STATEMENT

Saideep Pharmacy withdraws all medications and consumables **2 months before their expiry date.** All such items shall be identified, labelled, segregated, and subjected to the actions described in this policy. No near-expiry or expired medication shall be dispensed without explicit documented authorisation under exceptional circumstances (Section 6.6). No expired item shall ever be dispensed or administered to patients.

5. RESPONSIBILITIES

Role	Responsibility
Chief Pharmacist / Pharmacist In-charge	Overall oversight of near-expiry monitoring; authorise returns; escalate to PTC; maintain records.
Dispensing Pharmacist / Pharmacy Technician	Conduct monthly expiry checks; identify, label, and segregate near-expiry items; initiate withdrawal and action.
Nursing In-charge (Wards / ICU / OT)	Conduct monthly checks of drug trolleys and sub-stores; return near-expiry items to pharmacy; maintain ward-level expiry register.
Procurement / Store In-charge	Ensure expiry dates are checked at time of receipt; process supplier return or replacement for near-expiry stock; maintain stock register entries.
PTC / DTC	Quarterly review of near-expiry and expired drug data; recommend corrective procurement or formulary actions; oversee disposal approvals.
Bio-Medical Waste In-charge	Receive expired drugs for disposal; maintain disposal register; ensure compliance with BMW Management Rules.

6. PROCEDURE

6.1 Receipt of Medications and Consumables

- At the time of receipt, the Pharmacist / Store In-charge shall verify the expiry date of every batch against the purchase order.
- Expiry dates for all received items shall be recorded in the stock register / Hospital Information System (HIS).
- FEFO (First Expiry First Out) rotation shall be applied at the time of stocking shelves.

6.2 Routine Expiry Monitoring

- Monthly physical expiry checks shall be conducted by the responsible Pharmacist in the main pharmacy and all satellite stores.
- Monthly checks of ward / ICU / OT drug trolleys and emergency medications shall be conducted by the Nursing In-charge with support from the pharmacist.
- Items expiring within the next 3 months shall be flagged during monthly checks for heightened surveillance.
- Items reaching the 2-month threshold (near-expiry as per Saideep Pharmacy policy) shall be immediately auctioned as described in Section 6.3.

6.3 Identification and Labelling

- Near-expiry items (≤ 2 months to expiry) shall be stored in a box, clearly marked label —stating, "NEAR EXPIRY – Use/Return by [Date]".
- Expired items shall be stored in a box with a label stating "EXPIRED – NOT FOR USE" immediately upon identification.
- Near-expiry / expired items shall not be mixed with standard stock at any point after identification.

6.4 Segregation

- All near-expiry items identified in wards, ICUs, OTs, or satellite stores shall be returned to the main pharmacy/store promptly with proper documentation (near-expiry return note).
- Near-expiry items at the store shall be placed on a clearly designated separate shelf labelled "NEAR EXPIRY — ACTION PENDING".
- Expired drugs shall be stored in a separate, locked cupboard or room labelled "EXPIRED DRUGS – NOT FOR USE", under the supervision of the Officer-in-charge / Pharmacist In-charge.

6.5 Action on Near-Expiry Items

Upon segregation of near-expiry medications or consumables, the Pharmacist In-charge shall explore the following options in order of preference:

Priority	Action	Details
1	**Supplier / Manufacturer Return**	Initiate return to manufacturer or supplier for credit or replacement with fresh stock. The Procurement/Store In-charge shall process the return documentation and update the stock register.
2	**Redistribution within Facility**	Transfer to high-consumption departments (intra- or inter-departmental) where the item is likely to be consumed within its remaining shelf life. This transfer shall be documented.
3	**Priority Dispensing**	Near-expiry items shall be dispensed ahead of non-expiry stock (FEFO). Dispensing staff shall be alerted to prioritise these items.
4	**Disposal**	If the item cannot be consumed or returned before expiry, it shall be disposed of as per Section 6.6 once expired.

6.6 Exceptional Use of Near-Expiry Medication

In exceptional circumstances only — where an item is urgently required, no unexpired replacement is available in pharmacy or store, and no alternative drug is clinically feasible — the Nursing In-charge may use a near-expiry item until its last day of expiry. This must be:

- Authorised in writing by the Chief Pharmacist and the treating physician.
- Documented in the patient record and the near-expiry register.
- Immediately followed by procurement of replacement stock.

Expired medications shall NEVER be used under any circumstance.

6.7 Disposal of Expired Medications

- All expired medications from wards and departments shall be returned to the drug store with proper documentation before disposal.
- Details to be recorded: generic name, formulation, strength, batch number, expiry date, quantity, department name, date of return.
- The Pharmacist In-charge shall compile the expired drug list and submit to the PTC / DTC for disposal approval.
- After approval, expired drugs shall be sent to the Bio-Medical Waste In-charge for disposal as per BMW Management Rules 2016.
- Cytotoxic/cytostatic drugs and contaminated items shall be segregated in YELLOW non-chlorinated plastic bags/containers and incinerated at >1200°C or returned to manufacturer.
- All other expired pharmaceuticals shall be returned to manufacturer or disposed of by incineration as per Schedule I of BMW Rules.
- Transport of expired drugs shall be in pilferage-proof, sealed, properly and labelled containers with bio-hazard/cytotoxic symbols as applicable.
-

7. DOCUMENTATION AND RECORDS

Record	Maintained By	Frequency
Near-Expiry Tracking Register / HIS Module	Pharmacist In-charge	Monthly / Ongoing
Ward / ICU / OT Expiry Check Register	Nursing In-charge	Monthly
Near-Expiry Return Note (intra-departmental)	Sending Dept. + Pharmacist	Per event
Supplier Return Documentation	Procurement / Store In-charge	Per event
Expired Drug Register (separate)	Pharmacist In-charge / Drug Store	Per event
Drug Disposal Register (BMW Dept.)	BMW In-charge	Per disposal
PTC/DTC Review Minutes	PTC/DTC Secretary	Quarterly

8. MONITORING AND QUALITY INDICATORS

- **Process Efficiency Criterion:**
- The number of near-expiry items identified per month should show a declining trend over time.
- The number of expired drugs disposed of annually should decrease over time, approaching nil.
- Monthly inspection compliance rate (pharmacy and wards) — target 100%.
- Percentage of near-expiry stock successfully returned to supplier or redistributed — tracked quarterly.

The PTC/DTC shall review near-expiry and expiry data at least quarterly and initiate corrective procurement or formulary adjustments where recurring patterns are identified.

Periodic unannounced audits of pharmacy shelves, ward trolleys, and sub-stores shall be conducted by the Quality/Pharmacy team to verify compliance.

9. SAFETY CONTROLS

- No expired medication or consumable shall be dispensed or administered to any patient under any circumstance.
- Near-expiry medications shall only be used after explicit verification and, if in exceptional circumstances, documented authorisation as per Section 6.6.
- Staff shall be trained annually on this policy; training records shall be maintained.
- Any dispensing error involving near-expiry or expired medication shall be reported as a medication error and subjected to root cause analysis.

10. CROSS REFERENCES

- MOM/01 – Medication Management Policy
- Medication Storage Policy
- Procurement and Receiving Policy
- Biomedical Waste Management Policy
- Medication Error Reporting Policy
- Drugs & Cosmetics Act, 1940 and Rules, 1945
- The Pharmacy Act, 1948
- Bio-Medical Waste Management Rules, 2016

AMENDMENT SHEET

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
2	01	01	1 Nov 2020	For compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition for effectiveness of EWS.
5	01	02	1 JAN 2026	No changes.

	SAIDEEP HOSPITAL PHARMACY & MEDICATION MANAGEMENT MANUAL	Doc No	SDH/MOM/3.12
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	Pharmacy Return Policy		

Saideep Medical Store pharmacy has the following policy for return of medicines/ other products sold to the clients on OPD as well as IPD basis.

i. Items are eligible for a return exclusively under the following circumstances.

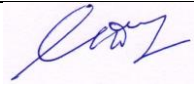
- Product(s) dispensed do not match the prescription.
- Product(s) were delivered in damaged/non-working condition.
- Product(s) have missing parts or accessories or different from their description on the product page.
- Product(s) are returned in original packaging i.e. with labels, barcode, price tags, original serial no. etc.
- Batch number of the product(s) being returned matches with the one(s) mentioned in the invoice.
- Product(s)/medicines(s)/bottle(s) are unused.
- Opened medicine strip(s)/bottle(s) are not eligible for returns.
- The damages/defects are covered under the manufacturer's warranty only.
- Medicines once dispensed are eligible for return within the 6 months from the date of invoice in case the drugs are stopped on doctor's order e.g. allergic reaction, ADR, change in the line of treatment etc.
- (Above all The drug name, strength, batch number and expiry date must be visible.)

ii. Certain categories of products are not eligible for return

Categories	Type of products
Temperature controlled medicines	Vials, Injections, Pen-fills, Vaccines or other products or specialty medicines cold storage
Baby Care	Breast Pumps, Diapers, Ear Syringes, Wipe Warmers, Bottle Nipples
Food and Nutrition	Health supplements and drink
Healthcare device	Glucometer Lancet, Healthcare Devices, Surgical, Health Monitors
Sexual Wellness	Condoms, Fertility Kit, Lubricants, Pregnancy Kit
Personal Care	Oral Care (Toothbrushes, toothpastes, mouthwashes etc); Feminine Hygiene (Sanitary Pads, Panty Liners, Menstrual Cups etc.); Shaving and Hair Removal (Men's Shaving – Razors, Blades, Shaving Foams, Brushes etc.; Men's Beard Care – Beard Oil, Beard Serum etc.; Women's Hair Removal – Wax Strips, Creams, Razors etc
Family Nutrition	Infant Baby Food, Toddlers' and Kids' Health Drink
Vitamin and Mineral Supplements	Core Letter Vitamins, Multi-Vitamin Preparations
Health Care Product	Ayurveda Products, Pain Relief Products, Herbal Supplements, Medical Supplies, Adult Diapers, COVID masks (N95, surgical masks and others if unpacked)
Others	Any wearable (COPD vest, bandages, bandage, knee caps) and any item (solid, gel, aerosol) which may have been partially used

iii. Return Process:

1. To return the eligible items the customers are directed to the exclusive return counter.
2. The customer is required to handover the product in original packaging.
3. Refund will be initiated once Saideep Medical Store receives the product and verifies the same.
4. Refunds are carried out immediately either in cash or by bank transfer depending upon the amount of refund.
5. Refunds cannot be processed to third-party accounts. The name on Saideep Medical Store account should match with the name of the bank account holder. Saideep Medical Store will not be liable for any delay caused in refunds due to delay by third party affiliates (including banks), in providing information by the customer, technical issues and other reasons beyond its control.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

REFERENCES : NABH 6TH Edition MOM 6F

AMENDMENT HISTORY

Si 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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	No changes review completed.
5	01	02	1 Jan 2026	No changes.

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, Morphineand 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

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

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

SUMMARY	This document provides instruction and guidance to Hospital staff on handling the chemotherapy drugs and its protocols. The HOD concerned of the hospital is 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 Management

INTRODUCTION

Chemotherapy drugs is a vital category of high risk medication handled in a hospital and requires specialized arrangements and process to handle them by trained personnel for their own safety and safe administration for patients.

PURPOSE AND SCOPE

The purpose and scope of this policy are to:

1. To ensure that chemotherapy medications are prescribed, prepared and administered safely.
2. To ensure that any appropriate records are maintained.
3. To increase staff knowledge and understanding of chemotherapy medication handling process and as far as possible, develop an institutionalized approach for same

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.

HOD ONCOLOGY

It is the responsibility of the HOD oncology to implement these policies in his/her department.

The personnel permitted to administer a chemotherapy drug to the patient (IP) in our institution are Doctors /House surgeons / Staff nurse

Administration of chemotherapy drug to the patient is based on the doctor's prescription. The drugs are administered by experienced staff nurses under the supervision of the head nurse.

The direction for drug administration in the prescription is strictly followed which includes:

- Preliminary physical check-up. (general condition)
- Whole blood test.
- Vital signs.

Necessary precautions are taken which includes administration of pre-medications, monitoring; followed by administration of the chemotherapeutic drug checking the patient's vital signs.

In case of any adverse drug reactions the administration of drug is stopped and reported to the Doctor.

The patient is monitored for one hour before sending to room/discharge.

Chemotherapy drugs are also **high risk drugs** hence

Verbal orders are not permitted and

Additionally 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 pre-programmed 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:

- 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 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 9

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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

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 counselled on do and donts related with the implant / device including contraindicated medications where applicable. They are also counselled 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

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 ofMaharashtra.

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.

5.4Issues 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

NABH Standards : MOM 1

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL PHARMACY & MEDICATIONMANAGEMENTMANUAL	Doc No	SDH/MOM/3.17
		Issue No	01
		Rev No.	02
		Date	1 JAN 2026
		Pages	6
	Document Title : Retail Pharmacy		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

SUMMARY	This document provides instruction and guidance ensuring quality assurance of pharmacy services through audits and other mechanisms
DISTRIBUTION	To all departments, units and wards through the Hospital Manual

1. PURPOSE:

To describe the processes established for quality assurance in pharmacy services of the hospital.

2. SCOPE:

This procedure is applicable to managing of quality of medication management practices within the hospital including selection and procurement drugs and therapeutics, storage and preservation, dispensing, administration and monitoring of medication effectiveness.

3. DEFINITIONS

Nil

4. RESPONSIBILITY

The Drugs and Therapeutics Committee is responsible for overall monitoring and implementation of the quality assurance system established for pharmacy services and medication management within Saideep Hospital.

The Chief pharmacist will have the responsibility for ensuring adherence to various practices as described in this procedure and coordinating the quality assurance practices through out all storage, dispensing and issue points for drugs through out the hospital.

5. DESCRIPTION

Pharmacy services and medication management forms a vital component of the overall hospital services contributing to palliative, symptomatic and curative treatments of diseases and conditions.

A quality assurance program for the pharmacy services covering the safe and effective medication management practices within the hospital involves various individuals and units working in close coordination.

The quality assurance program shall cover the following aspects of the pharmacy services and medication management system.

- Selection and procurement of drugs
- Storage and Preservation of Drugs
- Dispensing Practices
- Drug Information Services
- Administration of Drugs and monitoring of effects at units
- Control of high risk / controlled drugs
- Customer Feedback

5.1 Selection and procurement of drugs

The drugs available for dispensing and administration within the hospital shall be selected, listed and procured as per the hospital formulary.

The hospital formulary shall be compiled under theactive guidance and participation of the Drugs and Therapeutic Committee.

The drugs included in the formulary shall be selected based on sound therapeutics, good benefit-to-risk ratio and cost effectives.

The formulary should aim at

a. Promotion of rational therapeutics
b. Prevention of unnecessary duplication, waste and confusion
c. Delivering cost optimization to both patients and the hospital

The additions and deletions of drugs to the formulary shall be the responsibility of DTC (Refer to the relevant procedure for more details).

The formulary shall include indications for use, effectiveness, risks and costs.

5.2 Control of Expired Medications / Non-Conforming Items

Control of Expired Pharmaceuticals & Therapeutics at Central Pharmacy, Retail Pharmacy and Surgical Store

The respective pharmacy / stores in-charges will generate a two lists from the HIS.

- Items nearing expiry (3 months from expiry date)
- Items for expiry (1 month from expiry date)

The items with short expiry times (less than six months); if any shall be identified under the second category if their expiry dates falls within a period of four weeks.

A physical verification shall be performed to identify and tally these items.

All items for expiry shall be removed from the stock and segregated to a separately identified rack / shelf. These shall be returned to the manufacturer/ supplier and credit notes obtained for the same.

The items nearing expiry shall be monitored on a daily basis and shall be issued on a priority basis. Efforts shall be made in coordination with the user department for their first use.

Control of Expired Pharmaceuticals & Therapeutics at Units

The responsibility for identification, segregation and return of expired drugs in stocks / emergency supplies at the various units lies with the respective unit in-charges.

At the beginning of every month the unit in-charge or a person assigned by the unit in-charge shall physically verify the stocks, emergency trays, refrigerators etc. for expired drugs (All drugs falling within the period on one month within the date of expiry and four weeks for short expiry drugs; shall be considered expired).

On identification of expired drugs they shall be segregated, listed and forwarded to the pharmacy for replacement.

Random Checks / Inspections

The Chief pharmacist will perform random checks at various units / stocks for effective implementation of the control of expiry drugs. In case of discrepancies he shall make arrangements for immediate segregation and replacement of those items and shall report the matter to the next meeting of the PTC.

DTC also may consider surprise hospital wide inspection to verify the implementation of the system by the various units.

Non-conforming Items

The common type of non-conformance in case of pharmaceuticals and therapeutics are damages, opened containers, exposure to unfavorable storage conditions etc.

The periodic physical inspections of the stocks shall be done to identify these non-conformances and these items segregated and suitably disposed.

All units shall consider those items stored in room temperature for long periods (Incase of drugs to be maintained under refrigeration) as non-conforming. Efforts should be taken to avoid such exposures.

Highly sensitive items like vaccines should be periodically examined to ensure their integrity.

5.3 Drug Information Services

The chief pharmacist in coordination with the DTC shall run an active drug information service within the hospital with a view of keeping medical, nursing and pharmacy staff up-to-date with continuous change and development on matters relating to drugs.

The information service shall issue regular bulletins on new drugs, banned drugs, adverse drug reactions etc. These bulletins shall be circulated to all units and clinical staff. These shall be prominently displayed in appropriate notice / display boards. The chief pharmacist shall maintain a central repository of such information and bulletins.

5.4 Customer Feedback

The chief pharmacist shall be responsible for obtaining feedback from patients, relatives, staff and outside customers regarding the services of the pharmacy including staff courtesy, promptness of service, adequacy of patient education, effectiveness of drug information services etc.

The patients shall be provided an avenue for providing feedback and registering complaints through feedback forms, complaints / suggestion books or complaints / suggestion boxes provided at convenient location.

An analysis of such feedback shall be done and report submitted to the hospital management.

5.5Quality / Performance Indicators

QI

6. RECORDS

Record Code	Record	Format	Responsibility	Indexing	File No	Minimum Retention Period
R-MAT-24	Adverse Drug Reaction Reports	Electronic/Manual	Unit In-charges	Nil	NA	3 Years
R-MAT-25	Medication Error Reports	Electronic/Manual	Unit In-charges	Nil	NA	3 Years

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 labeled 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

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 labelling 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.

.

6. RECORDS

NABH Standards : MOM 7 h

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
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

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 & TherapeuticCommittee 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

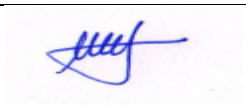
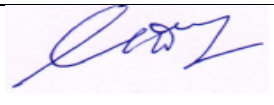
MOM 7

JOB DESCRIPTION

DESIGNATION: Pharmacy In-Charge of Purchase	**REPORTING TO**: Pharmacy In-charge, Director Pharmacy, Administrative Officer
DEPARTMENT: Pharmacy	**RESPONSIBLE FOR**Purchase of medicinal, Surgical and related products, wholesale as well as ad hoc basis.
QUALIFICATION: D-Pharm/ B-Pharm, , Past experience of purchasing in a major outlet & purchase unit for at least 5 years	**TO BE REVIEWED**: 1st April every year
SKILLS SET REQUIRED: Should have knowledge of purchasemajor pharmacy outlet, market analysis for seasonal trends, negotiating with sales reps and should be fluent in English, Hindi and Marathi.	

RESPONSIBILITIES AND ACCOUNTABILITIES:

- Wholesale purchase forthe central pharmacy store.
- Managing ad-hoc purchase in case of stock out scenarios.
- Preparing purchase orders on monthly basis for bulk purchases based on the requisition received from the retail outlets.
- Supervision of received goods for quality as well as quantity.
- Supervision of GRN preparation and stock entry in the stock register.
- Coordinates with Pharmaco-therapeutics committee for major procurements.
- Communicates with operations head in the event of a drug shortage, drug recall scenarios.
- Preparing market analysis for the alternate brand availability to minimize purchase cost and communicating with Pharmacy Director.
- Takes feedback of inventory, goods movement and adjusting purchases accordingly.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

JOB DESCRIPTION

DESIGNATION: Pharmacy **In-ChargeofOperations**	**REPORTING TO**: Pharmacy In-charge,Director Pharmacy, Administrative Officer
DEPARTMENT: Pharmacy	**RESPONSIBLE FOR**Daily functioning of all Pharmacy outlets,Sales, Inventory management. Staff management.
QUALIFICATION: D-Pharm/ B-Pharm, , Past experience of supervision a major outlet & purchase unit for at least 5 years	**TO BE REVIEWED**: 1st April every year
SKILLS SET REQUIRED: Should have knowledge of handling patients, billing and stock management, should be fluent in English, Hindi and Marathi.	

RESPONSIBILITIES AND ACCOUNTABILITIES:

- Looks after daily sales in all outlets.
- Manages inventory. Performs regular stock checks and generating stock report.
- Arranges and conducts periodic stock takings in Pharmacy.
- Prepares duty roster and ensures adequate manpower deployment in all pharmacy outlets.
- Heads monthly meetings for resolving problems and for the improvement of systems in the department.
- Generates various MIS Reports.
- Represents the Department in various meetings.
- Liaisoning between hospital administration and FDA authorities.
- Prepares the hospital formulary.
- Communicates with clinical staff about the changes in drug availability status by circulars, messages or notices.
- Communicates with government authorities for communicable diseases, schedule H drugs, narcotic drugs, Anti-TB drugs sales.
- Interacting with the patients / by standers to deal with any complaints or clarifications related to Pharmacy.

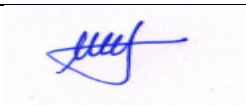
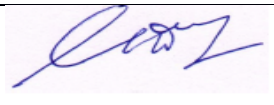
JOB DESCRIPTION

DESIGNATION: Pharmacy **In-ChargeofQuality**	**REPORTING TO**: Pharmacy In-charge, Director Pharmacy, Administrative Officer
DEPARTMENT: Pharmacy	**RESPONSIBLE FOR:** All statutory compliances, Quality monitoring especially NABH standards implementation.
QUALIFICATION: D-Pharm/ B-Pharm, , Past experience of 2 years in quality standards implementation	**TO BE REVIEWED**: 1st April every year

SKILLS SET REQUIRED: Should have knowledge of various healthcare and drug related laws, should be familiar with NABH standards, ISO standards etc. Should be fluent in English, Hindi and Marathi.

RESPONSIBILITIES AND ACCOUNTABILITIES:

- Co-Ordinates with the Quality Department.
- Attends meetings and prepares reports connected to NABH.
- Monitors all pharmacy relevant patient safety, patient education standards are being implemented.
- Performs all relevant audits especially in NABH's COP, MOM chapters.
- Presents the MIS and audit reports to the superiors and contributes in quality improvement programmes.
- Prepares pharmacy quality improvement budget.
- Oversees the environmental surveillance and safe drug storage conditions. Looks after pest control in the storage areas.
- Promotes awareness in drug safety among patients/clients by preparing placards, bills, digital displays etc.
- Prepares and updates the high risk medicine list, LASA list.
- Monitors safe dispensing of medicines especially high risk drugs.
- Monitors on-the job training given to new recruits through Job rotation.
- Ensures proper implementation of the software related to Pharmacy and gives inputs and suggestions for improvement in the system.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	