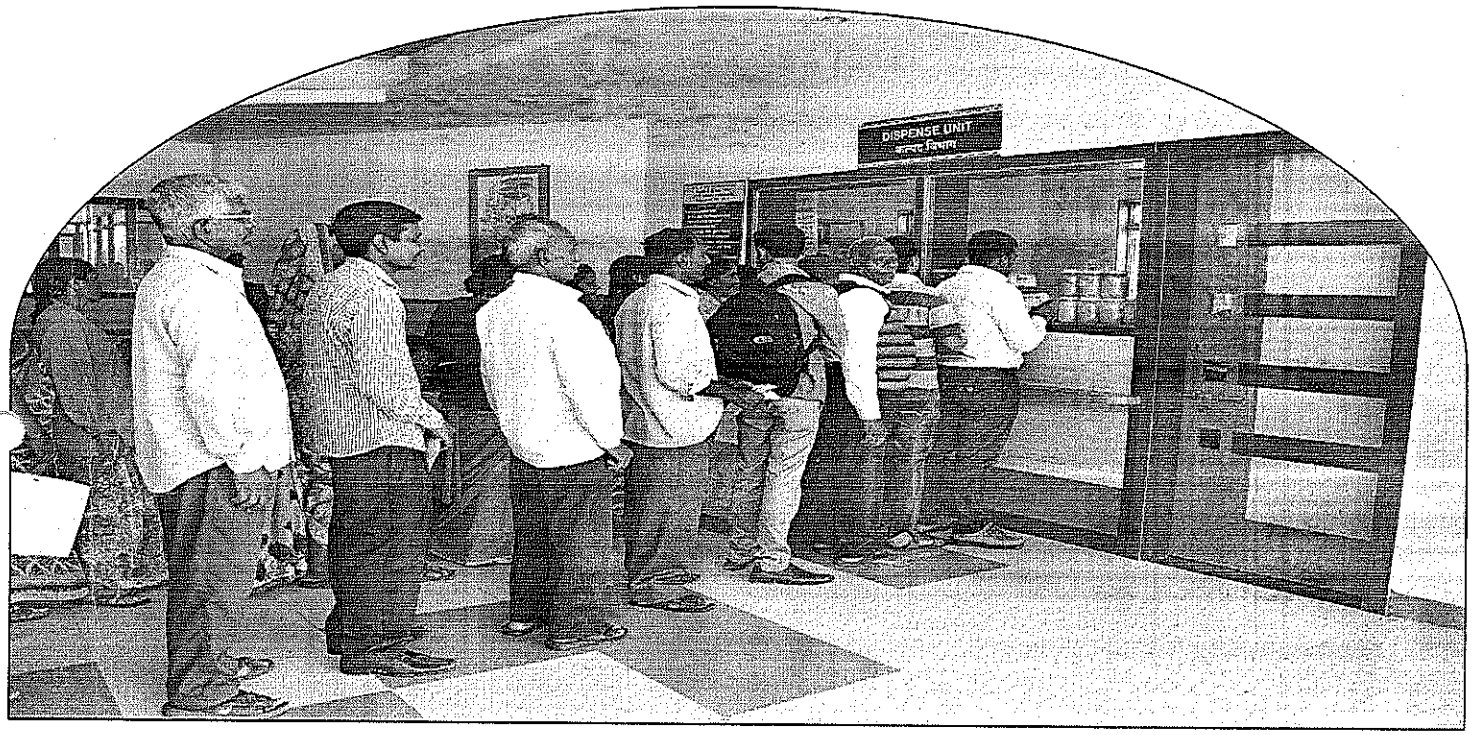
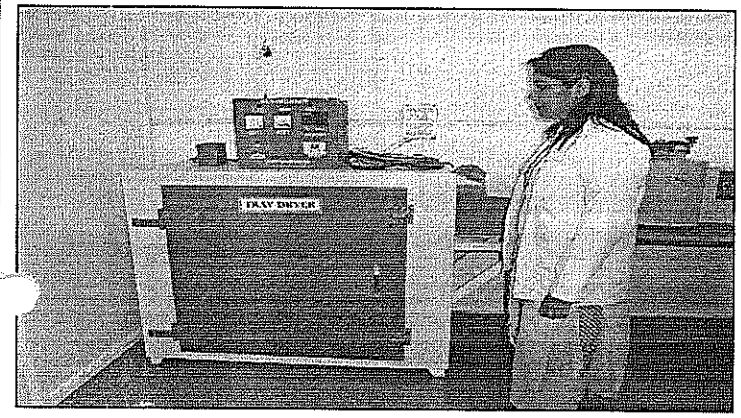
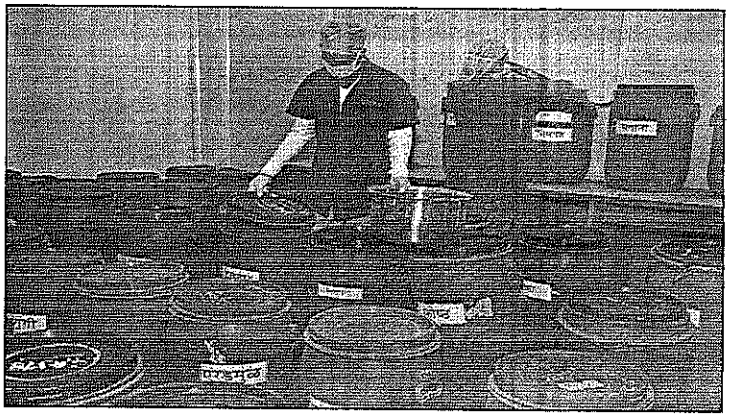
DPU

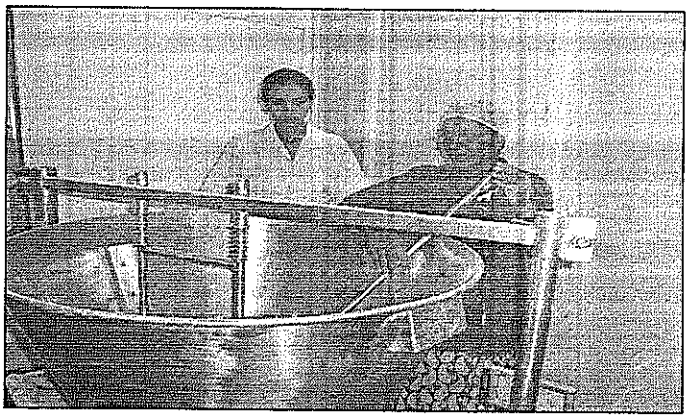
Dr. D. Y. Patil Vidya Pratishthan Society's
DR. D. Y. PATIL COLLEGE OF AYURVED, HOSPITAL & RESEARCH CENTRE, PIMPRI, PUNE

MANAGEMENT OF MEDICATION (MOM)









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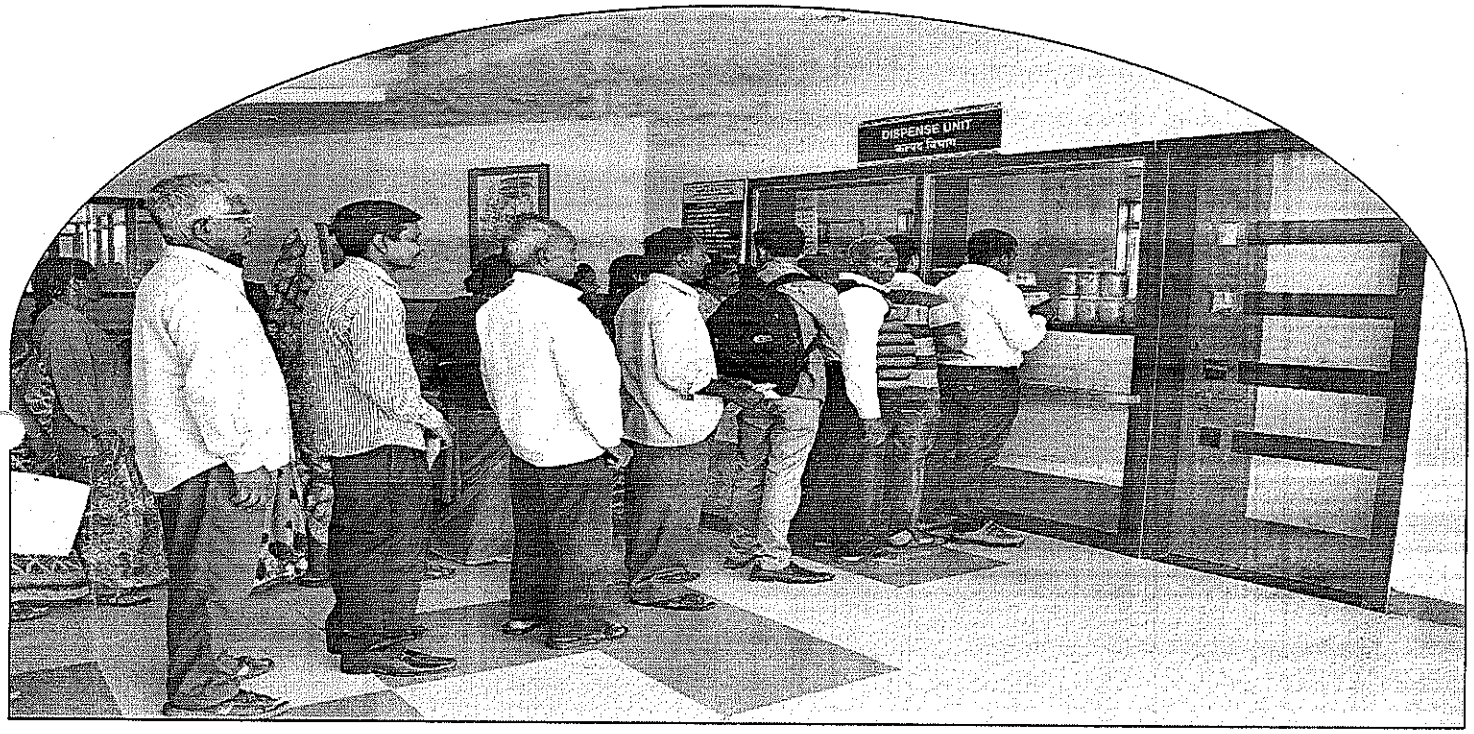

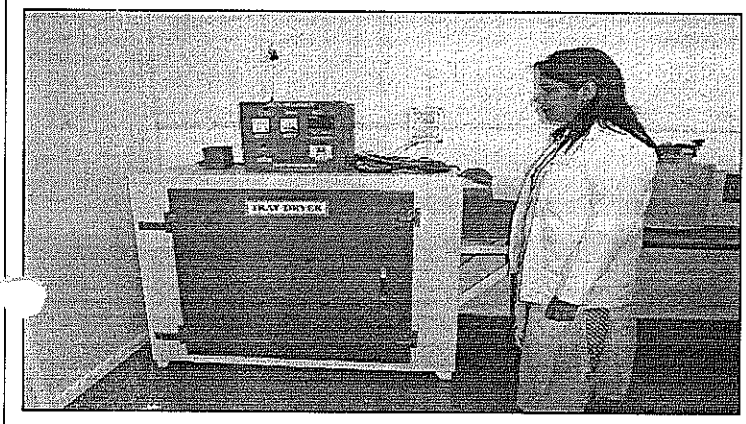

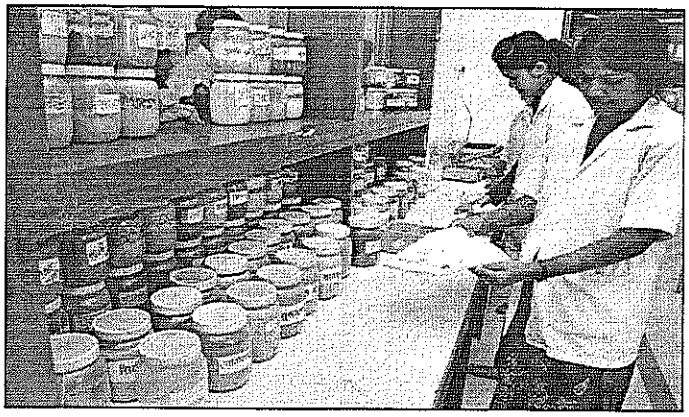

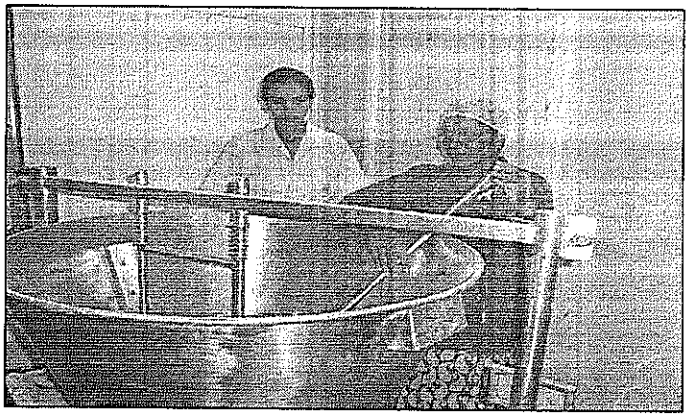

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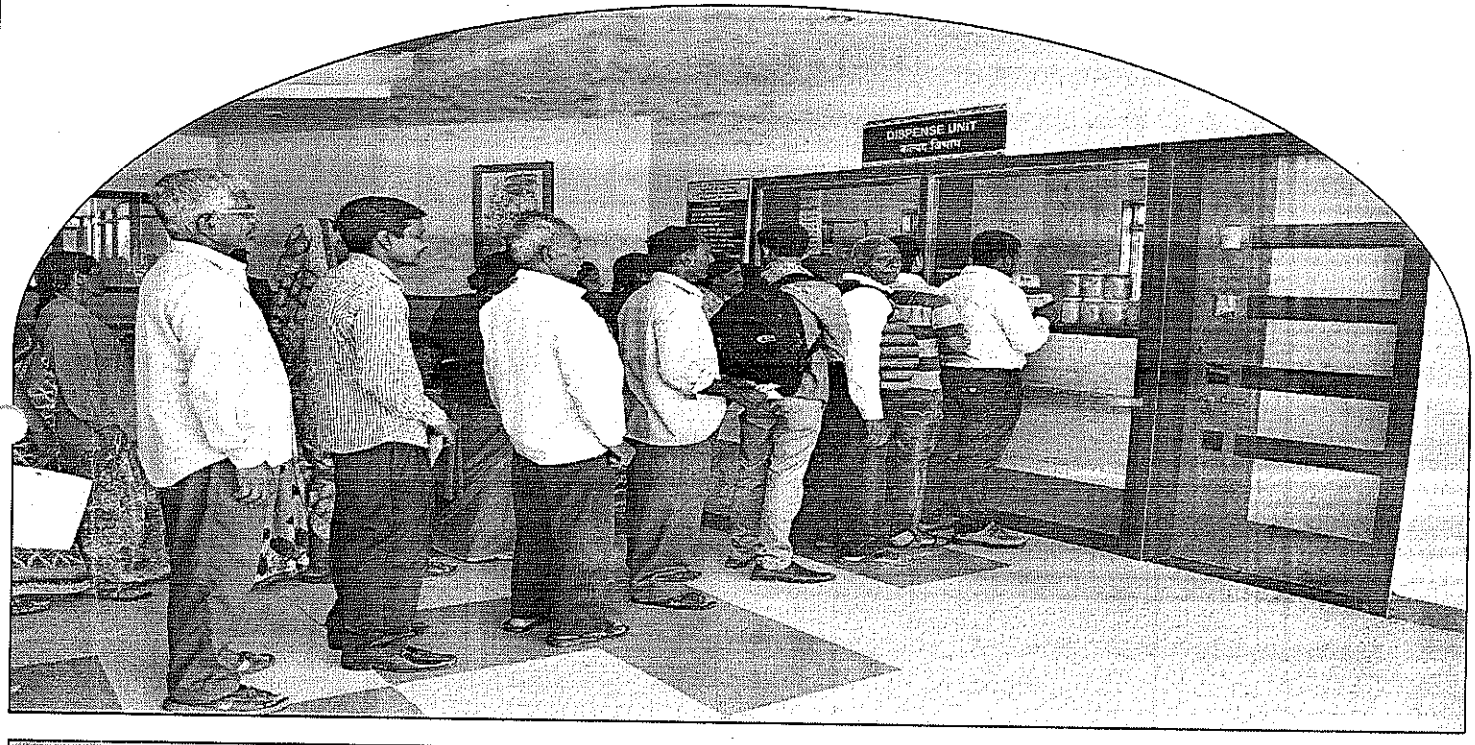

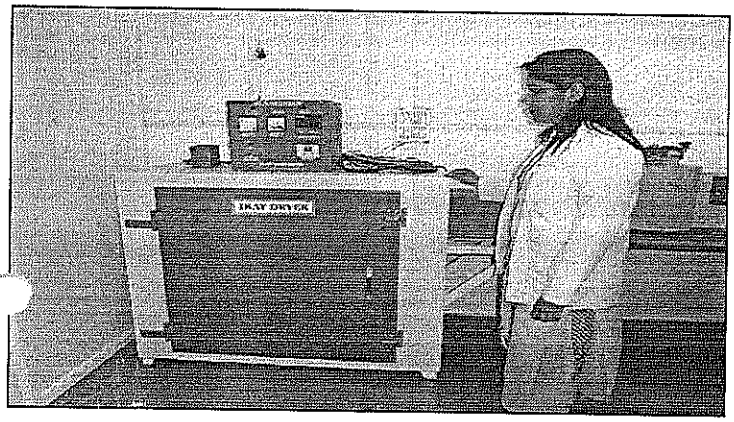

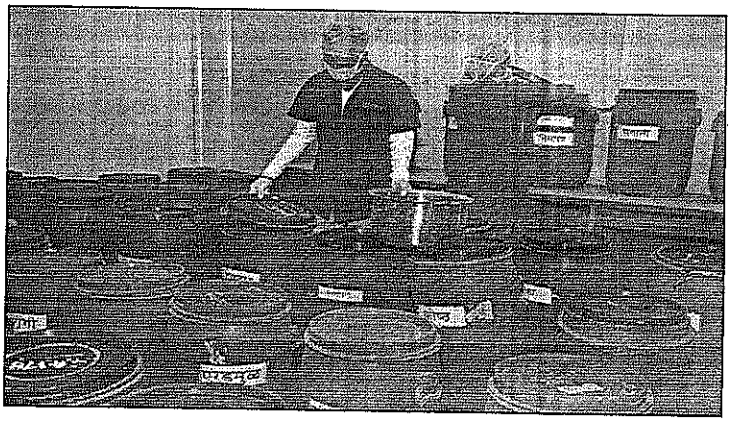

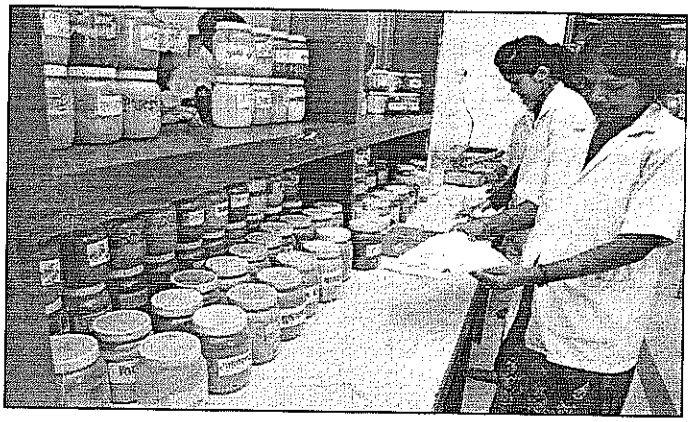

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Document Name :	**MANAGEMENT OF MEDICATION**
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Prepared By :	**Designation :** Pharmacy Incharge **Name :** Dr. Nilima Dharkar **Signature :**
Approved By :	**Designation :**Principal/MS **Name :** Prof. Dr. B. P. Pandey **Signature :** PRINCIPAL
Responsibility of Updating :	**Designation :** NABH Coordinator **Name :** Prof. Dr. Jayashree Patil **Signature :**

AMENDMENT SHEET

Sr.No.	Section no & page no	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

CONTROL OF THE MANUAL

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable.

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

RMO is responsible for issuing the amended copies to the copyholders, the copyholder should acknowledge the same and he /she should return the obsolete copies to the RMO.

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

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

The authority over control of this manual is as follows:

Preparation	Approval	Issue
Pharmacy Incharge	Principal, Dr. D.Y. Patil College of Ayurved, Hospital & Research Centre, Pimpri, Pune.	Accreditation coordinator

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy', and the photocopies of the master copy for the distribution are considered as 'Controlled Copy'.

Distribution List of the Manual:

S.No.	Designation
1	Principal/ MS
2	RMO (Residential Medical Officer)
3	Accreditation Coordinator

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MOM 1 – PHARMACY SERVICES AND USAGE OF MEDICATION

1.0 PURPOSE:

1.1 To Manufacture and supply of Ayurvedic medicines for Dr. D. Y. Patil Ayurved Hospital & to provide guide lines for the organization for Pharmacy services, management and usage of Medication

2.0 SCOPE:

2.1 Pharmacy and other Patient Care Areas

3.0 RESPONSIBILTY:

3.1 Principal/MS, Doctors(RMO, Duty Doctor), Pharmacy Incharge, Formulary Officer, Purchase Officer, Stores Incharge and Pharmacists.

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board for Hospitals and Healthcare providers

4.2 MOM : Management of Medication

5.0 DEFINITION:

6.0 REFERENCE:

6.1 NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2017

7.0 POLICY

7.1 Dr. D.Y. Patil College of Ayurved, Hospital Pharmacy is Inhouse Teaching Pharmacy.

7.2 Pharmacy complies with the following laws and regulations: Drugs and cosmetics act; Food and drug act; Drugs and magical remedies act.

7.3 A 08 hours Pharmacy (Medicine Manufacturing Unit) & Kalpad Vibhag (Formulary) services is provided in Dr. D.Y. Patil College of Ayurved, Hospital & Research Centre. Medicines are available in departmental IPD for 24 hours. Hospital drug formulary is approved by the pharmacy and therapeutic committee and all the drugs are procured based on the list of drugs available in the formulary.

7.4 All the medications are stored at the specific temperature.

7.5 Manufacturing of ayurvedic medicines are preparing on demand of formulary and physicians in Pharmacy.

7.6 In Formulary medicines are procured from Pharmacy and outside supplier as per requirement.

7.7 Outside prescription are not accepted.

7.8 In case of oral orders / telephonic instructions of the consultant, the same are noted in the prescription by the PG students/staff nurse .

7.9 Read back policy is followed.

7.10 All the medications are administered by the registered nurse based on the doctor's order, if there is any ambiguity in the prescription same is cross verified with the concerned doctor either in person or through telephone.

7.11 Prescription not made in the hospital letter head or without Consultant name / signature / date, is not be accepted in the Formulary and the same is returned back to the concerned doctor with the reason for returning back.

7.12 A pharmacies and therapeutic committee organized as per the medication needs of the patients. The committee is annually review the appropriateness of the hospital formulary to meet the needs of hospital. Acquisition of medicine is as per the procedure.

MOM 02 – THERE EXISTS A HOSPITAL FORMULARY

1.0 List of Medicines appropriate for the patients & hospital's resources is developed

2.0 List is developed by pharmaco therapeutic Committee.

3.0 Formulary is available to all treating doctors of the hospital.

4.0 Prescription are given as per the availability.

5.0 There is a define process for preparation of medicines.

MOM 03 - POLICY AND PROCEDURES TO GUIDE STORAGE OF MEDICATION

1.0 PURPOSE:

1.1 To provide guidelines on storage of medicines.

2.0 SCOPE:

2.1 Pharmacy and Formulary

2.2 All Medication storage areas

3.0 RESPONSIBILTY:

3.1 Principal

3.2 Purchase Manager

3.3 Pharmacy Incharge

3.4 Formulary Officer

3.5 Pharmacists

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

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7.0 POLICY & PROCEDURE:

7.1 All the drugs are stored as per the prevalent laws and regulations:

7.1.1 Pharmacy Act;

7.1.2 Drugs and cosmetics Act

7.1.3 Food and Drugs Act;

7.1.4 Drugs and magical remedies Act.

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

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

7.4 Medications are stored in a clean, well lit, and ventilated environment.

7.5 Refrigerator storage temperature is recorded once a day in the stores and in the pharmacy, whereas in other storage areas, it is recorded once a day and the same is verified and counter signed by the in-charge staff.

7.6 Medications are protected from loss and theft.

7.8 Sound alike and look alike medications are stored separately.

7.9 Emergency medicines should be available all time.

7.10 Emergency medications are replenished in a timely manner when used.

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

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

7.13 Organization conducts audits at regular intervals.

MOM 4 - POLICY AND PROCEDURES TO GUIDE PRESCRIPTION OF MEDICATION

1.0 PURPOSE:

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

2.0 SCOPE:

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

3.0 RESPONSIBILTY:

3.1 Principal/MS

3.2 Doctors,

3.3 Matron

3.4 Pharmacist

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

4.2 MOM : Management of Medication

5.0 REFERENCE:

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2017

6.0 POLICY:

6.1 The authorization of raising medication orders is limited to the registered/credentialed physician only.

6.2 All consultants are use only standard Prescription format for prescribing medications for the patients and every prescription contains name, date and signature of the consultant in the prescription. It is recommended that prescription sheet is affixed with the stamp of the hospital.

6.3 Each prescription entry in IPD patients are signed, named, timed and dated by the Physician ordering; in case of oral order by the consultant name is written by the junior doctor and counter signed by the senior consultant within 24 hours.

6.4 Separate prescription is written for every patient.

6.5 Doctors on Duty writes all medicines in the prescription paper as well in the doctors' order sheet in the patient file.

6.6 The prescription is include the Matra, Kal, And Anupan of administration of the drug.

6.7 The patient record is facilitate and reflect the medication and coordination of care.

6.8 The prescription is transcribed by the licensed pharmacist, checked for completeness and then only medication is dispensed.

6.9 Verbal orders are utilized only in situations where the ordering doctor is not available to write the order and delay will result in a compromise in patient care. Every effort is made to minimize the use of verbal orders.

6.10 In case of any emergency, verbal order is given by the treating consultant. Read Back Policy is followed by the concerned Staff. The same is followed by a written order and verification by the consultant who has prescribed and the same is cross signed by the Consultant within 24 hours.

6.11 Whenever there is doubt regarding a particular prescription (such as illegible handwriting, wrongly written strength/dose or frequency, doubt regarding similar sounding medicines, duplication etc.,) or when a prescription is incomplete (without sign, date, etc), the junior doctor/pharmacist /nurse is promptly call the Doctor and get it corrected without causing inconvenience for patient.

6.12 Prescriptions & Orders raised by all consultants are honored as long as the patient is eligible for care.

6.13 All medicines are checked for name of the drug and expiry date prior to dispensing.

6.14 Drugs are ordered from the formulary for an IPD patient on prescription basis by indent procedure.

6.16 Pharmacist/ Care providing nurse is verify the allowable dosage as per standard and prescription for high risk medicines before dispensing. Also special attention is paid to educate the patients while using high risk medicines by nursing staff. High risk medicines are identified from the high risk medicines list available with the pharmacist.

6.17 Nursing station requests crash cart drugs from the formulary using approved Indent. The Indent is approved by HOD of Concerned department, Matron, RMO, DMS and MS

6.18 Administering medications are limited to credentialed physicians and credentialed doctors only..

6.19 The Pharmacy Service is responsible for the proper packaging and labeling of all drugs Dispensed by the Formulary for use in patient treatment. Labels and batch no. used by the Pharmacy is distinctive and not used by other Hospital departments.

7.0 PROCEDURE:

7.1 Rational prescription of medication:

7.1.1 The patients examined by the doctors are to be prescribed only the medicines required by that particular patient appropriate to his / her clinical needs, in yogya matra , anupan & Kal.

7.1.2 When the patients are discharged the remaining medicines are handed over to the patients/relatives and they are instructed on how to use them at home. If the medicines are not sufficient they are given fresh continuation prescriptions.

7.2 Requirements of prescription:

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

7.2.2 The following details are contained in all prescriptions, minimum:

a) Patient's name & date of prescription;
b) Generic name of medicine;
c) Matra;
d) Kal
e) Anupana
f) Directions for use;
g) Prescriber's signature, name (hospital stamp if provided), time and date shall be mentioned.

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

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

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

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

7.3 **Verbal orders:**

7.3.1 In the case of IPD patients, in emergency situations if the doctor gives any verbal orders or telephonic orders regarding medicines to be administered to a particular patient.

7.3.2 The individual accepting the verbal order, documenting that the order was "read back" (RB).

7.3.3 Nursing staff are permitted to act upon verbal orders provided the orders contain the appropriate information.

7.3.4 Verbal and telephone orders are signed or initialed by the prescribing practitioner as soon as possible, not later than 24 hours.

7.3.5 When the ordering physician is unavailable, it is acceptable for another team member or the attending staff to authenticate the verbal order.

7.3.6 Whenever there is doubt regarding a particular prescription (such as illegible handwriting, wrongly written strength/dose or frequency, doubt regarding similar sounding medicines, duplication etc.) or when a prescription is incomplete (without sign, date, etc), the junior doctor/ pharmacist should promptly call the doctor and inform him and get it corrected without causing inconvenience for the patient.

7.3.8 The attending nurse reminds the treating doctor about the patients known drug allergies as marked with red ink on the patients file so that the patient does not receive that drug.

7.4 **High-risk medication:**

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

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

7.4.2.1 Poorly handwritten medication orders.

7.5 **Verbal directions/orders.**

7.5.1.1 Similar product packaging.

7.5.1.2 Similar medication name.

7.5.1.3 Improper packaging leading to improper route of administration.

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

7.5.1.5 Similar abbreviations. Improper storage of concentrated electrolytes

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

7.5.2.1 **Medication arrangement:** Avoid storing look-alike, sound-alike drugs next to each other. Limit high risk drug storage.

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

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

7.5.3 **List of High risk medications:**

1. Sedative
2. Thrombolytic
3. Antihypertensive
4. Antri Arrhythmic
5. Bronchodilator
6. Opioid Analgesic
7. Adrenergic
8. Antibiotic
9. Anaesthetic
10 Steroids
11. Vaccines Etc

8.1.1 The record in the register includes the following details for each receipt and issue which are dispensed by formulary:

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

8.1.1.2 Quantity of medicines received or supplied;

8.1.1.3 Balance remaining;

8.1.1.4 Name of Department

8.1.1.5 Signature of person making the entry;

8.1.1.6 Signature of person checking.

8.1.1.7 This record to be maintained by Formulary Officer and is responsible for any Irregularity.

8.1.1.8 Modern Medicines Stock register entry must record the following details :

- Date
- Time
- OPD/ IPD No.
- Amount administered
- Balance remaining
- Signature of person making the entry
- Signature of person checking

8.1.3 The record in the register is include the following details for each Ayurvedic formulations supplying from pharmacy.

8.1.3.1. Raw material record

8.1.3.2 Medicine manufacturing record

8.1.3.3 Quality control record of raw material & Finished good

8.1.3.4 Medicine issued to fomulary record

8.1.3.5 Signature of person checking

8.1.3.6 This record to be maintained by Pharmacy Incharge and is responsible for any Irregularity

8.2 **Scope of the audit:**

8.2.1 The scope of the audit includes:

8.2.1.1 The appropriateness of the drug, dose, frequency and route of administration.

8.2.1.2 The presence of therapeutic duplication

8.2.1.3 The possibility of drug interaction and measures taken to avoid the same

8.2.1.4 The possibility of food – drug interaction and measures taken to avoid the same

8.2.1.5 The requirements to ensure completeness of prescription

8.2.1.6 The requirements to ensure completeness of entries in the medication charts.

8.2.1.7 The completeness of medications orders to ensure that they are clear, legible, dated, timed, named and signed.

8.2.1.8 The completeness of medications orders to ensure that they contain the name of the medicine, route of administration, dose to be administered and frequency / time of Administration.

MOM 5 - POLICY AND PROCEDURES TO GUIDE SAFE DISPENSING OF MEDICATION

1.0 PURPOSE:

1.1 To establish policies for drug dispensing in all IPD patients, OPD patient areas and guide lines for medication recall.

2.0 SCOPE:

2.1 Pharmacy & Formulary department

3.0 RESPONSIBILTY:

3.1 Pharmacy In-Charge

3.2 Formulary officer

3.3 Quality control officer

3.4 Pharmacy & Formulary Staff

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

4.2 MOM : Management Of Medication

5.0 DEFINITION:

6.0 REFERENCE:

NABH: Pre Accreditation Entry Level Standards for Hospitals. April 2017

7.0 POLICY

7.1 Dispensing of medication is conformed to applicable laws and regulations governing pharmacy practice in state of Maharashtra and India.

7.2 The order is screened for appropriateness of drug, dose, and frequency, route of administration, therapeutic duplications, drug to -drug interactions, allergies, and formulary status. Labeling requirements (at a minimum, labels must include the drug name, frequency of administration (in a language the patient understands) shall be documented and implemented by the organization.

7.3 Expiry dates are checked prior to dispensing.

7.4 In case of contaminations, short expiry drugs, expired drugs etc., drugs are recalled as per the procedure. Drugs to be sent back to pharmacy and informed about this status in written to pharmacy incharge.

7.5 All medications are verified by the Quality Control with the help of Quality Control Officer at the time of receipt of goods and the same is checked for damages and contaminations.

7.6 According to the feedback from patients or staff, the pharmacy & formulary should have a recall procedure if the medicine is contaminated or expired.

7.7 In case of any such incidence, same is returned back to the pharmacy along with the bill (batch and serial number).

MOM 6 - POLICY AND PROCEDURES FOR MEDICATION ADMINISTRATION

1.0 PURPOSE:

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

2.0 SCOPE:

2.1 Hospital Wide

3.0 RESPONSIBILTY:

3.1 Doctors / Consultants,

3.2 Nursing staff

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

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5.0 DEFINITION:

6.0 REFERENCE:

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2016

7.0 POLICY

7.1 **Personnel for medication administration:**

7.1.1 The individual who administers the medication is responsible for ensuring that the right medicine with right dose is administered to the right patient through the right route at the right time.

7.1.2 All medications are administered as ordered by the physician, by an authorized health care professional.

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

7.2 **Labeling of medication:**

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

7.3 **Patient identification prior to administration:**

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

7.4 **Medication verification:**

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

7.4.1.1 Treatment orders

7.4.1.2 General appearance of the medicine

7.4.1.3 Medication name

7.4.1.4 Dosage

7.4.1.5 Frequency and time

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

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

7.4.4 The documentation after administration is done in the medication chart.

7.5 **Dosage verification:**

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

7.6 **Route verification:**

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

7.7 **Timing verification:**

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

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

7.8 **Documentation of medication administration:**

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

7.8.2 All the entries in the chart is include the:

7.8.2.1 Date of entry

7.8.2.2 Name of medication

7.8.2.3 Dosage

7.8.2.4 Route of administration

7.8.2.5 Timing

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

7.8.3 In case of infusions, it is captured the start time, the rate of infusion and end time.

7.9 **Self-administration of medication:**

7.9.1 Self-administration of injectable drugs are not permitted in the IPD patient care areas. 7.9.2 Patients own oral medications brought in by the patients who are on chronic therapy (e.g. Conditions like Hypertension, Diabetes mellitus, Cancer, TB) is known to the treating physician and is allowed to administer to the patient under the supervision and certification of treating physician, such medications are also be recorded in patient's record.

7.10 **Medications brought from outside:**

7.10.1 In case of non-availability of some drugs, this may be allowed.

7.10.2 Bill, Label, Dose and Expiry date are verified before administering to patient.

7.10.3 Doctor or nurse educates the patients and the family members about safe and effective use of medication and about the food-drug interactions.

MOM 7- PROCEDURES FOR MEDICATION ADMINISTRATION

1.0 PURPOSE:

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

2.0 SCOPE:

2.1 Hospital Wide – All IPD patient care areas

3.0 RESPONSIBILTY:

3.1 Consultants, all Doctors,

3.2 Nursing Staff &

3.3 Pharmacy and Therapeutic Committee

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

4.2 MOM : Management Of Medication

4.3 RR :: Recovery Room

4.4 RMO : Resident Medical Officer

5.0 REFERENCE:

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2017

6.0 POLICY:

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

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

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

7.0 PROCEDURE:

7.1 Procedures to ensure appropriate patient monitoring after medication:

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

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

7.1.3 The different charts to be maintained are:

- Medication
- Temperature, pressure and heart rate (TPR)
- Intake – Output
- Nurses' notes

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

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

MOM 8 - ADVERSE DRUG EVENTS MONITORING

1.0 PURPOSE:

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

2.0 SCOPE:

2.1 Hospital Wide – All IPD patient care areas

3.0 RESPONSIBILTY:

3.1 Consultants, all Doctors

3.2 Nursing Staff

3.3 Pharmacy and Therapeutic Committee

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

4.2 MOM : Management Of Medication

4.4 M.S. ::Medical Superintendent

4.5 RR : Recovery Room

4.7 RMO : Resident Medical Officer

5.0 DEFINITION:

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

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

5.2 **Medication errors:** A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional. Such events may be related professional practice, procedures, and systems, including prescribing; communication; labeling, packaging, and nomenclature; dispensing; distribution; administration; education; monitoring and use.

5.3 **Types of errors: Order Error** – Types of ordering errors include: inappropriate medication selected, inappropriate dose, illegible order, duplicate order, order not dated/timed, wrong patient/chart selected, contraindications, verbal order misunderstood, verbal order not written in the drug chart, wrong frequency, route, illegible writing, therapy duration, alert information bypassed or use of nonstandard nomenclature or abbreviations.

5.4 **Transcription error** –Transcription involves both the orders that are manually transcribed onto manual record (e.g. Drug chart). **Types of transcription errors include**: wrong medication, time, dose, frequency, duration, rate patient/chart, verbal order misunderstanding, verbal orders not entered into patient case sheet.

5.5 **Preparation/Dispensing Error** – Types of preparation and dispensing errors include: Inaccurate Labeling, wrong quantity, medication, dose, diluents, formulation, expired medication, Pyxis refill error, and delay in medication delivery.

5.6 **Administration Error – Types of administration errors include:** Wrong patient, dose, time, Medication, route, rate, extravasations (may be an ADR) and unauthorized dose given

6.0 REFERENCE:

NABH: Pre Accreditation Entry Level Standards For Hospitals. April 2017

7.0 POLICY:

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

7.2 A report is submitted to Formulary & Pharmacy and Therapeutic committee chairman for corrective actions.

7.3 If the patient has sustained serious illness as a result of the incident, Risk Management must be notified. The medication error report includes: 1. Patient demographics (name, location, medical service); 2. Notation as to medical personnel who were notified of the incident (i.e. physician); 3. Severity rating of the incident; 4. Accurate description of incident.

7.4 All patients are monitored after medication administration by enquiring every patient or by documenting if the patient tells.

7.5 **Indications of adverse drug reactions:** Indications of an ADR include anaphylaxis, arrhythmia, convulsions, hallucinations, shortness of breath, rashes, itching, hypotension, dystonia, leukopenia, urinary retention, symptoms associated with neuroleptic malignant syndrome, initial report of tardive dyskinesia, EPS related to non-antipsychotic drugs and also includes true allergic (hypersensitivity) reactions and idiosyncratic reactions. All adverse drug reactions shall be reported to the consultant / M.S. / D M.S. within 10- 15 minutes and the interventions observed will be documented in the patient case sheet. All adverse drug reactions will be reported to the pharmacy and therapeutic committee in a standardized format. All adverse drug reactions are intensively analyzed by Pharmacy and Therapeutic committee and the corrective actions are taken based on the discussion.

8.0 PROCEDURE:

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

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

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