ADD –ON COURSE

MANAGEMENT OF MEDICATION

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Labeling of medication:

Already prepared medications/ Readymade Preparations shall be labeled with the name of the drug, dosage, timing, start date & time, sign of the personnel prior to preparation of the second medication, applicable only for parenteral drugs. (Antibiotics like Meropenem/ Imipenem before administration)

Patient identification prior to administration:

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

Medication verification:

- The medication shall be checked by the administering personnel with respect to:
- Treatment orders
- General appearance of the medicine
- Medication name
- Dosage
- Frequency and time
- In case of verbal orders, the verification shall be done by 'read back' method.
- In case of high risk medications, the verifications shall be done independently by atleast 2 staff, either a nurse-nurse or nurse-doctor and documented.
- The documentation after administration shall be done in the medication chart.

Dosage verification:

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- ROUTE VERIFICATION:
- TIMING VERIFICATION:
- DOCUMENTATION OF MEDICATION ADMINISTRATION:

- All the entries in the chart shall include the:
- Date of entry
- Name of medication
- Dose & Dosage
- Route of administration
- Timing/ Frequency
- Name and signature of the person who has administered the medication.
- In case of infusions, it shall capture the start time, the rate of infusion and end time.

SELF-ADMINISTRATION OF MEDICATION:

MEDICATIONS BROUGHT FROM OUTSIDE:

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MONITORING OF PATIENTS AFTER MEDICATION ADMINISTRATION

PURPOSE:

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

SCOPE:

Hospital Wide – All Inpatient care areas

RESPONSIBILTY:

Consultants, all Doctors,

Nursing Staff &

Pharmacy and Therapeutic Committee

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

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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; labelling, packaging, and nomenclature; dispensing; distribution; administration; education; monitoring and use.

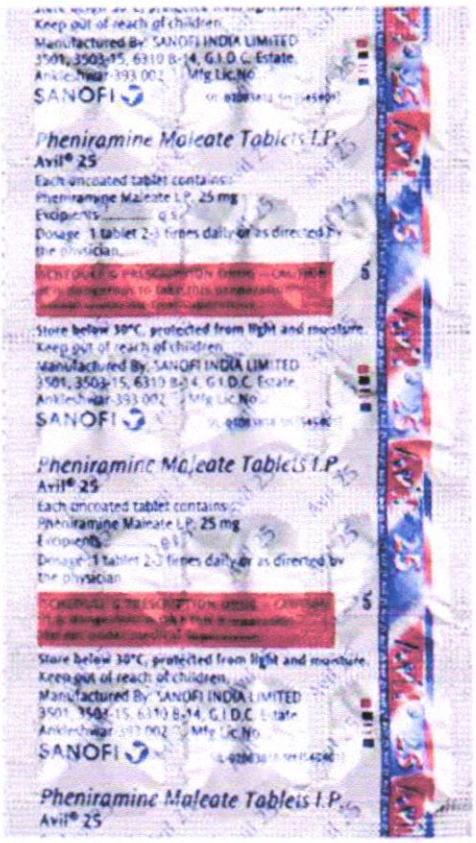
Types of errors: Order Error – Types of ordering errors include: inappropriate medication selected, inappropriate dose, illegible order, duplicate order, order not dated/timed, wrong patient/chart selected, contraindications, verbal order misunderstood, verbal order not written in the drug chart, wrong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

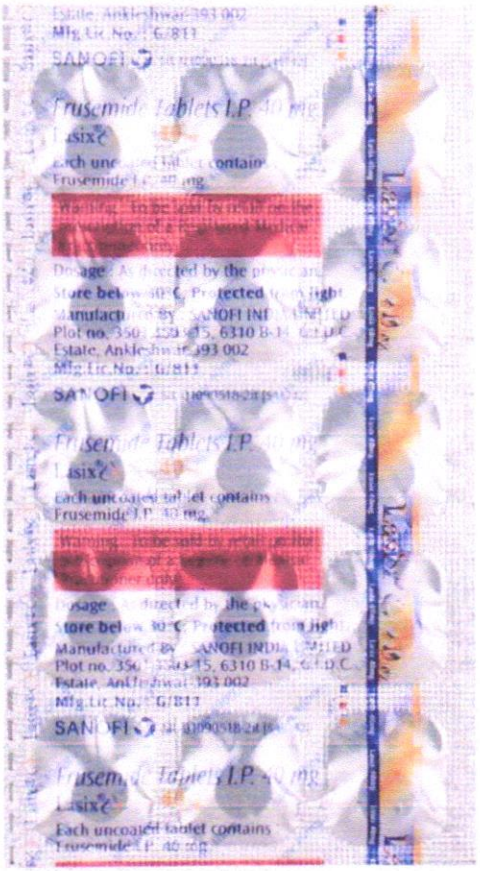
Transcription error –Transcription involves both the orders that are manually transcribed onto manual record (e.g. Drug chart). **Types of transcription errors include**: wrong medication, time, dose, frequency, duration, rate patient/chart, verbal order misunderstanding, verbal orders not entered into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

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

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

Look alike & sound alike an near miss medications





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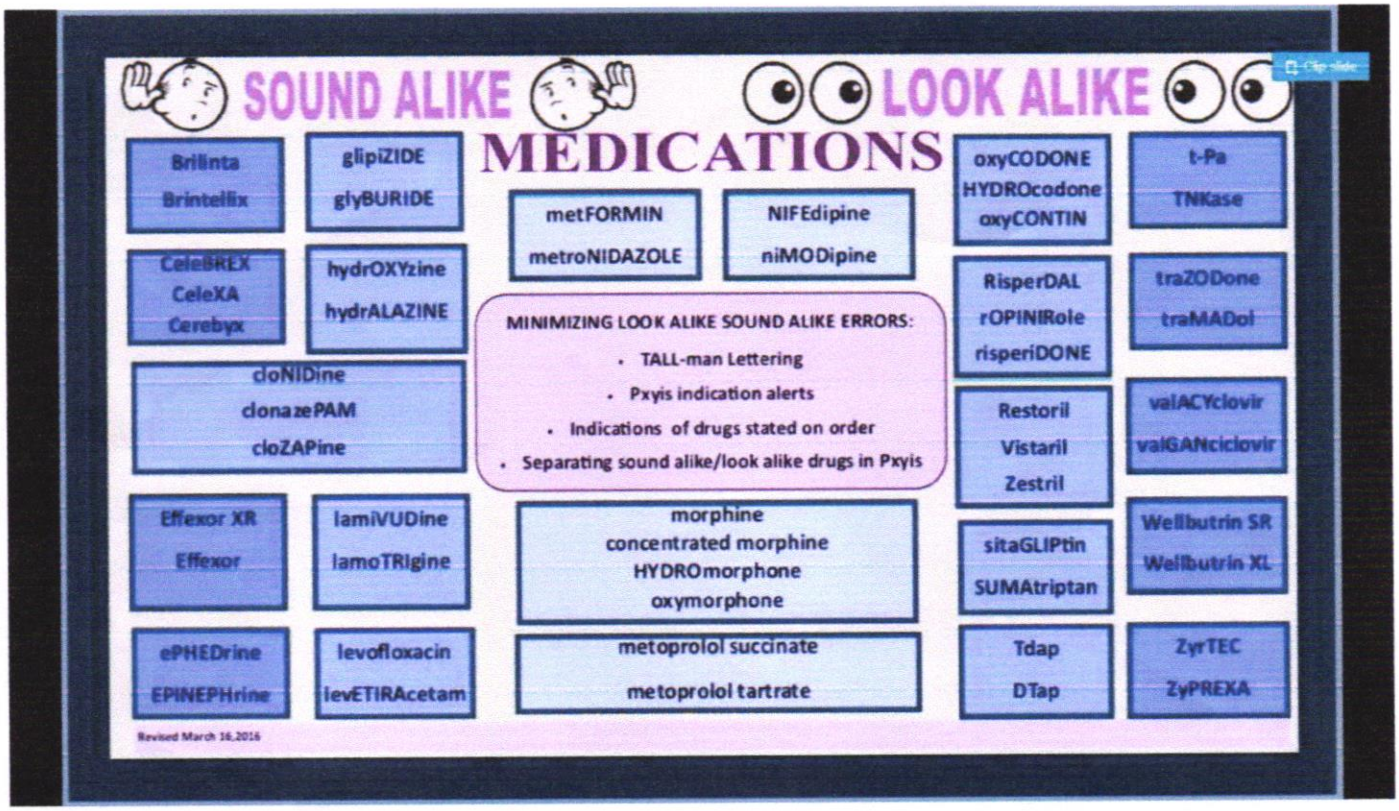

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MONITORING OF PATIENTS AFTER MEDICATION ADMINISTRATION

POLICY

PROCEDURE:

- Procedure for the Identification and Review of any Medication Errors:
- Procedure for the Identification and Review of Adverse Drug Reactions (ADR):

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REPORTING OF NEAR MISSES, MEDICATION ERRORS AND ADVERSE DRUG EVENTS

PURPOSE:

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

SCOPE:

Hospital Wide – All Inpatient care areas

RESPONSIBILTY:

Consultants, all Doctors,

Nursing Staff &

Pharmacy and Therapeutic Committee

POLICY:

PROCEDURE:

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POLICY AND PROCEDURES FOR USE OF NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES

PURPOSE:

To provide guidelines governing adequate control for procurement, proper storage, dispensing and record keeping of Narcotic and Psychotropic Drugs in a Hospital.

SCOPE

All the important activities related to the procurement, storage, dispensing and record keeping of Narcotic and Psychotropic Drugs in accordance with the Narcotic and Psychotropic substances Act as well as Drugs and Cosmetics Act, 1940 and Rules framed there under.

RESPONSIBILTY:

Consultants / Doctors,

Nursing Staff

Pharmacy And Therapeutic Committee

POLICY :

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POLICY ON VERBAL ORDERS

VERBAL ORDERS:

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

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POLICY ON VERBAL ORDERS

HIGH-RISK MEDICATION:

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

Circumstances Increasing Errors in High Risk Medications: Poorly handwritten medication orders.

Verbal directions/orders.

- Similar product packaging.
- Similar medication name.
- Improper packaging leading to improper route of administration.
- Storage of products with similar names in the same location.
- Similar abbreviations. Improper storage of concentrated electrolytes

Strategies to Avoid Errors Involving High Risk Medications:

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

- Formulary selection: Minimize look-alike, sound-alike formulary combinations.
- Prior verification: As an additional precaution, high risk medication orders are
- verified prior to dispensing

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ROLES AND RESPONSIBILITIES OF NURSING STAFF

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