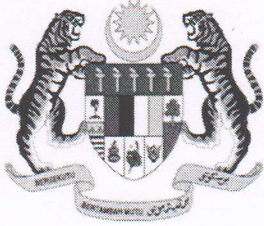
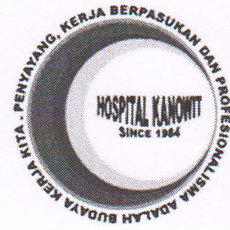
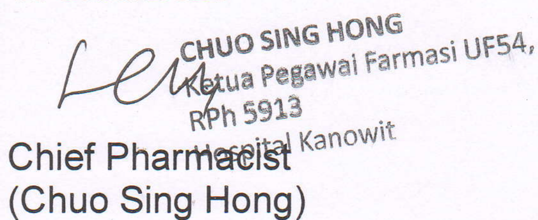




PHARMACY UNIT OPERATIONAL POLICIES

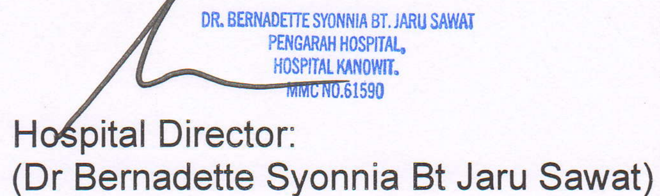
HOSPITAL KANOWIT

Effective date:
10 Julai 2023



Chief Pharmacist
(Chuo Sing Hong)

Valid until:
10 Julai 2025



Hospital Director:
(Dr Bernadette Syonnia Bt Jaru Sawat)

PREPARED BY:

NAME : CHUO SING HONG
POST : KETUA PEGAWAI FARMASI UF54
DATE : 10 JULY 2023

CHECKED BY:

NAME : DR. BERNADETTE SYONNIA BT JARU SAWAT
POST : PENGARAH HOSPITAL
DATE : 10 JULY 2023

APPROVED BY:

NAME : DR. BERNADETTE SYONNIA BT JARU SAWAT
POST : PENGARAH HOSPITAL
DATE : 10 JUL 2023

REVISION DATE:

FIRST : 1 FEB 2019
SECOND : 14 OCTOBER 2021
THIRD : 10 JUL 2023
FOURTH :

PHARMACY UNIT OPERATIONAL POLICIES
KANOWIT HOSPITAL

1.0 MISSION, VISION, OBJECTIVES, FUNCTIONS, SCOPE OF SERVICE

1.1 Vision

Untuk memberikan perkhidmatan farmasi yang terbaik demi kesihatan dan kesejahteraan Negara.

1.2 Mission

Menerajui perkhidmatan farmasi yang dynamic dengan memberi penekanan pada tahap kewibawaan yang tinggi, profesionalisme dan kecemerlangan, sejajar dengan aspirasi dan cabaran Negara.

1.3 Objectives

a. To provide efficient and effective pharmacy service to the patient and clients of the hospital.

b. To ensure that patients are supplied with appropriate amount of medications that are safe and efficacious, clear instructions will be given to patients regarding dosage of medications.

c. Procure and supply medications which are of high quality, effective, safe and at appropriate time.

d. To plan, manage, monitor and assess the services provided by pharmacy department.

e. To supply the latest information regarding drugs which are available in this hospital whenever required.

1.3 Functions

The pharmaceutical services provided by the Pharmacy Department, in general, have the following functions:

a. Effective and efficient management of the department
b. Provision of drug information
c. Drug supply management
d. Educational activities

These functions are carried out in cooperation with other hospital departments and programs.

1.5 Scope of services

a. Dispensing services to out-patients from OPD, ETD Department and discharged patients from the wards.

b. The supply of drugs to all wards and units using either Complete Floor Stock System or the “unit-of-dose” System.

c. Supply of Psychotropic Substances/ Dangerous Drugs in the hospital.

d. Provision of Drug Information Service.

e. The preparations of mixture, lotions, creams, ear, nose medication and extemporaneous syrup in accordance with “Good Manufacturing Practice”.

f. The pharmaceutical services shall be available during office hour from 8.00am to 5.00pm. For weekends and public holidays, pharmacy will be opened from 9.00am to 12.00noon.

g. “On-Call” services will be provided by pharmacy after office hours. However, it should be restricted to only the supply of life-saving items and new admissions in which medications are not available in wards.

2.0 ORGANIZATION & LOCATION

2.1 Organization

The Chief Pharmacist of the Hospital is responsible for the overall administration of all the units in the Pharmacy Department including the hospital pharmacy store. He/ She is responsible for the operating policies and procedures of the Hospital Pharmacy Department, its organization and manpower requirements, plans of action for financial allocations, supervision of various activities and the preparation of progress reports in meeting the objectives of the department.

a. Pharmacy Organization Chart (please refer attachment)

b. Operational hour of Pharmacy Department is 8am-5pm on working days. On call pharmacist and pharmacist assistant is available after office hour and will be scheduled on a weekly rotation basis. Out-patient Pharmacy is open 9am to 12noon on weekends and public holidays to cater for ETD patients, ward prescriptions and discharge patients. Out-patient Pharmacy remains open at lunch hour to ensure continuity of patient care.

c. All staff shall attend structured orientation program where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.

d. There are security requirements for the Pharmacy services that address to both facilities and staff protection including proper controls. Staffs are allowed to enter into pharmacy premises using access card or password. Staff from other units can enter if allowed by pharmacy staff.

e. All the patients and providers involved in performance improvement activities should remain anonymous.

f. All the complaint received from patient will go to Hospital Complaint Board. A hardcopy of the complaint form will be filed in pharmacy.

2.2 Location

The Pharmacy Unit is located in between Out-patient Department and Radiology Department. It is divided into 10 areas namely:

a. Out-patient dispensing
b. Counseling room
c. In Patient Area
d. Tablet pre-packing room
e. Internal extemporaneous room
f. External extemporaneous room
g. Sub store
h. Staff restroom
i. Chief Pharmacist room
j. Pharmacist Room (Drug Information Unit)
k. Prepacked Drug Store
l. Stationery Room

Logistic Pharmacy is a separate building located at the back of the hospital next to the mortuary.

3.0 CLIENT'S CHARTER FOR PHARMACY UNITS

3.1 Client's charter shall be prepared for each unit to meet the client's demand (please refer to attachment).

3.2 Client's charter shall be revised at least every two years or whenever there are changes.

3.3 Client's charter achievement shall be monitored every 6 months and the achievement for Jan-June & Jan-Dec is to be displayed for respective client's information.

4.0 MANAGEMENT OF HOSPITAL KANOWIT DRUG FORMULARY

4.1 Ministry of Health Drug Formulary (FUKKM)

4.1.1 DIS Unit will be responsible in updating Hospital Kanowit's Drug Formulary once a year (in hard copy) and every time when there is new listing or deletion (in softcopy).

4.1.2 Formulary updates shall be done via Drug & Therapeutics Committee (DTC) meeting of Hospital Kanowit as per meeting Term of References:

a. Committee members to consider listing of new medications that are approved in the FUKKM and quota items into hospital formulary (dossier D4 as in Guidelines for Submission of Dossier for Listing into the MOH Medicines Formulary)

b. Proposal of listing quota items into hospital formulary shall be presented and endorsed in DTC meeting whereby all committee members should sign the Declaration Letter of Conflict of Interest.

4.1.3 Hospital Kanowit drug formulary updated in hard copy must be approved by hospital director for record and reference in Pharmacy Unit. All Dossier 4 and Declaration of Conflict of Interest shall be filed together with the updated formulary copy.

4.1.4 Updated formulary shall be distributed to all pharmacy staff and Head of Units via email or QR code.

4.2 Special Approval Drugs (Quota items)

4.2.1 Procurement and use of drugs out of Hospital Kanowit Drug Formulary must obtain approval from hospital director by using the Quota Item Application Form.

4.2.2 Procurement of quota items is subject to budget availability.

4.2.3 DIS Unit will be responsible in processing all application and updates in the quota items list from time to time.

4.2.4 DIS Unit will inform the DTC committee members during every meeting the latest quota items list for Hospital Kanowit.

4.3 Use of Sample drugs

4.3.1 Medicines Access Schemes offered by pharmaceutical companies to Ministry of Health includes sample medicines, Patient Access Schemes (PASc) and Patient Assisted Program (Special Approval) (PAPSA).

4.3.2 Use of all sample medicines and MASc not available in FUKKM or indication not as per FUKKM must be approved by Director General of Health before they can be used on patients in Hospital Kanowit.

4.3.3 The receiving of sample drugs and MASc will be considered as "*hadiah*" and special approval as per instruction issued by *Jabatan Perkhidmatan Awam* in *Pekeliling Perkhidmatan Bilangan 3 Tahun 1998* must be obtained before they can be used on patients in Hospital Kanowit.

4.3.4 Use of sample medicines must be presented and approved during JKUT meeting before submission for approval from Director General of Health, by taking into consideration the financial impact, drug usage and continuity of care in the event the sample drugs or MASc are discontinued.

4.3.5 Pharmacy will assist in the application submission to Director of Health for approval and receiving of stock as "*hadiah*". Pharmacy will inform all stakeholder on the approval of application and a copy of approval will be forwarded to the applicant.

4.3.6 The maximum duration of application is 12 months, except treatment for cancer patients is not more than 6 months. Renewal of the application can be submitted by taking into consideration the budget impact to Hospital Kanowit.

4.3.7 Pharmacy will only keep the sample medicines and MASc that has gotten approval from Director General of Health.

4.3.8 Supply of sample medicines and MASc must be ordered by Specialist or Medical Officer using prescription. Prescriber must remark "SAMPLE" on the prescription. Pharmacy will only supply the sample medicine and MASc to patient with complete approval.

4.3.9 The efficacy and safety of using sample medicine and MASc must be monitored by prescriber and documented in patients' medical records. Any ADR after initiation of this sample drug must be reported to BPFK through proper documentation.

4.3.10 Prescriber must explain the terms of supply, possible risks and obtain patients' consent before starting patients on sample medicines/MASc. Patient consent form must be signed and kept in patient's medical record.

4.3.11 Hospital Kanowit is not obliged to ensure continuity of supply of sample medicines or MASc as it is subject to clinical condition of the patient and supply from pharmaceutical company. In the event the supply of sample medicine/MASc is discontinued, existing medicine in FUKKM list with the same indication will be prescribed to the patient to ensure patient's treatment will not be jeopardized.

4.4 Use of porcine based drugs

4.4.1 Use of drugs with porcine content shall comply to the *"Panduan Penggunaan Ubat-ubatan yang Mengandungi Unsur Tidak Halal"* published by the Pharmaceutical Services Division, MOH.

4.4.2 DIS is responsible in updating the List of medications with porcine content at least once a year and endorsed in DTC meeting.

4.4.3 Consent form for undergoing treatment using medications with porcine content [*Borang Keizinan untuk Menjalani Rawatan dengan Ubat Bersumberkan Khinzir (Pesakit Muslim)*] shall be signed by patients.

4.4.4 A copy of the completely filled form shall be filed with patient case note and one copy is to be given to the patient or caregiver.

4.5 Policy of List A Medication Application *(Permohonan Penggunaan Ubat Kategori A*/A oleh Pegawai Perubatan di Hospital/ Klinik Kesihatan yang Tiada Pakar)*

4.5.1 With reference to the "*Prosedur Operasi Piawai untuk Permohonan Penggunaan Ubat-ubatan Kategori A oleh Pegawai Perubatan di Hospital dan Klinik Kesihatan yang tidak Mempunyai Pakar" (PPUA) (2017),* medical officers, upon receiving verbal approval from specialist, may prescribe List A medication by filling in the "*Permohonan Penggunaan Ubat A (PPUA)"* form.

4.5.2 Specialist approval can be either be obtained via phone call or Whastapp chat. A snapshot of the Whatsapp conversation chat is required to verify the specialist approval.

4.5.3 Pharmacist shall receive and screen the form for its completeness and to query for further information if needed.

4.5.4 PRIC Pharmacist then shall record in the PPUA registry upon receiving and send the forms to referring facility to be signed by designated specialist.

4.5.5 The referring facility, upon receiving specialist signature, will send the completed forms back to the referred facility, which will be recorded and kept in folder as record.

5.0 GENERAL OPERATIONAL POLICIES

5.1 Prescription writing

5.1.1 In accordance to Poison Act 1952, Section 21 (1), all prescriptions must be written and signed by an authorized Specialist/ Medical Officer/ Dentist. Pharmacists should verify the authenticity of the prescriber via sample signature before proceed to dispensing.

5.1.2 All prescriptions should be completed with the particulars below:

a. Patient's name
b. Identity card number
c. Registration number
d. Age
e. Diagnosis
f. Prescriber's name and chop

Prescriptions with incomplete particulars will be sent back to the prescriber.

5.1.3 Prescriber's Category

Prescriber's category refers to the prescribers authorized to initiate the prescription for the medicine listed in the Ministry of Health Formulary.

A*	Pakar Perunding / Pakar bagi Indikasi yang Spesifik sahaja
A	Pakar Perunding / Pakar
A/KK	Pakar Perunding / Pakar / Pakar Perubatan Keluarga
B	Pakar Perunding / Pakar / Pakar Perubatan Keluarga / Pegawai Perubatan
C	Pakar Perunding / Pakar / Pakar Perubatan Keluarga / Pegawai Perubatan / #Anggota Paramedik
C+	Pakar Perunding / Pakar / Pakar Perubatan Keluarga / Pegawai Perubatan / #Anggota Paramedik/ #Anggota Paramedik Perbidanan
# Kumpulan Paramedik: Hanya boleh membekalkan ubat dengan/tanpa preskripsi dan tidak dibenarkan untuk menulis preskripsi berdasarkan surat Pemberian Kuasa di Bawah Peraturan 23A [No. Ruj: KKM.600-12/4/6 Jld. 2 (19) bertarikh 31 Oktober 2018]	

For medications under A, A/KK, A* prescriber category, countersignature and stamp by authorized specialist must be obtained.

For medications under C, C+ prescriber category, paramedics can initiate the medication but countersignature by Medical Officer must be obtained as soon as possible, not later than 24 hours.

5.1.4 All prescriptions should be written in generic name with acceptable abbreviation and trade name as approved in Hospital Kanowit JKUT meeting. List of Acceptable brand name & abbreviation will be revised at least once a year and to be approved in JKUT meeting.

5.1.5 Prescribers' sample signature will be updated from time to time in hard copy for reference by pharmacy staff.

5.1.6 Verbal orders

Pharmacy will accept verbal order from Medical Officer in emergencies/urgent situations only, whereby pharmacy will supply the medication first before receiving the prescription or appendix A (if applicable). However, prescription must be made available to pharmacy as soon as possible or within 24 hours.

5.2 Dispensing of medication

5.2.1 Pharmacy shall ensure Good Dispensing Practices as outlined in Guide to Good Dispensing Practice, first edition (2016) issued by Pharmaceutical Services Division, Ministry of Health is practiced at all time.

5.2.2 Work processes for dispensing shall include the following:
a. Screen the prescription
b. Enter prescription data into PhIS
c. Cross checking patient medication profile in PhIS
d. Fill the prescription
e. Counter check the prescription
f. Dispense the medication (Out-patients & discharge patients)

5.2.3 Flow charts for every medication dispensing processes must be updated, verified by Chief Pharmacist and displayed as easy reference by frontline staff.

5.2.4 Amendments or updates in medication dispensing processes must be informed to all pharmacy staff clearly.

5.2.5 Two medication safety practices shall be incorporated in dispensing process:

a. Crosschecking against the original prescription in all dispensing process
b. Practise Two-identifiers during screening and dispensing process.

5.2.6 Upon receipt of prescription, screening process shall comply to the following:

a. Administrative information on the prescription must be checked for completeness (name & identity card number, date, diagnosis, signature and stamp of prescriber)
b. Information of the medication must be checked for completeness (formulation, route of administration, name, dose, frequency, duration and special instructions eg location of application)
c. Patient’s home-based card or discharge note shall be routinely for prescriptions from Outpatient clinic or discharge prescriptions.

5.2.7 Transcribing of orders into PhIS must be carried out in accordance to standard operational procedures prepared by Pharmaceutical Services Division, MOH and MOH PhIS project team to ensure that medication safety is safeguarded at all time. *(Ruj: KKM.600-5/2/5 Jld. 7 (55) bertarikh 23 Nov 2016 susulan daripada perbincangan bersama Pengarah MSQH di Hospital Rehabilitasi Cheras pada 29 Julai 2016).*

a. Transcribing of orders by pharmacy staff is only a temporary work process until PhIS is fully integrated where prescriptions will be prepared online by Medical Officer.

b. Transcribing of orders into PhIS can only be done by pharmacy staff who have undergone user training and password access to PhIS with approval from Chief Pharmacist.

c. Crosschecking against the original prescription during order transcribing, filling and dispensing must be practiced in Outpatient & Inpatient Pharmacy work process.

5.2.8 Filling of prescription must comply to the following requirements”

a. Drug information on the prescription must be read completely (brand name, formulation and strength) so that correct drug is filled.

b. Attention must be given to counter stock drug bin label, especially with medication safety elements (Look-Alike & Sound-Alike and High Alert Medication).

c. Expiry date of medication must be checked to ensure the medications supplied to patients can be used until the next refill date or throughout the dispensed duration.

d. PhIS drug label must be sticked on the medication package or envelope tidily to ensure readability by patients.

e. Medications must be packed in condition to ease cross checking to be done by another pharmacy staff.

f. Expiry date of extemporaneous and galenical preparations must be written clearly on the drug label for patient’s knowledge and reference.

5.2.9 Dispensing of medications to patients can only done by qualified pharmacy staff, namely Fully Registered Pharmacist, (FRP) and *Penolong Pegawai Farmasi (PPF).*

5.2.10 Information of patient’s history of allergy towards antibiotics must be obtained during dispensing. Enquiry on patient’s allergic history on other medications are encouraged during dispensing also.

5.2.11 All outpatient prescriptions and medication charts shall be kept for two (2) years.

5.3 Supply and administration of medication

5.3.1 Supply of medications to patients and other health facilities must be in accordance of MOH or Sarawak State Health Department’s policies, and Hospital Kanowit’s internal policies decided during Drug & Therapeutic Committee meetings or Medical Advisory Committee (MAC) meeting:

a. Partial medication supply for 1 month to outpatients of Hospital Kanowit. *(Pekeliling Pengurusan Farmasi Bil. 1/2009: Garispanduan bagi Perbelanjaan Ubat-ubatan secara Berhemat, Bahagian Amalan &*

Perkembangan Farmasi KKM melalui surat BPF KKM Ruj: KKM-55/104/008/01(42) bertarikh 13 Jan 2009 dan Polisi Operasi Farmasi Ambulatori, Edisi 1 (2011) BPF KKM.)

b. *Surat JKN Sarawak Ruj: JKNSWK/F-5/02(21) Jld.5 bertarikh 15 Nov 2016: Isu Pengendalian Surat Rujukan (Salinan Kedua) dan Pembekalan Ubat kepada Pesakit yang telah Didiscaj untuk Meneruskan Rawatan di Fasiliti Kesihatan KKM.*

c. *Surat JKN Sarawak Ruj: JKNSWK/F-21-1/02(22) Jld.5 bertarikh 19 Mei 2017: Pembekalan Ubat untuk Klinik Lawatan Pakar di Fasiliti Kesihatan Negeri Sarawak.*

5.3.2 Supply of medications to wards/units and administration of medications to patients must be recorded according to requirements or respective locations:

a. Outpatient

i. Drug orders for outpatients in clinic and ETD shall be recorded in the clinic card, triage form or case notes before prescribing on prescriptions or medication charts.
ii. Administration of medications in outpatient clinic shall be recorded in the clinic card, while administration of medications in ETD shall be recorded in the triage form or medication chart.

b. Inpatient
i. Supply of medications to inpatients shall comply to *Garis Panduran Pembekalan Ubat Farmasi Pesakit Dalam, BPF KKM 2019 Edisi ke-3.*

5.4 Handling of Psychotropic Substances

5.4.1 Handling of psychotropic substances in Hospital Kanowit must be done in accordance to the following (please refer to the original policy for full description):

a. Poisons (Psychotropic Substances) Regulations 1989

b. Garis Panduan Pengendalian Bahan Psikotropik di Dewan Bedah Fasiliti KKM melalui Surat Pekeliling KPK Bil. 12/2016 melalui surat KPK Ruj: KKM.600-34/3/7 (7) bertarikh 26 Apr 2016.

c. Policy on Handling of Psychotropic Substances Hospital Kanowit

d. Handling of psychotropic substances includes indenting, receiving, storing, issuing, stock return, documentation and disposal process.

5.4.2 Pharmacist (PF) handling psychotropic substances will be officially appointed by Hospital Director.

5.4.3 Appointed pharmacists (PF) to handle psychotropic substances will also be authorized to hold psychotropic substances cabinet key.

5.4.4 Logistic Pharmacy needs to prepare psychotropic substance register book to receive stock from supplier and direct issue to Psychotropic substances Sub-store.

5.4.5 Psychotropic substances sub-store needs to prepare psychotropic substance register book to receive stock from Logistic Pharmacy and direct issue to Outpatient/Inpatient counter.

5.4.6 Psychotropic substances indent from user unit to Pharmacy must be submitted online via PhIS or Psychotropic substances indent form (BP1, HKWT/F-DD001).

5.4.7 Outpatient/Inpatient counter must prepare psychotropic substances register book for every type of psychotropic substances received and issued.

5.4.8 Psychotropic substances must be kept in locked cabinet in the room or in controlled area.

5.4.9 Transportation of psychotropic substances between pharmacy and user unit should be in locked bag where a copy of the key will be held by pharmacy and user unit respectively.

5.4.10 Prescription for psychotropic substances must be written by Medical Officer. Self-prescribing of psychotropic substances is strictly prohibited.

5.4.11 Supply of psychotropic substances to outpatient and discharged patients shall comply to the following:

a. Staff who receive the prescription at screening counter shall obtain patient’s address (can write on original prescription).
b. Pharmacist who is responsible in issuing the psychotropic substances must record the following information into psychotropic substance register book:

   i. Date of supply
   ii. Name, IC number and address of patient
   iii. Original prescription serial number
   iv. Name, strength, quantity of psychotropic substances supplied.

v. Stock balance
vi. Signature of the pharmacist doing the supply

5.4.12 Psychotropic substance indent day is on every Thursday. Psychotropic substance indents during after office hour is not encouraged and can only be supplied by pharmacist on call.

5.4.13 Administration of psychotropic substances can be done by Medical Officer, Staff Nurse or Assistant Medical Officer.

5.4.14 Product recall or product complaint shall be done in accordance to *Tatacara Pengurusan Stor Farmasi KKM* guideline.

5.4.15 Expired psychotropic substances or returned stock disposal shall be done in accordance of *Peraturan-peraturan Racun (Bahan Psikotropik) 1989*. All psychotropic substances disposal shall be witnessed and endorsed by Pharmacy enforcement officer.

5.5 Medication counseling

5.5.1 Provision of medication counseling services shall comply to:

a. Garis Panduan Kaunseling Ubat-ubatan, BPF KKM, Edisi 3 (2019)

b. Panduan Pengurusan Pesakit yang Dirawat dengan AntiTB, BPF KKM, 2017.

5.5.2 All PRP shall undergo annual peer-review validation as per MOH guideline and achieve a minimum of 90%.

5.5.3 Medication counseling shall include education to patient or caregivers on the drug usage instruction and explanation on drug indication, storage, side effects, how to overcome the side effects and other aspects related to the use of medication. Use of counseling aids eg. medication charts are encouraged.

5.5.4 Medication counseling can be done in counseling room, bedside or over the counter if there is no privacy issue.

5.5.5 All counseling records must be entered into PhIS.

5.5.6 Medication counseling brochures shall be updated from time to time.

5.5.7 Counseling devices (eg. Spacers) shall be kept clean and taken care by the pharmacist in charge of counseling room.

5.5.8 Referral for counseling is only accepted during office hour. Referral during after office hour and public holiday is not encouraged.

6.0 OPERATIONAL POLICIES FOR OUTPATIENT PHARMACY

The operational policies of Outpatient Pharmacy of Hospital Kanowit is in accordance of Operational Policies of Ambulatory Pharmacy 2022, second edition, published by Pharmaceutical Services Program, Ministry of Health Malaysia. The open dispensing counters allow the transparency and enable communication between staff and patients. Outpatient Pharmacy provides pharmaceutical care services to patients from Outpatient clinics, Emergency & Trauma Department, patient discharged from wards and Daycare patients (if any).

6.1 Provision of services in Outpatient Pharmacy

- Dispense medications
- Dispense psychotropic substances and Dangerous Drugs
- Value-Added services (Collect Later, Appointment Card System, *MyUbat*, SPUB)
- Extemporaneous preparations
- Prepacking to consumer packs
- Medication counseling
- Drug information services
- Medication Therapy Adherence Clinic (MTAC)
- Health promotion and patient education
- Adverse Drug Reaction and Allergy reporting and monitoring
- Smoking cessation pharmacotherapy services

6.2 Prescription shall be presented by the patients at the receiving counter. All prescriptions shall be screened by a pharmacist to ensure validity and correctness of prescriptions. Prescribers may be contacted to verify issues. Prescribers and paramedical staff involved in the management of patients will be expected to help resolve arising issues in prescriptions. Pharmacists can make remarks on the prescriptions with prescriber’s consent and verify the amendment on the front page of the prescription.

6.3 All the medications prescribed shall be reflected in the patient’s medication history. Pharmacists may write into the patients’ medication history to indicate issues such as changes to dose, compliance etc. as may be necessary for the information of the prescribers. Drug orders are not transcribed.

6.4 Patients shall be given instructions on usage of the prescribed medications and the precautions to be taken during dispensing by qualified pharmacist.

6.5 Dispensing of prescriptions containing psychotropic substance shall comply with Policy of Handling Psychotropic Substances of Hospital Kanowit.

6.6 All prescriptions from outpatient clinic should have the next appointment date (TCA) indicated on the prescriptions. Pharmacy reserves the right to reject prescription without next TCA date written.

6.7 Drug counseling shall be given to patients that are identified by doctors or selected by the pharmacist. Pharmacist should provide a proper explanation and instructions on the use and storage of medications. There are provisions of education and counseling as appropriate to patients and their families relating to medicines prescribed.

6.8 Prescriptions for drugs should not exceed six months while prescriptions that contain DD or psychotropics substances should not exceed 90 days. Validity of the prescription will start from the date the prescription was written.

6.9 Drugs for long term duration will be given based on the availability of stocks but not less than a minimum of one month together with a part supplied note with an appointment date for collection of further supplies. The pharmacy may in some cases further limit the supplies to less than the minimum of one monthly if stocks are in short supply. Patients who default collection of part supplied drugs may be referred back to the doctor for confirmation of the drugs and diagnosis. “Backorders” of uncontrolled drugs will not be supplied. If a drug is not supplied due to non-availability of stocks, it will be the onus of the patient to check periodically as regards to its availability. Patients may leave their contact numbers and patients may be contacted when drugs become available.

6.10 SPUB (Sistem Pendispensan Ubat Bersepadu) – Integrated Dispensing System has been implemented since Nov 2003. The SPUB will not be implemented for prescriptions from polyclinics within Kanowit area. Pharmacy also provides Collect Later and Appointment Card system for the convenience of patients.

6.11 Besides that, Pharmacy services offer Diabetes Medication Adherence Clinic (DMTAC) and Anticoagulant Medication Adherence Clinic (ACMTAC). DMTAC will be conducted every Wednesday while ACMTAC will be conducted on every Friday.

a. The conduct, training and documentation of MTAC services provided by Hospital Kanowit is with accordance to the following guidelines and manual:

   i. *Manual PhIS, Ver.1 (2015), BPF KKM.*
   ii. *Surat BPF JKN Sarawak Ruj: JKNSWK/F-21-1/02(27) Jld. 5 bertarikh 6 Jun 2017: Penambahbaikan dalam Pengurusan Latihan dan Pelaksanaan Perkhidmatan Farmasi Klinikal Negeri Sarawak.*
   iii. Latest MTAC protocols (available from Pharmaceutical Services Division, MOH website).

b. All MTAC program activities must be conducted in accordance to the latest MOH protocols. MTAC protocol used in the hospital must be endorsed by Hospital Director and Chief Pharmacist for pharmacist reference during the provision of MTAC services.

c. All MTAC pharmacist must apply for privileging to Hospital Credentialing & Privileging Committee once fulfill the hospital level application criteria.

d. All MTAC clinical documentations must be entered into PhIS.

e. Internal audit on the clinical documentation shall be done at least once a year.

6.12 Corridor prescriptions

Every patient must get themselves registered at the Out-patient Counter together with their home-based card. All prescriptions should be reflected in the medication history records. Corridor prescriptions will not be entertained.

6.13 Supply of medications to foreigners

a. Supply of medications to foreigners in Ministry of Health facilities should be in compliance with Director General of Health's letter with reference Ruj:KKM-55/BPF/104/012/10 Jld.9 (41) dated 31st March 2014.

b. Medications supplied to foreigners with Non-Communicable Diseases (NCD) by facilities under Ministry of Health should be restricted to five (5) days only.

c. Full supply of medications to foreigners (not limited to five days) is subject to criteria stated in Director General of Health's letter with reference: Ruj.KKM-600-34/3/7 (37) dated 15th September 2016.

7.0 OPERATIONAL POLICIES FOR PHARMACY RESOURCE & INFORMATION UNIT (PRIC)

PRIC pharmacist is in charge of two different services, i.e. Drug Information Service and Quality Service.

7.1 PRIC Unit is responsible for the following activities:

a. Drug & poison information delivery
b. Drug & poison information dissemination
c. Preparation of reference to drug & poison information
d. Handling of drug allergy and adverse reaction
e. Handling of medication errors reporting

7.2 Policy on drug enquiry

a. Upon receiving query from enquirer (Doctor/Staff Nurse/ other health professions /Public), always obtain the enquirer's particular eg. name, address (ward/ unit), contact number & profession.

b. Always classify the query and obtain the necessary background information. E.g. body weight, age, drug allergic, co-morbidity, etc.

c. Always assign priority to the query according to the urgency of the problem so that pharmacists are able to respond accordingly to avoid complaint from the enquirer.

d. Any enquiry for medication history tracing within the hospital facility shall be done by PRIC pharmacist based on current procedure. Enquiry on medication history tracing from other facilities shall be attached with CP4 form.

e. Our standard response time is 30 minutes for all urgent cases, while for non-urgent cases response time must not be more than 24 hours from the time we receive the enquiry until we feedback to the enquirer.

f. Always search for the information systematically through books, database, computer etc. Always use the well-established guidelines and references.

g. Always formulate the appropriate response/ answer, and provide alternative recommendation to the enquirer if necessary.

h. Communicate the response to the enquirer orally or in written form.

i. Always check with the enquirer whether the information provided is appropriate or not.

j. All query information needs to be recorded in PhIS as per protocol.

7.3 Policy and Procedure on Adverse Drug Reaction (ADR) & Adverse Event Following Immunisation (AEFI) reporting

a. All completely filled ADR & AEFI form needs to be submitted to DIS for further action.

b. Procedure of ADR reporting:

   i. Receive ADR report form from medical officers or pharmacist who encounters ADR case in pharmacy or wards.

   ii. Check the completeness of the ADR report form received. Ensure all the ADR forms are signed and stamped by the ADR reporter.

   iii. Contact the reporter if more information is needed.

   iv. Pharmacist should interview the patients for ADR cases encountered over the pharmacy counter.

v. If any of these basic elements remain unknown, a report on the incident should not be submitted because reports without such information make interpretation of their significance difficult, at best, and impossible in most instances.

vi. If the ADR case is an allergy case, an allergy card will be issued upon completing the allergy card request form by Medical Officers.

vii. Pharmacist will compile and report the ADR case online through PhIS system. PhIS system will send the complete ADR report form to Biro Pengawalan Farmaseutikal Kebangsaan (BPFK) through NPRA system.

viii. Concurrently pharmacist will report the ADR cases to JKNS via google form.

c. The hard copy ADR form will be filed and kept with pharmacy department for three (3) years. ADR forms more than 3 years will be disposed with approval from *Arkib Negara.*

7.4 Procedure of Allergy Card Request

a. When the ADR case is an allergy case, medical officers are required to fill the section A to C of the "*Borang Permohonan Kad Alahan*".
b. The form shall then be sent together with the ADR form to pharmacy for verification.
c. After the allergy card request is successful, the pharmacist shall sign as approved and make an entry to the PhIS and manual form.
d. The allergy card is then written and given to the patient while explaining its main purpose and to bring whenever the patient visits any health facility outside.
e. An allergy sticker will be pasted on the patient home based card as well.
f. Any request for allergy history record tracing shall be accessed via IWP PhIS by PRIC Pharmacist-in-charge.

7.5 Policy & procedures on medication errors reporting

a. Medication errors (ME) shall be reported in accordance to Guideline on Medication Error Reporting, Edition 2 (2019), BPF KKM.

b. Actual ME refers to medication errors occurred and reached the patient. If the error is detected by the patient, it is considered as actual error.

c. Near miss ME refers to medication errors that has the potential to cause an adverse event but did not reach the patient because of chance or because it is intercepted in the medication use process. If the healthcare personnel detected and corrected the error before it reached the patient, it is considered as near miss.

d. All category of staff in the hospital can report ME.

e. All completely filled ME reports shall be send to PRIC Unit for further action. Unit PRIC is responsible for determination of ME outcome category and data entry of ME report into Medication Error Reporting System (MERS) online via website: https://mers.pharmacy.gov.my).

f. For near-miss ME detected by pharmacy staff at the dispensing counter before medications are dispensed to the patient, QAP1 report has to be filled in and submitted to MERS online.

g. All ME reports shall be recorded in the Incident Reporting (IR) regardless of near miss or actual errors and IR forms are to be sent to Quality Unit of the hospital for their further action. Root cause Analysis (RCA) will be conducted based on severity of the incident decided by Hospital Quality Unit.

h. ME reports should be analyzed and presented in Pharmacy Unit Management meeting in a timely manner.

i. Educational session on ME reporting should be conducted at least once a year to all hospital staff (eg. CME, CNE, Medication safety awareness week).

7.6 Confidentiality of patient information:

a. All reports submitted to the authority are treated as being confidential and reporters are not required to divulge the identity of the patients involved.

8.0 OPERATIONAL POLICIES FOR IN-PATIENT PHARMACY

The supply of in-patient medications shall be in accordance to *Garis Panduan Pembekalan Ubat Farmasi Pesakit Dalam, BPF KKM 2019 Edisi ke-3.* The supply of in-patient medications in Hospital Kanowit are as following:

8.1. Complete Floor Stock (including after office hour and emergency trolley medication):

a. All Floor Stock indents must be sent to pharmacy via PhIS. Hard copy requisition voucher shall only be sent to pharmacy for emergency supplies during weekends/public holidays. Requestor for floor stock indent should be a

Staff Nurse or Assistant Medical Officer while the approver for the indent should be a Nursing Sister, Chief Medical Assistant.

b. For Emergency and Trauma Department, PhIS indent or requisition voucher must be sent together with prescriptions in accordance to the items ordered in the requisition voucher.

c. After receiving the online indent, Pharmacist or Pharmacist Assistant shall screen the indent. Manual requisition vouchers should be complete with date and signature of Medical Officer who approved and Staff Nurse who requested it. If there is any List A items, Lampiran A must be sent to Pharmacy with every indent.

d. Pharmacist or pharmacist assistant need to make sure that floor stocks requested is not more than the maximum quantity of floor stock allowed.

e. Pharmacist or pharmacist assistant need to determine the quantity supplied based on the stocks level.

f. For cough and cold preparations which are listed as Floor Stock in Emergency and Trauma Department, Assistant Medical Officer must consult Medical Officer before prescribing the medication to paediatric patients aged 2-6 years old. Therefore, cough and cold preparation prescriptions for 2-6 years old paediatric patients prescribed by Assistant Medical Officer must be countersigned by Medical Officer.

g. Serial number and the number of items supplied to ward will be recorded accordingly in the Floor Stock Registration File and the voucher itself.

h. Pharmacy shall keep the original copies of the voucher, and the wards shall keep the carbon copies.

8.2 Supply of Psychotropic Substances/Dangerous Drugs (DD) to ward:

a. The supply, use, recording and disposal of dangerous drugs should comply with the Policy of Handling Psychotropics Substances Hospital Kanowit. The Pharmacist-in-charge and the ward nurse in charge shall ensure that dangerous drugs are managed properly.

b. Dangerous drugs shall be indented by the wards and department on every Thursday.

c. Staff nurse will maintain the record of usage of DD in the wards. All indenting of DD shall be done by a MO/NS/SN/MA/CMA only.

d. Procedure for Psychotropic Substance/Dangerous Drug supply:

i. Receive indent form together with prescriptions via PhIS, Ward DD (Dangerous Drug) record book on DD indent day (Thursday) and empty DD ampoules, or by patient order with the prescription "*Helaian pendua*" (for those medications not in floor stock). If there is any List A Items must attached with Appendix B upon every indent.

ii. Check the usage in record book and contact staff nurse for any discrepancies or further clarification. In the event of broken ampoule or vials, BP4 form with or without incident report shall be submitted together to the pharmacy, and the waste need to be collected in a biohazard plastic bag.

iii. Record the serial number and quantity supplied in the pharmacy DD register book, indent voucher/Kew-PS.7, and ward DD record book in the respective pages or column for which drug is specified.

iv. For the case of indent by patients name and the DD is not floor stock, pharmacy staffs need to generate the serial number and record into the prescription "*Helaian pendua*".

v. All expired psychotropic substances must be returned to pharmacy for proper disposal under witness by Pharmacy Enforcement Officer.

vi. Make sure the collecting staff counter check again all the items and quantity supply and sign at the indent voucher to avoid any medication errors.

vii. File the copy of indent voucher/ Kew-PS.7.

8.3 Unit Dose System (UDS):

a. Ward supplies will be based on UDS system (daily supply). For medications that are not suitable to be supplied by UDS system (eg. syrups,inhalers), Unit of Use (UoU) system will be used.

b. For UDS system supply, medication trolleys along with the carbonized prescription copy (*Helaian Pendua*) written by Medical Officers will be brought to Inpatient Pharmacy for filling before 10am everyday (except during weekends and public holidays) for Male and Female Ward, while Maternity and Paediatric Ward's trolleys will be sent in before 3pm everyday (except during weekends and public holidays). The standard UDS filling time for medication trolleys is two (2) hours.

c. All prescriptions must be screened by pharmacists. If there is any query, pharmacists need to call the Medical Officer to confirm on their amendment.

d. All medications will be supplied daily, except for syrups, new prescriptions and supply over the weekends/public holidays. For new prescriptions, pharmacy will supply the remaining doses for the day itself, plus additional 1 dose for coming early morning for Male and Female Medical Ward. For Maternity and Paediatric Ward, medications will be supplied as above-mentioned but 2 extra doses will be given instead of 1. For weekends and public holidays, we will supply the medications the day before till next working day.

e. All in-patient prescriptions will be valid for 7 days only. In-patients requiring long stay, prescriber needs to prescribe new order for long standing medications for nurses' medication administration records and pharmacy supply records.

f. Procedures of UDS supply:

   i. Receiving the prescriptions "Helaian pendua", advice notes, and medication cart.

   ii. Pharmacists will screen the prescriptions, advice notes and UDS record files.

   iii. Update current patients' records and medication.

   iv. Arrange the prescriptions according to patient's bed number and file into the UDS record file. For discharged patients, remove their profiles from the UDS record file.

   v. One bin is allotted per patient. Each bin must be filled with the medication prescribed, with the correct quantity based on the prescription and in accordance with the administration times.

   vi. The medications of each patient shall be labeled with patient's name, name and strength of the drug and date of dispensing.

   vii. All supplies of medications shall be recorded in patients' medication prescriptions and tally cards.

   viii. All the trolleys filled need to be counterchecked by another staff.The staff needs to make sure the dose, frequency and the quantity supplied to each patient are correct.

   ix. Staff nurse on duty should check the medications received and inform the pharmacy if there are any discrepancies. After checking the medication supply, staff nurse should acknowledge receipt by signing the receipt column of the prescriptions.

x. Make sure the medication cart is taken back to the ward as soon as possible before 12pm for the morning session and 5pm for the afternoon session.

xi. Transcribe the prescriptions in PHIS system.

xii. Same procedure for all the new prescription that sent in after the medication cart sent back to wards, except without using the medication cart. Individual patient bins in the medication trolley have to be sent together with the prescriptions to Inpatient Pharmacy for UDS filling.

xiii. For cases admitted after office hours, medication from the Floor Stock/ After Office Hour shall be used and recorded in the medication chart. If there is a need of medication(s) other than floor stocks or AOH medication, on call pharmacist should be informed.

xiv. An updated list of patients' name should be sent to pharmacy after wards round. This will enable the pharmacy to manage the supplies accordingly.

8.4 Patient's Own Medicines (POMs):

a. POMs is defined as the medications prescribed or self-purchased by patients and are brought into the hospital during hospitalization.

b. It is responsibility of hospital staff to inform patients or family members to bring their own medications to the hospital as soon as possible during admission orientation so that healthcare personnel can conduct medication reconciliation for continuation of care. However, complementary medicines such as traditional medicines and supplements are excluded from POMs in view of the difficulty in identifying the content and indication.

c. Medical Officers are responsible to prescribe POMs in patient's medication chart for Staff Nurse to supervise and record drug administration in wards. These prescriptions should be noted with "Patient Own Medicines/POMs" on the prescription in both the ward copy and pharmacy copy. With the remark, pharmacy will not supply the POMs medications to prevent wastage.

d. However, pharmacy will still supply medications which are available in our hospital formulary during patient admission if necessary (eg. POMs are not in good condition upon medication reconciliation).

e. Patients need to return their medications and pharmacy will resupply to them upon discharge.

f. Administration of POMs medications by patient himself/herself in ward (eg, inhalers and insulins) must be supervised by Staff Nurse on duty.

g. If there is any doubt, Pharmacist or pharmacist assistant need to call for confirmation.

8.5 Under the Antimicrobial Stewardship Program, controlled antibiotic order must be initiated by authorized prescriber. Completely filled IPD Antibiotic Monitoring Form shall be attached together with antibiotic prescription before sent to pharmacy.

8.6 Medications that may be administered by the Nursing staff without a medical practitioner's order:

a. One gram stat dose of Paracetamol will be given to patients without prescription and verbal ordered by the Medical Officer for the purpose of pain management right after delivery.

8.7 Calling Order from wards:

a. Pharmacy will accept verbal order from **Medical Officer** in emergencies/urgent situations only, whereby pharmacy will supply the medication first before receiving the prescription or appendix A (if applicable).

b. This including Dangerous Drug supplied.

c. Emergency or code blue situation are as below but not limited as below: (Final decision will go to the pharmacist on call)

   i. Insufficient floor stock. (e.g. Dangerous Drug and appendix A item--IV Midazolam use for intubation)
   ii. The item is not included in the floor stock and urgently needed. (e.g. IV Pantoprazole, given during intubation)

d. The person responsible needs to make sure that the required documents are sent to pharmacy **within 24 hours**.

e. If there is any doubt, Pharmacist need to call for confirmation.

f. All verbal orders must be transcribed into PhIS system once the prescription is available, within 24 hours.

8.8 Over-the-counter and bedside dispensing

a. Pharmacy provides over-the-counter dispensing and bedside dispensing services to patients discharged from wards.

b. Bedside dispensing service is available between 8.00am to 12noon and 2.00pm to 4.00pm on working days. Pharmacy does not provide bedside

dispensing service on weekends and public holidays and patients/caretaker will need to collect discharge medications from Out-patient Pharmacy counter during the operational hours.

c. Supply of discharge medication after office hour is strongly discouraged to prevent the risk of medication errors. Should the supply of discharge medication is warranted during after office hour, on call pharmacist has to be contacted and PPF on call will come to supply the medications (except psychotropic substances). On call pharmacist will need to remotely screen and verify the supplied medications by the PPF before dispensing.

d. The procedures for receiving discharge prescriptions are as following:

i. Received discharged prescription.

ii. Screen the prescription for any pharmaceutical care issues (PCI). Contact prescriber if there are any queries that need clarification.

iii. Transcribe the prescriptions in PhIS. Print the label after transcribing.

iv. Record the amount supplied on the tally card if required.

v. Fill the medication as prescribed and paste the label to the respective medication.

vi. Counter checked by other staff. (During on call, supplying PPF will need to snapshot the medications filled to on call PF for verification)

vii. Dispense the medication to discharge patient either over the counter or at bedside and provide counseling.

viii. Reassess patient's knowledge to make sure they are capable to take the medications correctly and/or use the medical devices competently.

ix. Sign and file the prescription.

x. Record the counseling in PhIS system.

9.0 OPERATIONAL POLICIES FOR MANUFACTURING & PREPACKING

9.1 This activity includes the manufacturing of galenical preparations and prepacking of medicines.

9.2 All manufacturing procedures (preparation, handling, quality control, labeling, storage, disposal) in pharmacy must comply to Policy On The Use Of Standard Formulation of Extemporaneous/ Galenical/ Sterile Preparation & Practice, Good

Compounding Practice, Policies & Procedures On Infection Prevention and Control, and existing standard operating procedures to ensure the quality of end products.

9.3 Manufacturing process should follow the following infection control and prevention procedure:

a. Prepare the worksheet.

b. Prepare the batch number and record into the manufacturing book (only apply to galenical preparation).

c. Clean the container and rinse the container with distilled water before preparing any galenical product.

d. Wash and rinse all the apparatus with distilled water before the preparing any galenical product.

e. Wash the hands following the standard procedure.

f. Put on personal protective equipment (PPE) such as face mask, glove, apron, and hair cap before and throughout the manufacturing process.

g. Spray alcohol 70% on a gauze, and wipe the surface of preparation area with the direction of “Z”

h. Put a layer of tissue paper on the surface preparation site and all the manufacturing procedure are done on top of that tissue layer (only apply to extemporaneous preparation).

i. Store the end product into the container, and label it immediately.

j. Label the name and strength of the medication, the expiry date and batch number (only apply to galenical preparation).

k. Take three samples of the preparation for sterility testing (only apply to galenical preparation).

l. Quarantine the whole batch until the product passes the sterility test (only apply to galenical preparation)

m. Record in PHIS system.

9.4 All preparations (galenical & extemporaneous) must be prepared with reference to a valid master formula and updated at least once a year.

10.0 OPERATIONAL POLICIES FOR WARD PHARMACY

10.1 Ward pharmacist need to do medication reconciliation for all newly admitted patients via medication history assessment using CP1 form. Original copy of the CP1 needs to be attached with patient’s case note while the carbonized copy should be kept with ward pharmacist to make entry into Pharmacy Information system (PhIS).

10.2 Patient's case must be clerked using CP2, by going through patient drug profile. All relevant particular in CP2 must be recorded down for future references. All CP2 need to be documented in PhIS.

10.3 During the clerking process, pharmacist must screen patient case notes, and patient drug profile for any pharmaceutical care issue (PCI), such as inappropriate dose, frequency, duration of therapy, drug, route of administration, or insufficient dose, frequency, drug regime, duration, and etc. All interventions must be documented in PhIS.

10.4 Follow medical officer ward round on daily basis to:

a. Identify any PCI and do intervention on the PCI
b. Interact with the medical officer regarding the medication therapy to maximize outcome
c. Inform and identify any adverse drug reaction, and drug-drug interaction.
d. Provide information for appropriateness in selection of medication.
e. Answer medical officer or nurses' query and try to give them a proper solutic

10.5 Do counseling and assessment to all patients that required it or requested by medical officer, and all counseling must be documented in PHIS

10.6 If there is any ADR occurs, ward pharmacist needs to prepare the ADR report, and prepare the allergic card for patient.

10.7 Ward pharmacy is responsible to achieve the yearly KPI target set by MOH. Ward pharmacy achievement report must be compiled every three months. CP1, CP2 and CP3 reports must be kept, documented and filed in PhIS.

10.8 Drug Reconciliation Policy

Patient's medication list including drug name, dosage, frequency and route need to be updated in accordance to prescriber's order and patient's latest medical record at all transition points within the hospital.

10.9 Policy of POM use

a. Patient or caregiver is required to bring all his/her own medications to hospital during each admission. Staff nurse needs to provide a brief explanation regarding POMs to patient during patient's orientation session in ward.

b. POMs will only be implemented on patient after receiving consent from patient/ caregiver.

c. Pharmacist or pharmacist assistant need to make sure the medications are in good conditions during admission or once medications are brought to hospital. Ward

pharmacist will check the medications and record in CP1 form. A copy of CP1 will be kept in patient's case note.

d. POMs shall be under the supervision of healthcare workers to avoid medication errors.

e. Staff nurses need to provide a POMs storage area in ward, according to the proper storage procedures. POMs should be clearly labeled with the patient's name and his/her registration number.

f. Patient should be informed clearly as follows:

    i. POMs will be evaluated in terms of suitability and given based on patient's current clinical condition.

    ii. The POMs will be given back to patient during discharge if the treatment regimen is continued as previous. Self-purchased POMs will be returned back to patient upon discharge despite the treatment is discontinued in ward.

    iii. Extra POMs will be returned back to in-patient pharmacy during discharge if the treatment regimen shortened or changed.

    iv. Patient is not allowed to take/use POMs in ward without medical professional's permission.

g. Pharmacist or pharmacy assistant need to clearly record down the amount of POMs and remainder of POMs returned to the patient or caregiver once patient discharged.

11.0 OPERATIONAL POLICIES FOR CYTOTOXIC DRUG RECONSTITUTION

11.1 Pharmacy department **does not** provide in house cytotoxic drug reconstitution services. All cytotoxic preparations required will be reconstituted by CDR unit of Hospital Sibu and dispatched to Hospital Kanowit.

11.2 Pharmacy department will ensure that the chemotherapy is delivered to the patients safely by following proper procedures and to protect healthcare personnel from inadequate safe practice of handling cytotoxic drugs.

11.3 The decision to initiate a chemotherapy treatment should only be made by a qualified oncologist, gynaecologist, haematologist or paediatric oncologist. Kanowit Hospital should only cater patients who wish to complete the remaining course(s) of his/her chemotherapy following the initiation course with the approval from the state oncologist.

11.4 All the patients should be treated according to the established chemotherapy protocols and variances from protocols should be monitored. For that reason, a specific patient-tailored protocol should be obtained prior to each course of chemotherapy.

11.5 CDR preparations to be ordered on the day patients come for chemotherapy before 10am to CDR Pharmacy Hospital Sibu if patient's blood taking day is on chemo day itself (applicable to both patients whom will be discharged on chemo day or the following day).

11.6 Collection of CDR preparations from Sibu Hospital shall be arranged by Kanowit Hospital and shall be done by personnel trained for Cytotoxic Drug Spillage Management.

11.7 Collection shall be done at Sterile Production Pharmacy of Sibu Hospital by 12:30 (Mon-Thurs) or 11.25am (Fri). Cool box, ice packs and Chemo Spillage kit that are needed for transportation shall be prepared by Kanowit Hospital Pharmacy Unit.

11.8 Spill kit should be made available for immediate use. All personnel should know the location of spill kit and trained in the management of cytotoxic spill. Spill kit will be prepared and replenished by Pharmacy Unit.

11.9 Cytotoxic waste, including used consumables, PPEs, infusion bottles and contaminated body waste should be disposed properly. Sharps should be discarded into yellow sharp bin and the rest of the cytotoxic waste should be thrown into yellow clinical waste bag.

12.0 OPERATIONAL POLICIES FOR CLINICAL PHARMACOKINETICS SERVICES

12.1 Clinical Pharmacokinetic Services shall be conducted in accordance to Policy & Guidelines Clinical Pharmacokinetic Services, 1st edition (2015) BPF KKM, and Clinical Pharmacokinetics Pharmacy Handbook, second edition 2019.

12.2 Pharmacy Unit of Hospital Kanowit does not provide in house analysis for Therapeutic Drug Monitoring (TDM) samples and all samples will be sent to Hospital Sibu. The CPS provided by Pharmacy Unit of Hospital Kanowit includes calculation and interpretations of TDM results and give recommendations on necessary dosage adjustments.

12.3 Effective from August 2020, Pathology Department of Hospital Sibu runs the analysis of TDM samples and results will be dispatched to Pharmacy Department, Hospital Sibu. Once the results are available, Hospital Sibu pharmacist will report the result to Pharmacy Unit of Hospital Kanowit through PhIS.

12.4 CPS is provided to outpatients, warded and ETD patients of Hospital Kanowit.

12.5 Procedures for requesting CPS:

a. Prescriber to identify patient that requires TDM and to fill in the TDM request form (v1 Year 2022). Carbonized copy of the TDM form is **NOT** accepted to prevent request error.
b. For Outpatients, prescriber will send the patient to OPD pharmacy together with the request form.
c. For warded or ETD patients, prescriber need to contact the clinical pharmacist or in-patient pharmacist on the TDM request for verification during office hour. Meanwhile, after office hour requests should be directed to on-call pharmacist.
d. Pharmacist will screen the request form to ensure the form is complete with the following information:
    i. Patient's name, identification number, body weight
    ii. Latest laboratory investigation results
    iii. Patient's current state or condition, such as frequency of fitting and patient's compliance level.
    iv. Present dose regime and date started, date and time of last medication administration.
    v. Indication of TDM, such as therapeutic level monitoring, toxicity or compliance investigation.
    vi. Concurrent medication
    vii. Signature and stamp of prescriber.
e. Pharmacist shall contact the prescriber who requested for the TDM investigation if there is any doubt.
f. TDM investigation which does not fulfill the requirements will be rejected (not limited to below):
    i. Incorrect blood sampling time
    ii. High possibility of non-compliance to medication
    iii. Medication taken by patient still not reaching the steady state
    iv. Incomplete laboratory investigations.
g. Pharmacist will send the TDM request form to TDM Pharmacy, Hospital Sibu through PhIS.
h. After receiving blood sample in Pathology Unit, the lab personnel need to make sure patient's name and identification number are attached to the test tube.
i. Serum will be extracted from the blood sample through centrifugation and kept in fridge while waiting for transportation arrangement to Hospital Sibu.
j. All serum samples shall be attached with TDM request form, kept in a container with sufficient ice packs to maintain cold chain during transportation to Pathology Department, hospital Sibu.
k. TDM results will be informed by Hospital Sibu through PhIS within 24 hours from the time the serum samples reached Pathology Department of Sibu Hospital.

l. Pharmacist will calculate and interpret the results received from Hospital Sibu, and feedback recommendations to the requester within 24 hours from the time the TDM results were notified to Hospital Kanowit through PhIS.
m. A photocopied TDM request form with results and recommendations will be send to OPD/ward/ETD and kept in TDM file.
n. All documentations will be entered into PhIS and hard copy forms will be filed.

13.0 OPERATIONAL POLICIES FOR PRESCRIBING ANTIBIOTICS

13.1 Prescribing of Antibiotics in Hospital Kanowit shall comply with the following guidelines:

a. Policy & Procedures for Antibiotic Prescribing in Hospital Kanowit
b. Policy & Procedures for Antimicrobial Stewardship Committee Team in Hospital Kanowit
c. National Antibiotic Guideline 2019
d. Revised Policy of List A Antibiotic Usage in Non-Specialist Facilities in Sarawak, [JKNSWK.BPF.600-24/2/4 (61) Jld.3 dated 12th June 2023]
e. Protocol On Antimicrobial Stewardship (AMS) Programme in Healthcare Fcilities, Second Edition 2022.

13.2 Antimicrobial Stewardship Program in Hospital Kanowit is formulated based on the following core strategies:

a. Surveillance and feedback mechanism on specific antimicrobial consumption.
b. Implementation of prospective audit and feedback according to local needs.
c. Establishment of formulary restriction and preauthorization/approval system.
d. Establishment of antimicrobial order tools for restricted antimicrobials.
e. De-escalation/streamlining the antibiotic usage.
f. Antimicrobial selection and dose optimization of the antimicrobial.
g. Initiation of intravenous (IV) to oral (PO) switch program.

13.3 All inpatient and outpatient antibiotic prescriptions shall be attached with Antibiotic Monitoring Form.

13.4 Usage of List A antibiotics in Hospital Kanowit shall strictly follow the updated Policy of List A Antibiotic Usage in Non-Specialist Facilities in Sarawak [JKNSWK.BPF.600-24/2/4 (61) Jld.3 dated 12th June 2023]. Initiation of STAT dose List A antibiotics shall be based on clinical judgment.

13.5 Identify antibiotics that need to get verbal or “whatsapp” approval within 24 hours. Fill in the “Lampiran A” completely with name of specialist, time, and date of referral and send the form to pharmacy.

13.6 Failure to obtain verbal approval from specialist will render the discontinuation of antibiotic supply from pharmacy after 24 hours.

13.7 Antimicrobial prescribing must be reviewed not later than 72 hours after it has been initiated and de-escalated to narrow spectrum agents promptly when appropriate or based on microbiology results.

13.8 Prescribing Policies for List A antibiotics as stated in Policy of List A Antibiotic Usage in Non-Specialist Facilities in Sarawak [JKNSWK.BPF.600-24/2/4 (61) Jld.3 dated 12th June 2023] as following:

No	Antibiotics		Prescribing Policies
1	Carbapenems	Imipenem Inj Meropenem Inj Ertapenem Inj	i. The use of Carbapenem is allowed for patients discharged from referral hospitals for **continuation of treatment** after referral to ID Physician/AMS team if duration of treatment is more than 72 hours. ii. Pharmacy from referral hospitals need to supply sufficient stock until completion of treatment in hospital without specialist.
2	4th Generation Cephalosporin Or Extended spectrum penicilin	Cefepime Inj Or Piperacillin/ Tazobactam Inj	i. The use of Cefepime or Pip/Tazo is allowed for patients discharged from referral hospitals for continuation of treatment. Pharmacy from referral hospitals need to supply sufficient stock until completion of treatment in hospital without specialist. ii. The availability of Cefepime or Pip/Tazo for initiation is subjected to hospital antimicrobial policy with the input from AMS team of referral hospital. • Pharmacy is allowed to keep minimum standby stock for the purpose of **STAT DOSE** prior transfer to specialist hospital. • The initiation of **STAT DOSE** is **STRICTLY** by consulting specialist from referral hospitals based on approved indications and prescribing restrictions. However, if continuation of treatment in these hospitals is required, it MUST be under

			instruction/approval of the specialist of the referral hospital. • AMS activities need to be implemented such as AMS round, antimicrobial order tools, 72 hours antibiotic review for this restricted antibiotic. • Referral to ID physician/AMS team from referral hospital is required if the duration of treatment is more than 72 hours.
3	Quinolones	Ciprofloxacin Tab/inj	i. Criteria for Use: • For patient which is allergic to penicillin (severe allergic reaction eg Anaphylaxis, bronchospasm) or cephalosporins. • Can be used in complicated UTI. Convert to oral once patients tolerate orally or at least after 7 days (whichever comes first). ii. Referral to ID physician /AMS team form referral hospital is required if the duration of treatment is more than 1 week. iii. Based on clinical judgment to initiate **STAT** dose and **MUST** obtain approval of use from specialist in referral hospital via PPUA. iv. IV to oral switch does not require further approval as long as the use of the same antibiotic in IV form has been approved.
		Levofloxacin Tab/Inj	i. The use of levofloxacin inj /tab is only allowed for patients discharged from referral hospital for continuation of levofloxacin treatment in Non-specialist Hospital. ii. Pharmacy from referral hospital to supply sufficient stock until completion of treatment in district hospital.
4	3rd generation Cephalosporins	Ceftriaxone Inj Cefoperazone Inj Ceftazidime Inj	i. Initiation of treatment is based on approved indications and prescribing restriction at respective hospitals.
5	Broad spectrum penicilins	Amoxycillin/ clavulanate inj	

		Ampicillin/ Sulbactam inj	ii. Based on clinical judgment to initiate STAT dose and MUST obtain approval of use from specialist in referral hospital via PPUA. iii. AMS activities need to be implemented iv. IV to oral switch does not require further approval as long as the use of same antibiotic in IV form as heen approved.
6	2nd generation cephalosporin	Cefuroxime Inj	
7	Broad spectrum penicillins	Amoxycillin/clavulanate Tab/suspension Ampicillin/Sulbactam Tab/suspension	i. Initiation of list A oral antibiotic is based on approved indications and prescribing restriction at respective hospitals. ii. **MUST** obtain approval of use from specialist in referral hospital via PPUA.
8	2nd generation cephalosporins	Cefuroxime Tab	

14.0 OPERATIONAL POLICIES FOR LOGISTIC PHARMACY

14.1 Logistic Pharmacy services should comply with the policy as following:-

a. *1Pekeliling Perbendaharaan (Am 6/2014 – Tatacara Pengurusan Stor), Kementerian Kewangan Malaysia.*
a. Garis panduan Pengurusan Stor Farmasi di Hospital & KK di KKM, BPF KKM, 2014.
b. Garis panduan Pengurusan Farmasi Logistik Kementerian Kesihatan Malaysia, Edisi 1, 2020
c. Garis panduan Pengurusan Produk Rangkaian Sejuk di Fasiliti Kementerian Kesihatan Malaysia,2019
d. Surat BPF JKN Sarawak Ruj: JKNSWK/F-21/1-03/(74) Jld. 14 bertarikh 18 Mac 2016: Pelaksanaan Pemeriksaan Mengejut di Bawah Arahan Perbendaharaan (AP) 309.
e. Appendix 5 – Panduan Pemeriksaan Stok Ubat di Sub Stor Farmasi, Panduan Pelaksanaan Langkah Mengoptimumkan Perbelanjaan & Kawalan Penggunaan Ubat di KKM, BPF KKM, 2016 (melalui Surat BPF KKM Ruj: KKM.100-1/6/4 (1) bertarikh 30 Ogos 2016).
f. Prosedur Pengurusan Aduan Kualiti Produk, BPF JKNS, 2017 (melalui Surat BPF JKNS Ruj: JKNSWK/F-21-1/03(14) Jld. 18 bertarikh 10 Jan 2017).

14.2 The pharmacist shall oversee the level of stocks in the pharmacy and in his/her absence, the senior pharmacist assistants will take over the responsibility of the pharmacy store management.

14.3 Pharmacy logistics will procure the standard items approved under the MOH drug list from Pharmaniaga Logistics (M) Sdn. Bhd. and central contract items from appointed MOH contract supplier through Pharmacy Information System (PhIS).

14.4 Drugs under the Local Purchase List are under the supply responsibility of Sibu Divisional Pharmacy Office (PFB Sibu). Logistic Pharmacy will send indents to PFB Sibu through Pharmacy Information System (PhIS) every 3 months.

14.5 All items purchased or indented will be received through Logistic Pharmacy. Stock level should be monitored from time to time to avoid any shortage of supplies from occurring. Stock holding in Logistic Pharmacy shall be maintained between 1-3 months.

14.6 All indents from end users shall be sent to Logistic Pharmacy via PhIS. The pharmacist shall receive and approve indents from indenting units based on the quantity they required through PhIS. End user without access to PhIS and indents for oxygen cylinders shall be done using KEW.PS-8. Indenter shall be responsible to enter correct item code, item description, quantity needed or items to be ordered. Store staff shall be responsible for the issuing and packaging of supplies according to the indents. Users need to sign and cop upon receiving stock.

14.7 All non-standard consumables procurement should be notified to Logistic Pharmacy. Pharmacist shall monitor purchase order of non-standard items (NSC) from units/ wards and inform if there are standard items in commitment form before purchasing. Purchasing orders, receiving and issuing stocks should be done through PhIS.

14.8 There is policy for drug recall procedure in this facility. Chief pharmacist will receive notification of product recall. Logistic Pharmacist should identify and quarantine products involved. Pharmacist should report to respective supplier and replace product from supplier.

14.9 Pharmacist shall investigate product complaints received and identify batches of products involved. Pharmacist shall document and report to National Pharmaceutical Regulatory Agency (NPRA) or Medical Device Authority (MDA). Investigation result from NPRA or MDA should be informed to end users.

14.10 Pharmacist will receive notification of replacing items supplied with shelf life less than 2/3 or vaccine with shelf life less than 6 months (Letter of Undertaking). Items involved should be identified and quarantined and notified to supplier. Stock will be replaced by supplier upon notification.

14.11 Pharmacist or pharmacist assistant shall check maximum level (3 months usage) and minimum level (1 month usage) 3 monthly and update tally card of the items accordingly. Pharmacist shall monitor slow-moving items or near expired items. These items shall be put up for re-distribution to other hospitals via PhIS, as well as for the information of prescribers within the hospital.

14.12 Expired drugs and pharmaceuticals shall be written off and disposed following Standard Operating Procedures. Disposable of discontinued, outdated, or unwanted or unused portions of medicines shall into clinical waste bin.

14.13 Pharmacist shall carry out sub store checking for all indenting units once per year.

14.14 Pharmacist shall do customer charter survey and customer satisfaction survey twice a year. Survey outcomes should be presented in Drug & Therapeutic Committee (JKUT) at the end of the year.

14.15 Pharmacy Logistics unit shall carry out stock check and verification once per year. Stock verification should be done by stock verifiers appointed by State Director of Health & Medical Services.

14.16 Supplier performance (APPL, MOH central contract & supply from PFB Sibu) shall be monitored regularly and penalty shall be charged accordingly via PhIS.

14.17 Stock keeping in Logistic Pharmacy and all substore in Pharmacy Unit shall comply to Good Storage Practice.

a. Drug and non-drug catalogue for Logistic Pharmacy and substore shall be prepared and updated at least once a year, or whenever there are changes in the inventory list.

14.18 Chief Pharmacist shall conduct spot check not less than once every six (6) months towards Farmasi Logistic and sub-store IPD/OPD in compliance to *Arahan Perbendaharaan (AP) 309*.

15.0 Policy & Procedure for Pharmacy Information System (PhIS)

15.1 Registration can be done by submitting completed application form to pharmacy.

15.2 Users are not allowed to share their user identification and password.

15.3 Users should inform person in charge of PhIS system to deactivate their account before transferring out or retirement.

15.4 Users should inform person in charge of PhIS system at least SEVEN days before their transfer or retirement.

15.5 All indents should be sent through online except for units which are not using PhIS system. Indent for drugs and non-drugs in floor stock, after office hour or emergency trolley list and Psychotropic Drug list should be sent to location “Farmasi Substor IPD/OPD” in PhIS. Indent for drip solution and non-drug should be sent to location “Farmasi Logistik” in PhIS.

16.0 Patient Safety and Staff Safety Activities

16.1 Medication Safety

a. Medication safety activities shall be conducted in compliance to updated MOH guidelines and policies:
   i. Guide on Handling Look Alike Sound Alike Medications, Edition 1st (2012), Pharmaceutical Services Division MOH.
   ii. Guideline on Safe Use of High Alert Medications, Edition 2nd (2020), Pharmaceutical Services Division MOH.

b. Good practices on handling look-alike/sound-alike (LASA) include:
   i. LASA drug list shall be prepared and updated by DIS Unit together with Medication Safety Committee at least once a year.
   ii. LASA drug list shall be circulated via hard copy or email to all hospital staff.
   iii. Tallman lettering or alert stickers shall be used for LASA drug labelling at storage bin/rack.
   iv. LASA drugs shall be stored separately. If segregation is not done, suitable approach shall be adopted to ensure no errors in taking the wrong LASA drugs.
   v. Good practice in handling LASA drugs shall be practiced in all pharmacy units, wards and other units keeping medication.

c. Good practices on handling High Alert Medication (HAM) shall include:
   i. HAM medication list shall be prepared and updated by DIS together with Medication Safety Committee at least once a year.
   ii. HAM medication list shall be circulated via hard copy or email to all hospital staff.
   iii. All racks, bins and storage location for HAM medications must be labelled with " Hight Alert Medication" sticker.
   iv. Pharmacy staff or other clinical staff shall cross check HAM medications during preparation, dispensation and administration to patients.
   v. Crosschecking by another staff against the raw material and worksheet calculation must be done on extemporaneous preparation.
   vi. Highly concentrated electrolytes (especially with LASA elements when compared to other medications) must be stored separately in restricted area.

d. Changes in brand or drug packaging must be handled following the following procedure:
   i. All pharmacy units must report LASA drugs to Medication Safety Committee whenever there is a change in brand or packaging.

ii. “Brand Change”notification shall be prepared and circulated by Medication Safety Committee to all hospital staff.

e. Medication safety awareness shall be raised through the following approaches:

i. Mediation safety talks shall be given to all new pharmacy staff during pharmacy orientation program and to all new hospital staff via hospital orientation program.
ii. Medication safety talks shall be organized to all hospital staff in conjunction with Medication Safety Awareness Week held annually (October).
iii. ADR, AEFI & ME summary reports shall be presented in JKUT meeting for further discussion on the preventive and corrective actions.
iv. Medication safety information circulated from MOH or JKN Sarawak shall be distributed to all hospital staff via email or hard copy memo.

f. Medication safety audit (Pharmacy) must be conducted by medication safety committee once (1) a year.

i. Audit shall be conducted using the Medication Safety Self Assessment Form (Hospital) -*Borang PF 11.6 (hospital)*
ii. Pharmacy Department must achieve full compliance (80-100%) in this audit. Failure to achieve the compliance level is subject to repeated audit soonest possible after corrective action ad preventive actions are taken by all units involved.
iii. Audit report must be circulated to all Head of Units for feedbacks on corrective and preventive actions to take to overcome non compliances (if any)
iv. Medication safety audit report must be verified by Chief Pharmacist. A copy of the report should be filed with Medication Safety Committee.

g. Medication safety audit (Ward) must be conducted by medication safety committee at least once (1) a year.

i. Audit shall be conducted using the Medication Safety Self Assessment Form (Hospital) -*Borang PF 11.6 (hospital)*
ii. Audit report must be distributed to ward/unit supervisors to feedback on the corrective and preventive actions to overcome non compliances (if any)
iii. Audit findings shall be presented in medication safety committee meeting .
iv. Medication safety audit report (ward) must be verified by Chief Pharmacist. Reports shall be filed with Medication Safety Committee.

16.2 Incident Reporting (IR)

a. Incident reporting shall be done based on Guidelines on Implementation Incident Reporting & Learning System 2.0 for MOH Hospitals, 1st Edition (2017), Patient Safety Unit, Medical Development Division MOH.

b. RCA must be conducted immediately once notified.

c. Information on the IR & ME (especially improvement and learning points eg Medication Error Alert) should be displayed on notice board for pharmacy staff knowledge.

d. IR file in Chief Pharmacist's room shall keep the following documents and make sure it is updated all the time:
   i. IR registry
   ii. RCA report verified by Chief Pharmacist
   iii. Progress Reports
   iv. Proof of improvement measures taken (eg memo, meeting minutes)

b. Summary of the IR & ME reports must be presented in Pharmacy Management Meeting.

16.3 Risk Management Plans

a. Risk management plans in Pharmacy Unit includes:
   i. Key and controlled access card management policy
   ii. Pharmacy facility safety plan
   iii. Fire safety plan
   iv. Flood contingency plan
   v. Disaster management plan
   vi. Chemistry safety plan
   vii. Cold chain management plan

b. Risk management plans shall be updated once a year or if there is any changes by the coordinator of each plan.

c. Briefings on the risk management plan shall be given to all pharmacy staff.

d. Chief Pharmacist will be responsible in giving a brief introduction to all the new staff during pharmacy orientation. New staff should be aware of the flow chart

of each contingency and emergency action to be taken when handling the identified risk.

e. Coordinator of each risk management plan is responsible to carry out preparedness audit once a year.

17.0 CONFIDENTIALITY & PATIENT'S RIGHT

17.1 Patient's general rights are safeguarded by hospital's updated patient's right policy.

17.2 Patient's specific right and confidentiality in pharmacy services will be taken care with respect to the following:

a. Provision of drug information on medications with porcine origins to Muslim patients.
b. Keeping the confidentiality of patient's diagnosis during dispensing over the counter.
c. Use of counseling rooms for drug dispensing to patients upon request to protect the confidentiality.
d. Protect patient and staff identity in incident reports, medication errors and during clinical case presentation, where patient's name will be abbreviated and use of full name is prohibited.

PHARMACY UNIT KANOWIT HOSPITAL

PATIENT AND FAMILY RIGHTS

1. **Right to Basic Needs**
   Healthcare is a basic need essential to live. It is your basic rights as an individual to have equitable access to medical care and medicine for health and wellbeing, Therefore, it forms the fundamental responsibilities of governments in every country to ensure that their people have equitable access to basic medicine needs.

2. **Right to Information**
   Consumers have the right to be well-informed of the medicines they are taking. Healthcare professionals and the labels on medicine products must inform consumers what kind of medicines they are taking, what re the side effects, how to take their medicines, how frequent to take it, and the stating precautionary health warnings.

3. **Right to Choose**
   The right to choose is essentially a consumer's right to choose a safe and healthy product of good quality over an unsafe or defective product.

4. **Right to Safety**
   Every consumer has the right to safe medication. All medicines, whether its prescription drug or health supplements must not in anyway, bring harm to consumers. In Malaysia, the Pharmaceutical Services Division of the Ministry of Health strives to ensure that every single medicine sold in the market is safe for consumer to use.

5. **Right to Redress**
   The right to obtain redress is an important element given to protect consumer interests. In Malaysia, redress mechanisms such as Consumer Tribunal and legal courts exist for consumers to gain redress and seek compensation for damages incurred.

6. **Right to be heard**
   The right to be heard means that consumers should be allowed to voice their opinions and grievances at appropriate channels eg. health authorities. Consumers should also have a right to voice their opinion on the services provided.

7. **Right to a Healthy and Sustainable Environment**
   The need for environmental conservation is seen as a necessary defense against deteriorating quality of live worldwide. As certain medicines are poisons, their disposal must be carefully and safely done so that it would not cause any significant harm to the surrounding living environment. Polluted environments lead to increased health costs and discomfort for consumers. Valuable resources are lost due to polluted environment and living conditions. Consumers need to understand that only a safe environment can ensure the fulfillment of their consumer rights.

8. **Right to Consumer Education**
   Consumer education empowers consumers to exercise their consumer rights and is perhaps the single most powerful tool for consumer protection. Consumer education is dynamic, participatory and is mostly acquired by hands-on and practical experience. Thus, in hear 2008, "Kenali Ubat Anda" campaign was launched by KKM to address patient rights on knowing their own medicine. The 5 Rights that has been addressed are:

i. Right Patient
- Make sure the patient's name is written on the label.
- Do not share medicines.
- Store medicines out of reach of small children.
- Store medicines for pets separately.

ii. Right Medicine
- Read the label to make sure the medicine which is going to be consumed is correct.
- When getting a new medicine which name is unfamiliar, ask if it is a generic.
- When refilling prescription, make sure that the medicine looks the same as before. If it does not, ask if it is a different brand.
- Put on your eyeglasses and turn on the lights to read label.
- For OTC medicines or supplements, read the ingredients list.
- Know the name of all the medicines prescribed to you.
- Know what medicines are used for.

h. Right Dose
- Read the directions on the label.
- Know how many tablets or doses should be taken each day.
- Know how long the medicine should be continued.
- Know the abbreviations for tablespoon and teaspoon.
- Use a medicine measuring cup or spoon for liquid, rather than a household spoon.
- Taking extra medicine is not always better. Always follow the dosage instructions.

i. Right Route
    - Read the label.
    - Make sure you know the proper way to take/use your medicines.
    - Remember that not all tablets should be swallowed. Know if the tablet can be chewed, crushed, dissolved or if it should be swallowed whole.

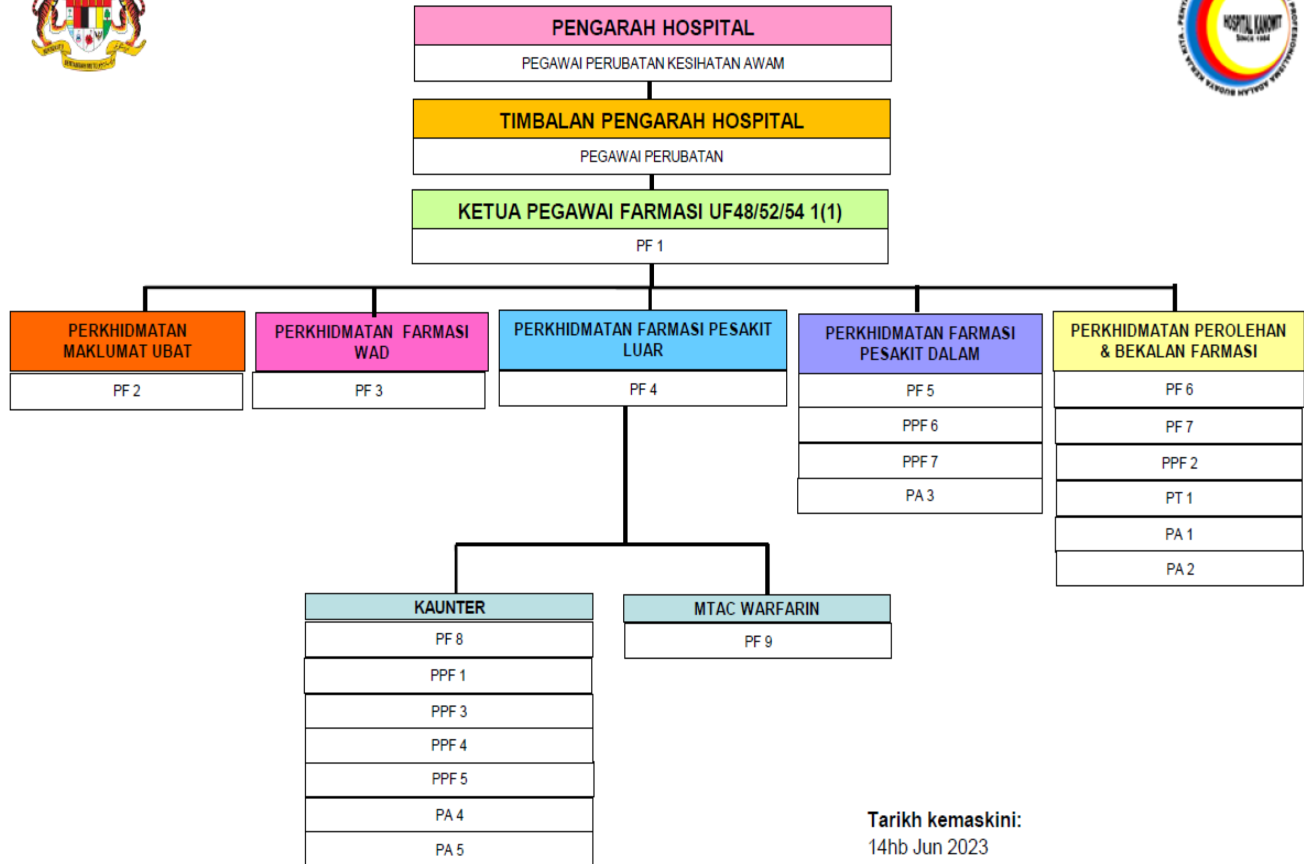
j. Right Time
    - Follow the label.
    - Know if the medicine should be taken at a specific time of day.
    - Know if the medicine will interact with food or other medicines.
    - Take medicine at the same time each day.
    - Know what to do if a dose is missed.

Patient's Privacy and Confidentiality

Counseling room is prepared for keeping the privacy and confidentiality of the communication between the patient and the Pharmacist.

Prepared by, Approved by,

Appendix 1: Organization chart for Pharmacy Unit



Appendix 2: Client's charter for Pharmacy Units

PIAGAM PELANGGAN
FARMASI PESAKIT LUAR

Kami berjanji dan komited untuk memberi perkhidmatan kepada pelanggan dengan:

Memastikan ubat-ubatan yang betul dibekalkan dalam tempoh tidak melebihi 30 minit bagi preskripsi yang lengkap diterima.

Untuk sebarang pertanyaan atau kemusykilan, sila hubungi:
Pegawai Farmasi : Theng Sie Ching
No. telefon pejabat : 084-752333 sambungan 262

Disediakan oleh	Disahkan oleh

PIAGAM PELANGGAN
FARMASI PESAKIT DALAM/BEKALAN WAD

Kami berjanji dan komited untuk memberi perkhidmatan kepada pelanggan dengan:

Memastikan pembekalan ubat-ubatan yang betul ke wad atau unit bagi preskripsi atau pesanan yang lengkap diterima dalam tempoh masa 2 jam semasa waktu pejabat.

Untuk sebarang pertanyaan atau kemusykilan, sila hubungi:
Pegawai Farmasi : Cik Carmen Wong Jia Jia
No. telefon pejabat : 084-752333 sambungan 262

Disediakan oleh	Disahkan oleh

PIAGAM PELANGGAN
FARMASI LOGISTIK

Kami berjanji dan komited untuk memberi perkhidmatan kepada pelanggan dengan:

1. Membekalkan item standard kepada pemesan tidak melebihi **14 hari bekerja** selepas pesanan yang lengkap diterima
2. Membekalkan item bukan standard kepada pemesan selepas pesanan yang lengkap diterima, tidak melebihi **14 hari bekerja** selepas bekalan diterima di Unit Farmasi Logistik.

Untuk sebarang pertanyaan atau kemusykilan, sila hubungi:
Pegawai Farmasi : Pn Ting Siew Chuan
No. telefon pejabat : 084-752333 sambungan 270

Disediakan oleh	Disahkan oleh

PIAGAM PELANGGAN
FARMASI KLINIKAL/WAD

Kami berjanji dan komited untuk memberi perkhidmatan kepada pelanggan dengan:

1. Memastikan penilaian sejarah pengubatan (CP1) dibuat ke atas pesakit yang pernah menerima terapi ubat sebelum kemasukan ke dalam wad.
2. Memastikan pemantauan farmaseutikal dibuat ke atas pesakit yang menerima terapi ubat di wad.
3. Memastikan kaunseling diberikan kepada semuat pesakit yang memerlukan.

Untuk sebarang pertanyaan atau kemusykilan, sila hubungi:
Pegawai Farmasi : Cik Winnie Lew Ee Ling
No. telefon pejabat : 084-752333 sambungan 262

Disediakan oleh	Disahkan oleh

PIAGAM PELANGGAN
PERKHIDMATAN MAKLUMAT UBAT

Kami berjanji dan komited untuk memberi perkhidmatan kepada pelanggan dengan:

1. Memastikan semua Pegawai Farmasi Berdaftar Penuh dan Penolong Pegawai Farmasi mencapai **40 mata CPD** setahun.
2. Memastikan pertanyaan mengenai ubat-ubatan dijawab dalam masa **30 min** untuk pertanyaan "*urgent*", manakala untuk pertanyaan yang tidak "*urgent*" akan dijawab dalam **24 jam.**

Untuk sebarang pertanyaan atau kemusykilan, sila hubungi:
Pegawai Farmasi :En Arthur Tiong Ing Jie
No. telefon pejabat : 084-752333 sambungan 262

Disediakan oleh	Disahkan oleh