



Pharmacy Information System (PhIS) and Clinic Pharmacy System (CPS)

Full Based User Manual Ward Pharmacy

Version	: 7 th E
Document ID	: FB_U. MANUAL_WARD PHARMACY



PhIS & CPS Project
User Manual – Ward Pharmacy



© 2011-2018 Pharmacy Information System & Clinic Pharmacy System (PhIS & CPS) Project

CONFIDENTIAL COPYRIGHTED MATERIAL–The information includes all concepts, comments, recommendations, and material, contained herein shall remain the property of Pharmacy Information System & Clinic Pharmacy System (PhIS & CPS) Project. No portion of this document shall be disclosed, duplicated or used in whole or in part of any purpose other than the purpose of the Pharmacy Information System & Clinic Pharmacy System (PhIS & CPS) Project execution only

Reference ID : FB_U. MANUAL_WARD PHARMACY-7th Edition

Application reference: PhIS & CPS v1.7.1



Table of Content

1.0	Introduction	1
1.1	Overview of PhIS.....	1
1.2	Purpose and Objectives	1
1.3	Organised Sections	1
2.0	Application Standard Features	2
2.1	PhIS Legend	2
2.2	Latest Enhancement and Updates	4
3.0	Ward Pharmacy	5
	Overview	5
	User Group	5
	Functional Diagram.....	5
	Functional Description	5
3.1	Ward Pharmacy (CP2).....	6
3.1.1	CP2.....	6
3.1.2	CP1.....	12
3.1.3	Daily Review	17
3.1.4	Vital Sign.....	19
3.1.5	I/O Chart	21
3.1.6	Lab Parameter	23
3.1.7	C&S	25
3.1.8	Pharmaceutical Care Issue	27
3.1.9	CP4.....	30
4.0	Acronyms.....	33
5.0	Links to Clinical Modules.....	33

1.0 Introduction

1.1 Overview of PhIS

Pharmacy Information System or better known as PhIS, is a complete and comprehensive system that integrates pharmacy related services geared towards pharmacy excellence. PhIS implementation would transform most of current manual process to electronic system would benefit facility end user in the health care sector.

There are 12 modules to assist services delivery by the health care sector which comprises of:

1. Order Management
2. Inpatient Pharmacy
3. Outpatient Pharmacy
4. Medication Counselling
5. Ward Pharmacy
6. Pharmacy Inventory
7. Manufacturing of Cytotoxic Drug Reconstitution, Parenteral Nutrition, IV Admixture & Eye Drop, Radiopharmaceuticals and Extemporaneous
8. Adverse Drug Reaction & Drug Allergic (ADR & DAC)
9. Clinical Pharmacokinetics Services (TDM)
10. Drug Information & Consumer Education (DICE)
11. Medication Therapy Adherence Clinic (MTAC)
12. Data Mining (PhARM)

1.2 Purpose and Objectives

This user manual outlines the Ward Pharmacy sub-module and its key features and functionalities. The primary objective is to help guide user through the process of completing PhIS application process.

User will understand the following activities in details:

- Ward Pharmacy (CP2)

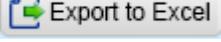
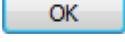
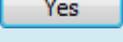
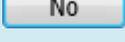
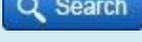
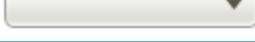
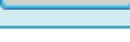
1.3 Organised Sections

These are the sections within this document:

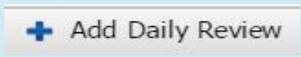
- Section 1: Introduction
- Section 2: Application Standard Features
- Section 3: Ward Pharmacy
- Section 4: Acronyms
- Section 5: Links to Clinical Modules

2.0 Application Standard Features

2.1 PhIS Legend

Standard Legend			
	Login to PhIS		Logout from PhIS
	Close All Open Tabs		Refresh Screen
	Expand Menu		Collapse Menu
	Expand Module		Collapse Module
	Add/Create New Record		Save
	Close Window		Calendar Icon
	Save Transaction		Delete Record
	Export Report From PDF file to Excel file		OK Button
	Yes Button		No Button
	Radio Button	<input type="checkbox"/>	Checkbox
	System Automatic Generate Record No.		Automatically Display/Retrieve Box
	Reset Login Screen		Show Help
	Display Home Tab		Search Record
	Cancel		Dropdown Box
	Search Icon	*	Mandatory Field
	Edit Record		Empty Text Box
	Cancel Button		



Ward Pharmacy (CP2) Module Legend			
	To record daily review patient		Add/update Record

Note

To learn more about Login Information, kindly click [Login Information](#) module for descriptive steps.



2.2 Latest Enhancement and Updates

Latest Functions	Page
No more compliance score (Morisky scale) and change to Adherence score	9 & 10
CP2 HPI - To set maximum 500 characters	9 & 10
CP1 a) PMHx - To set maximum 500 characters b) Reason For Admission - To set maximum 500 characters c) Comments - To set maximum 500 characters d) Pharmacist Note - To set maximum 500 characters (Pharmacist Note has been remove in CP1 screen following the request of removing MMAS score. User can use Pharmacist note in CP2 screen)	14

3.0 Ward Pharmacy

Overview

The Ward Pharmacy module include Implementing safe and organized CP2 form, CP1 form, CP4 form, Pharmaceutical Care Issue (PCI) and lab result reporting

User Group

This module is intended for pharmacist

Functional Diagram

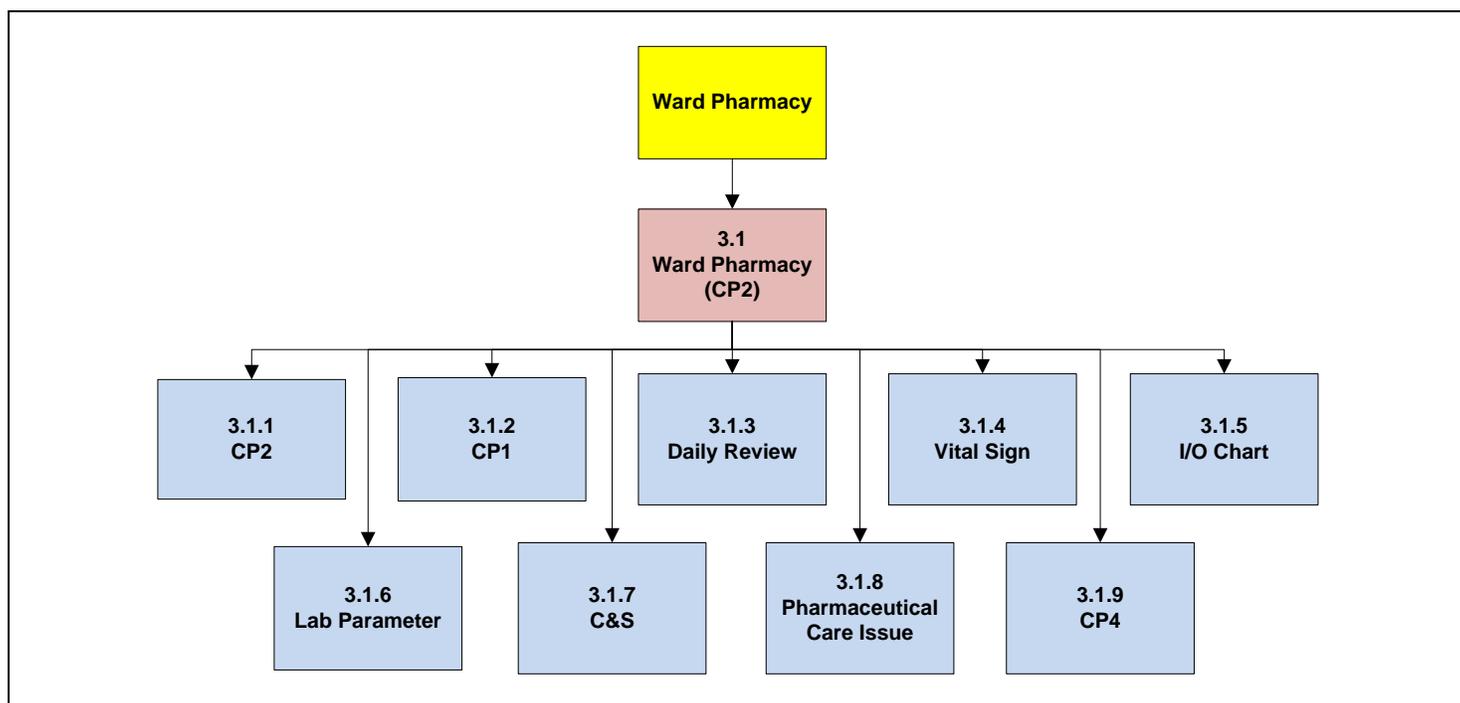


Figure 3.1

Functional Description

Ward Pharmacy comprises of nine (9) functions:

- CP1
- CP2
- Daily Review
- Vital Sign
- I/O Chart
- Lab Parameter
- C&S
- Pharmaceutical Care Issue
- CP4

3.1 Ward Pharmacy (CP2)

3.1.1 CP2

This function is used to transcribe CP2 form record in the system.

Figure 3.1.1-1 Ward Pharmacy Listing Page

Note

Phis Screen menu/sub menu will be displayed according to user access right.

STEP 1

Click on Pharmacy Transaction menu then click on Clinical follow by click on Ward Pharmacy CP2

STEP 2

To search for patient Ward Pharmacy (CP2) records, user can search by criteria as follows:

Search			
No	Field	Description	Remark
a	Location	Location	Allow to search by assigned location: - Inpatient visit - Emergency visit - Daycare visit
b	MRN	Patient MRN	Allow to search by patient full or partial MRN No
c	Bed No	Bed No	Allow to search by patient bed no
d	ID No	ID No	Allow to search by patient full or partial ID No
e	CP1 Recorded?	- All	All-Allow to search by status 'Yes' and 'No'
		- Yes	Yes-Allow to search by status 'Yes'
		- No	No-Allow to search by status 'No'
f	CP2 Recorded?	- All	All-Allow to search by status 'Yes' and 'No'
		- Yes	Yes-Allow to search by status 'Yes'

		– No	No-Allow to search by status 'No'
g	Admission Date	Date Enter Ward	Allow to search by date enter to ward
h	Discharged Date	Date Dismissed from Ward	Allow to search by date dismissed from ward

Table 3.1.1-1

STEP 3

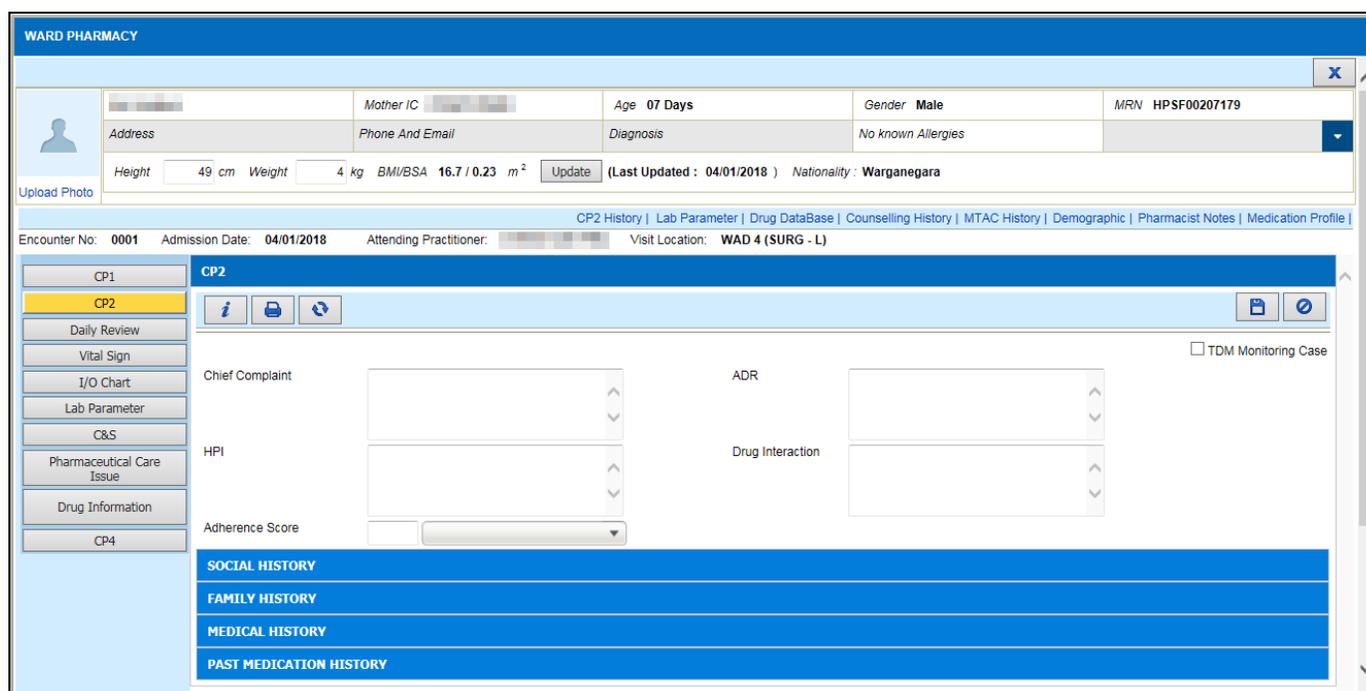
Click on the  button and result display will be based on the criteria

Note

If CP1 and CP2 already recorded for the particular patient, the listing will show Yes for both line.

STEP 4

Double click on patient name and user will enter the ward pharmacy CP2 function



The screenshot displays the 'WARD PHARMACY' interface. At the top, there is a patient information summary including Mother IC, Age (07 Days), Gender (Male), and MRN (HPSF00207179). Below this, there are fields for Address, Phone And Email, Diagnosis, and No known Allergies. A section for physical attributes includes Height (49 cm), Weight (4 kg), and BMI/BSA (16.7 / 0.23 m²), with an 'Update' button and a note '(Last Updated : 04/01/2018)'. Nationality is listed as 'Warganegara'. A navigation bar contains links for CP2 History, Lab Parameter, Drug DataBase, Counselling History, MTAC History, Demographic, Pharmacist Notes, and Medication Profile. The main area shows 'Encounter No: 0001', 'Admission Date: 04/01/2018', 'Attending Practitioner', and 'Visit Location: WAD 4 (SURG - L)'. On the left, a vertical menu lists tabs: CP1, CP2 (highlighted), Daily Review, Vital Sign, I/O Chart, Lab Parameter, C&S, Pharmaceutical Care Issue, Drug Information, and CP4. The main content area is titled 'CP2' and includes fields for Chief Complaint, ADR, HPI, Drug Interaction, and Adherence Score. At the bottom, there are expandable sections for SOCIAL HISTORY, FAMILY HISTORY, MEDICAL HISTORY, and PAST MEDICATION HISTORY. A checkbox for 'TDM Monitoring Case' is also present.

Figure 3.1.1-2 Ward Pharmacy

Note

- By default system will CP2 screen
- User can navigate to other screen using tab on the left side that consist of:
 - CP1
 - CP2
 - Daily Review
 - Vital Sign
 - I/O Chart
 - Lab Parameter
 - C&S
 - Pharmaceutical Care Issue
 - Drug Information
 - CP4

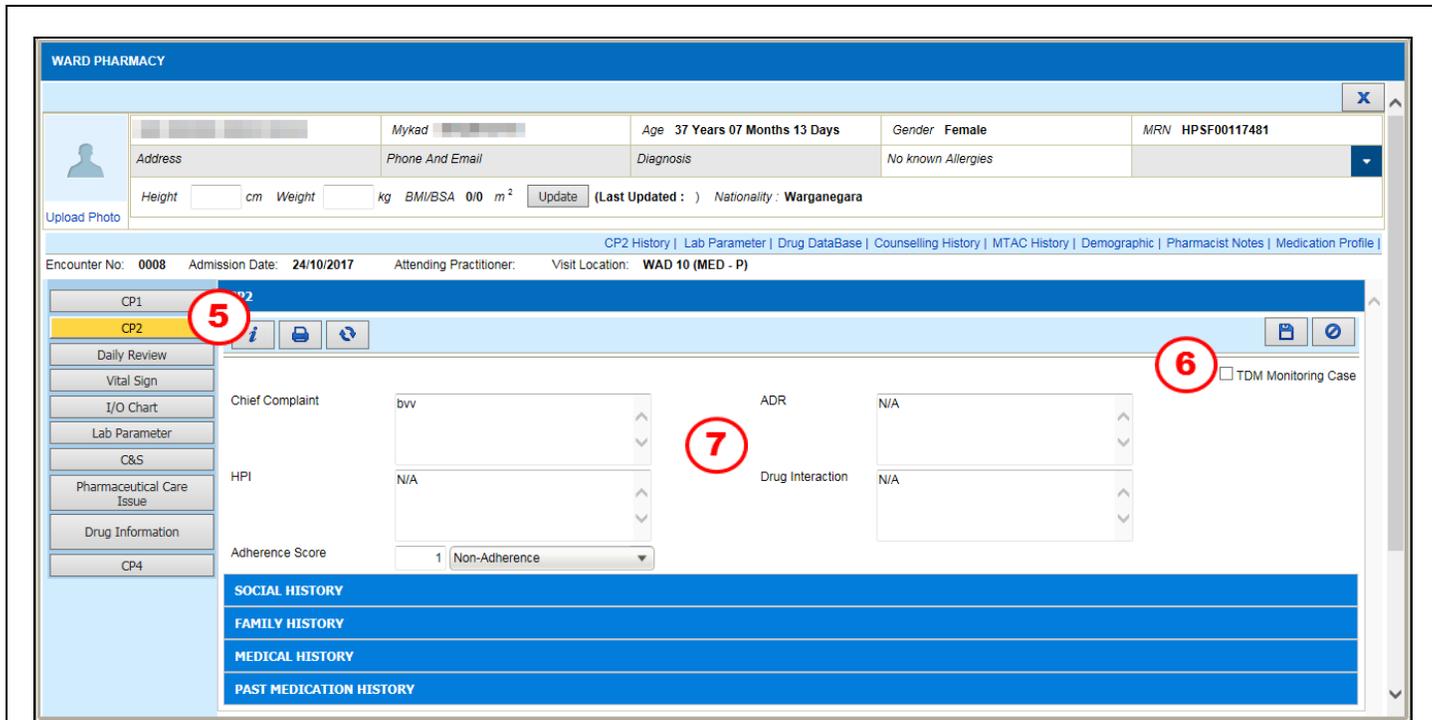


Figure 3.1.1-3 Ward Pharmacy

STEP 5

Click on the **CP2** tab on the left side

Note

CP2 consist of:

- Main
- Social History
- Family History
- Medical History
- Past Medication History

STEP 6

Select on **TDM Monitoring Case** checkbox if applicable

STEP 7

Enter the necessary information

- a) **Chief Complaint**
- b) **HPI**
- c) **ADR**
- d) **Drug Information**
- e) **Adherence Score**

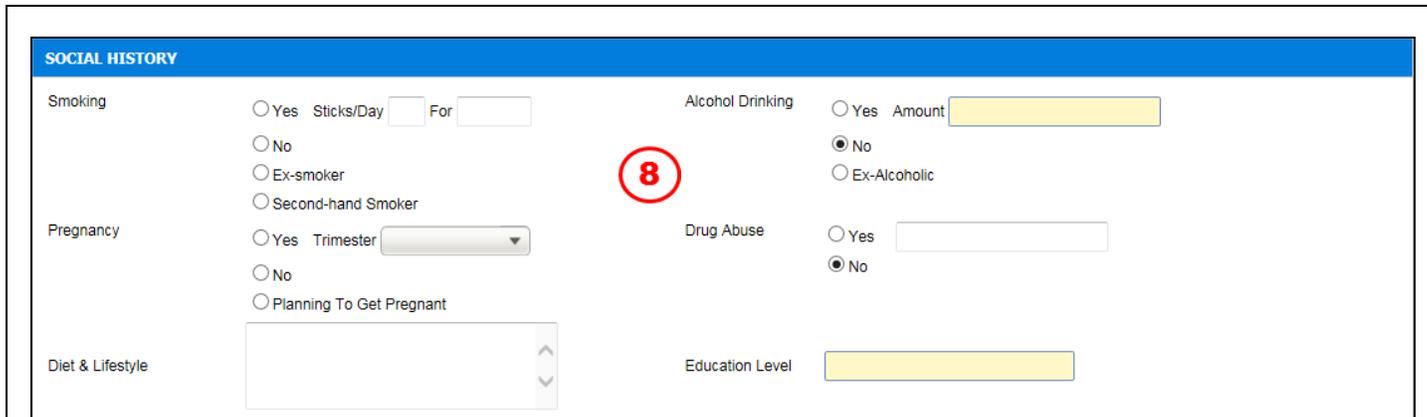


Figure 3.1.1-4 Social History

STEP 8

Enter the necessary information in Social History section. Social History section consist of:

- a) **Smoking**
- b) **Pregnancy**
- c) **Diet & Lifestyle**
- d) **Alcohol Drinking**
- e) **Drug Abuse**

Note

- **Pregnancy** field is disable if the patient gender is male
- **Education** is retrieved from **Patient Registration** function



Figure 3.1.1-5 Family History

STEP 9

Fill in the necessary information in Family History section. Family History section consist of:

- a) **Martial Status**
- b) **No Of Children**
- c) **Lives With**
- d) **Family History Of Illness**

Note

Information in **Martial Status** is available if information is filled during patient registration function.

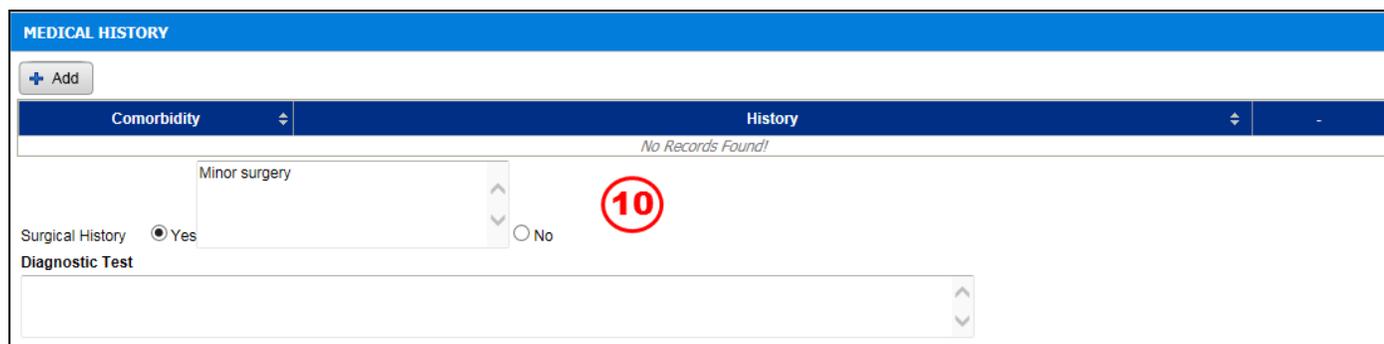


Figure 3.1.1-6 Medical History

STEP 10

Fill in the necessary information in Family History section. Family History section consist of:

- a) **Comorbidity**
- b) **Surgical History**
- c) **Diagnostic Test**

Note

User can add patient comorbidity by click on the  button

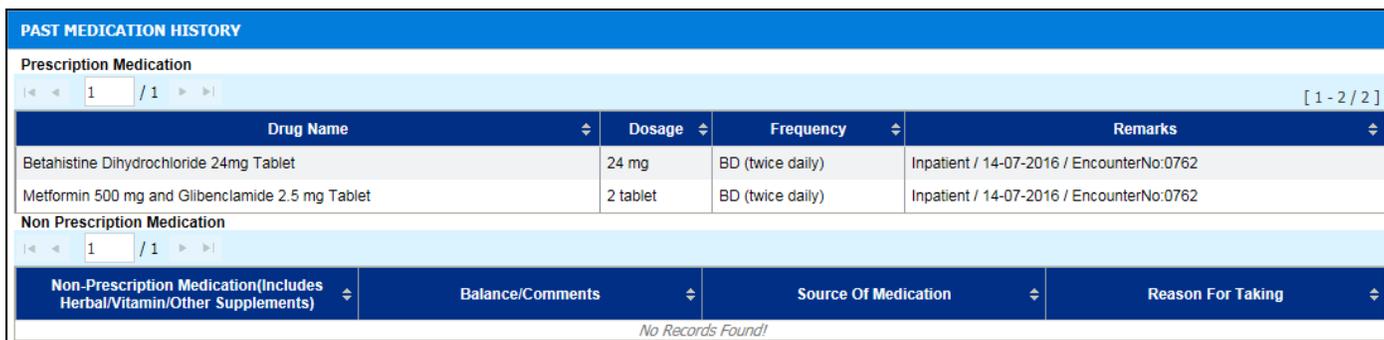
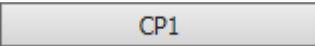
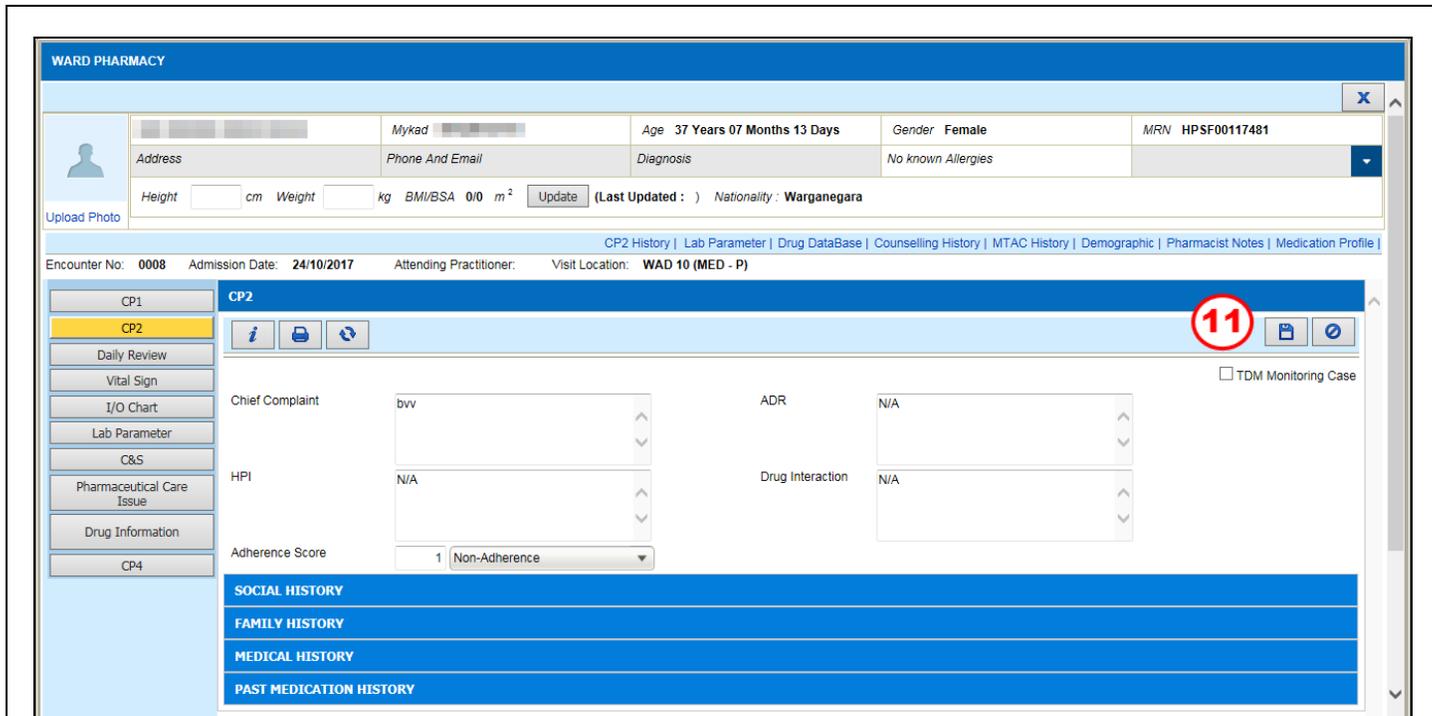


Figure 3.1.1-7 Past Medication History

Note

Past Medication History consist of:

- Prescription Medication
- Non Prescription Medication
- However, this field cannot be filling and need to be filled in  screen.



WARD PHARMACY

Mykad: [REDACTED] Age: 37 Years 07 Months 13 Days Gender: Female MRN: HPSF00117481

Address: [REDACTED] Phone And Email: [REDACTED] Diagnosis: [REDACTED] No known Allergies

Height: [REDACTED] cm Weight: [REDACTED] kg BMI/BSA: 0/0 m² Update (Last Updated:) Nationality: Warganegara

Encounter No: 0008 Admission Date: 24/10/2017 Attending Practitioner: Visit Location: WAD 10 (MED - P)

CP2

Chief Complaint: bvv ADR: N/A

HPI: N/A Drug Interaction: N/A

Adherence Score: 1 Non-Adherence

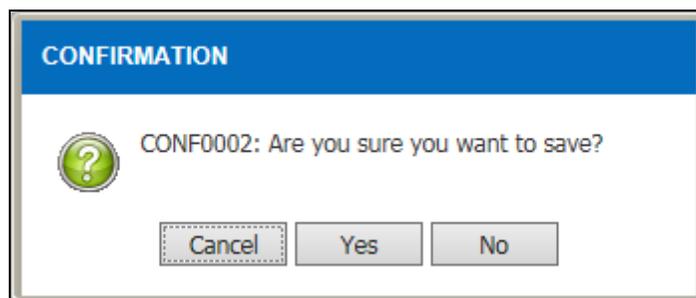
TDM Monitoring Case

SOCIAL HISTORY
FAMILY HISTORY
MEDICAL HISTORY
PAST MEDICATION HISTORY

Figure 3.1.1-7 Ward Pharmacy (CP2)

STEP 11

Click on the  button to save the CP2 record and system will display confirmation alert as figure 3.1.1-8



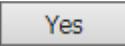
CONFIRMATION

CONF0002: Are you sure you want to save?

Cancel Yes No

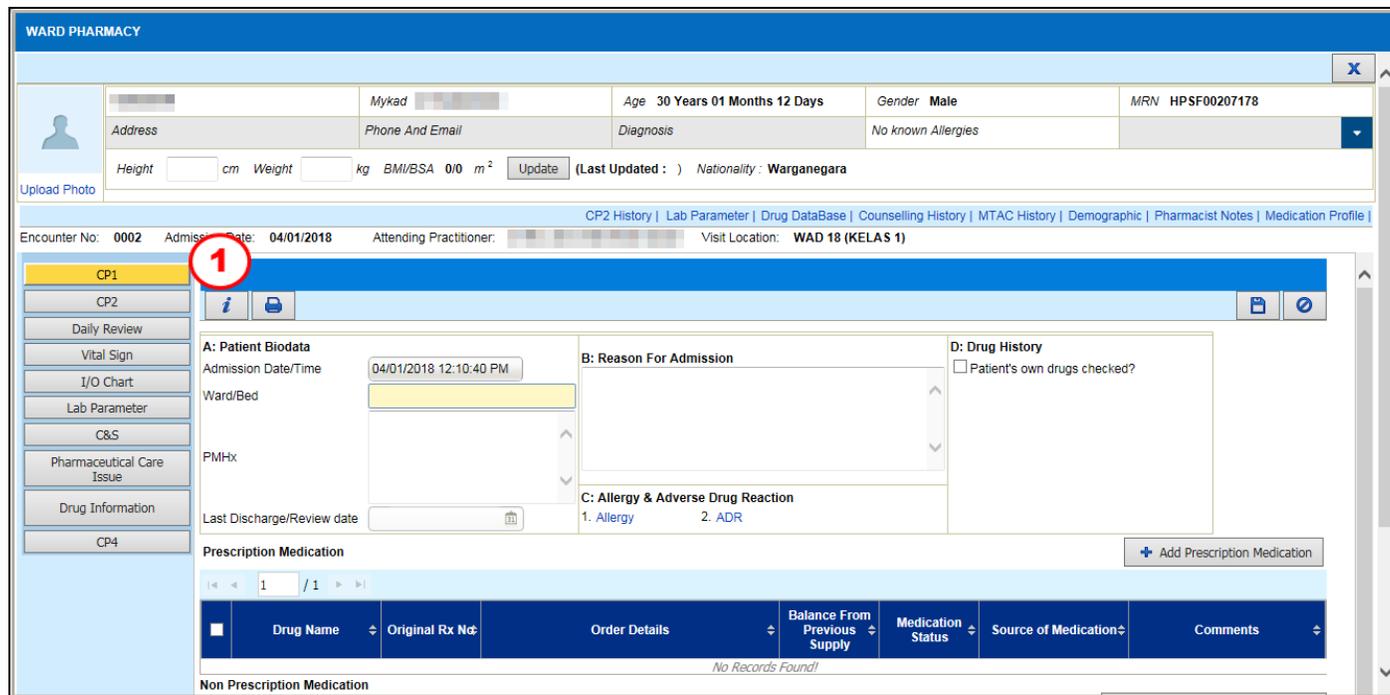
Figure 3.1.1-8 Confirmation Alert

Note

- Click on  the button to save the record.

3.1.2 CP1

The function of this menu is to record a complete patient medication history within 24 hours of admission.

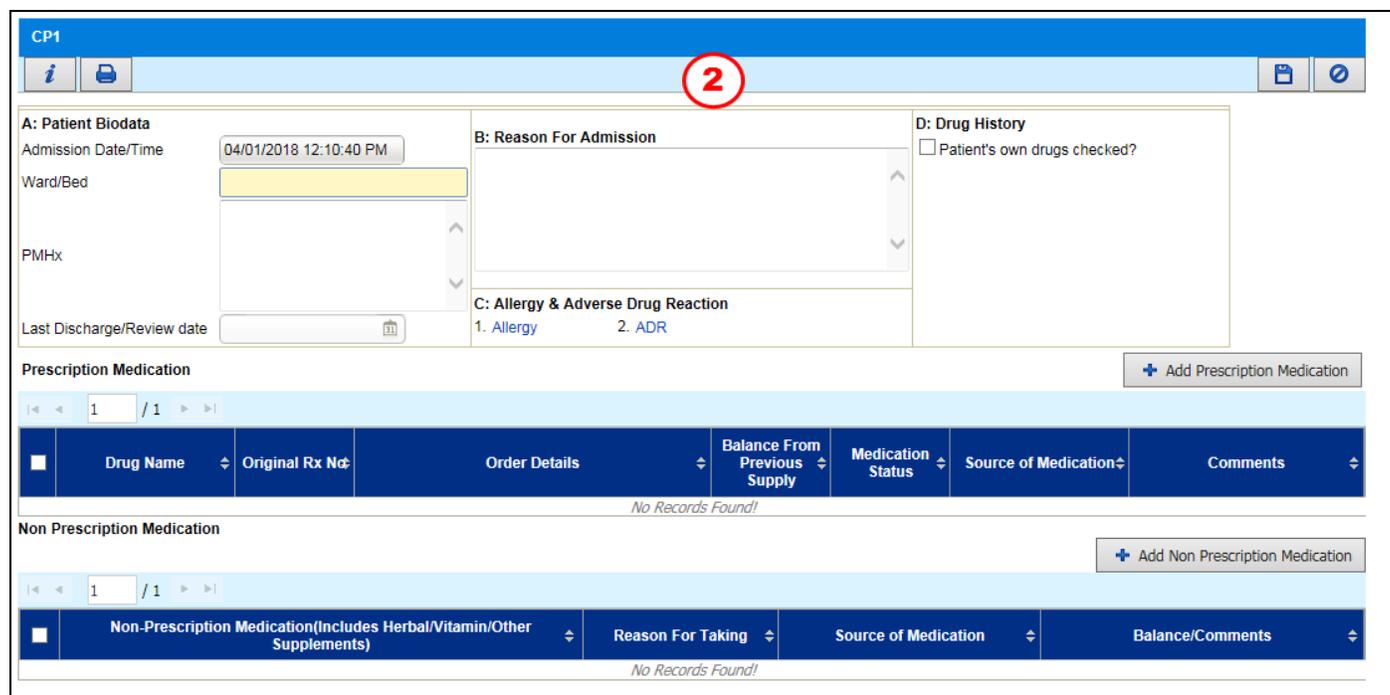


The screenshot shows the 'WARD PHARMACY' interface. At the top, there is a patient information summary including Mykad, Age (30 Years 01 Months 12 Days), Gender (Male), and MRN (HPSF00207178). Below this, there are fields for Address, Phone And Email, Diagnosis, and No known Allergies. A 'CP1' button is highlighted in yellow and circled with a red '1'. The interface also shows a navigation menu on the left with options like CP2, Daily Review, Vital Sign, I/O Chart, Lab Parameter, C&S, Pharmaceutical Care Issue, Drug Information, and CP4. The main content area displays patient biodata, reason for admission, drug history, and allergy information.

Figure 3.1.2-1 CP1 Button

STEP 1

Click on the **CP1** tab on the left side



The screenshot shows the 'CP1' form in the software interface. The 'CP1' tab is highlighted in yellow and circled with a red '2'. The form is divided into several sections: 'A: Patient Biodata' (Admission Date/Time: 04/01/2018 12:10:40 PM, Ward/Bed, PMHx, Last Discharge/Review date), 'B: Reason For Admission', 'C: Allergy & Adverse Drug Reaction' (1. Allergy, 2. ADR), and 'D: Drug History' (checkbox for Patient's own drugs checked). Below these sections are two tables: 'Prescription Medication' and 'Non Prescription Medication'. Both tables show 'No Records Found!' and have a '+ Add' button. The 'Prescription Medication' table has columns for Drug Name, Original Rx No, Order Details, Balance From Previous Supply, Medication Status, Source of Medication, and Comments. The 'Non Prescription Medication' table has columns for Non-Prescription Medication (Includes Herbal/Vitamin/Other Supplements), Reason For Taking, Source of Medication, and Balance/Comments.

Figure 3.1.2-2 CP1

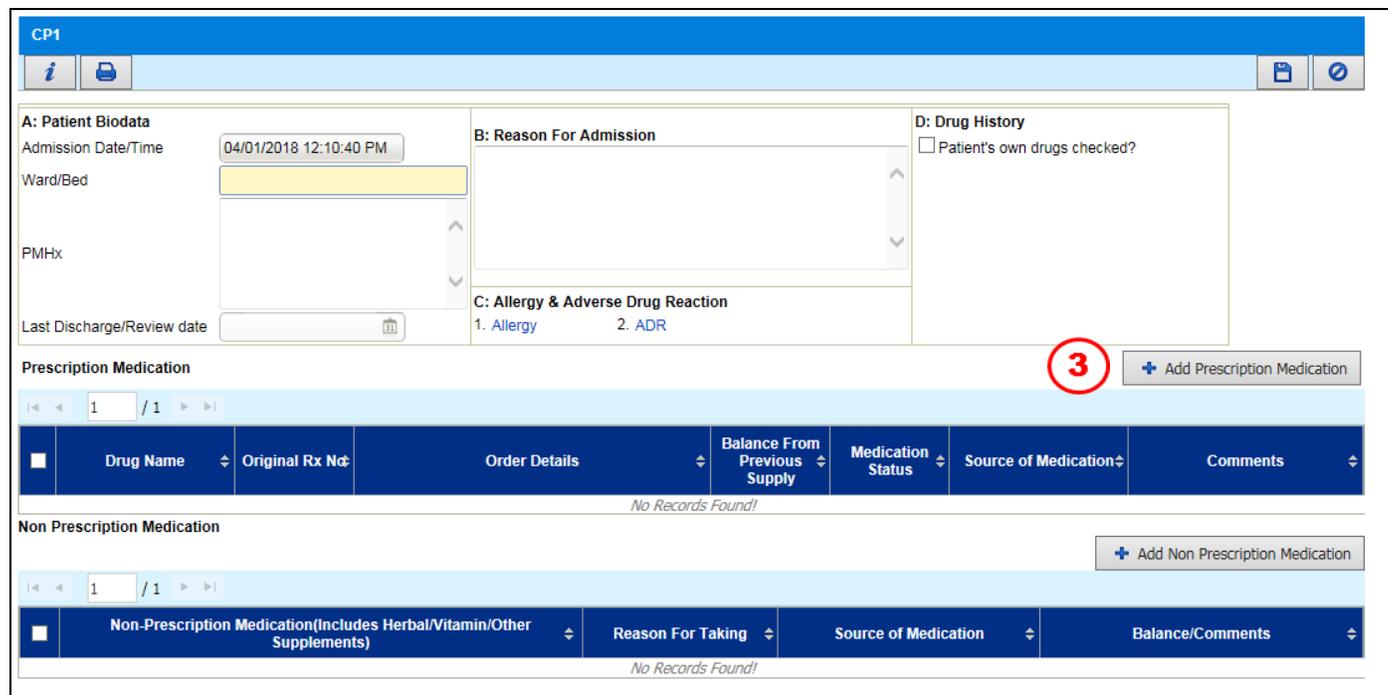
STEP 2

Enter the necessary information

- a) **A: Patient Biodata**
- b) **B: Reason For Admission**
- c) **D: Drug history**

Note

User can view information of patient Allergy and ADR at **C: Allergy & Adverse Drug Reaction** hyperlink



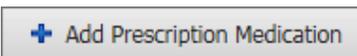
The screenshot shows the CP1 form interface. At the top, there are icons for information and printing. The form is divided into several sections:

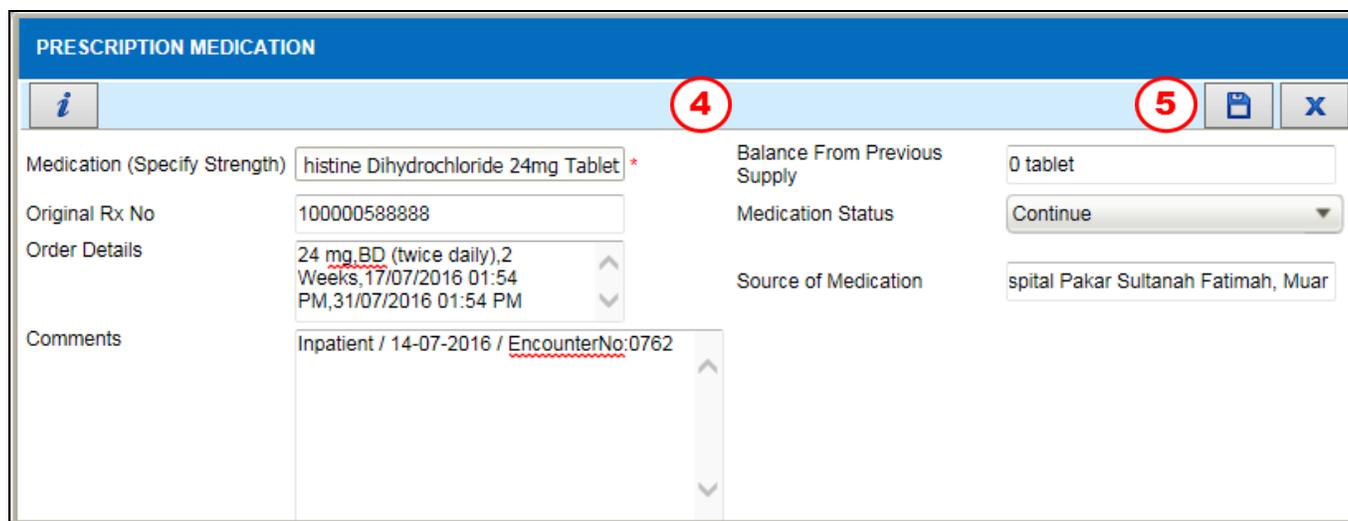
- A: Patient Biodata:** Includes fields for Admission Date/Time (04/01/2018 12:10:40 PM), Ward/Bed, PMHx, and Last Discharge/Review date.
- B: Reason For Admission:** A large text area for entering the reason.
- D: Drug History:** Includes a checkbox for "Patient's own drugs checked?".
- C: Allergy & Adverse Drug Reaction:** Lists "1. Allergy" and "2. ADR".
- Prescription Medication:** A table with columns: Drug Name, Original Rx No, Order Details, Balance From Previous Supply, Medication Status, Source of Medication, and Comments. Below the table, it says "No Records Found!".
- Non Prescription Medication:** A table with columns: Non-Prescription Medication (Includes Herbal/Vitamin/Other Supplements), Reason For Taking, Source of Medication, and Balance/Comments. Below the table, it says "No Records Found!".

 A red circle with the number "3" highlights the "+ Add Prescription Medication" button located to the right of the Prescription Medication table.

Figure 3.1.2-3 CP1

STEP 3

Click on the  button to enter the information as Figure 3.1.2-4.



The screenshot shows the PRESCRIPTION MEDICATION form. At the top, there are icons for information and saving. The form contains the following fields:

- Medication (Specify Strength):** histine Dihydrochloride 24mg Tablet *
- Original Rx No:** 100000588888
- Order Details:** 24 mg, BD (twice daily), 2 Weeks, 17/07/2016 01:54 PM, 31/07/2016 01:54 PM
- Comments:** Inpatient / 14-07-2016 / EncounterNo:0762
- Balance From Previous Supply:** 0 tablet
- Medication Status:** Continue
- Source of Medication:** spital Pakar Sultanah Fatimah, Muar

 A red circle with the number "4" highlights the information icon (i) at the top left, and a red circle with the number "5" highlights the save icon (floppy disk) at the top right.

Figure 3.1.2-4 Prescription Medication

STEP 4

Fill in the necessary information

- a) **Medication (Specify Strength)**
- b) **Original Rx No**
- c) **Order Details**
- d) **Comments**
- e) **Balance From Previous Supply**
- f) **Medication Status**
- g) **Source of Medication**

STEP 5

Click on the  button to save record and system will display confirmation alert as figure 3.1.2-5

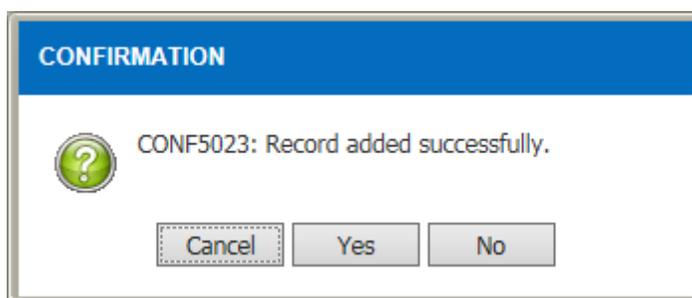
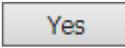
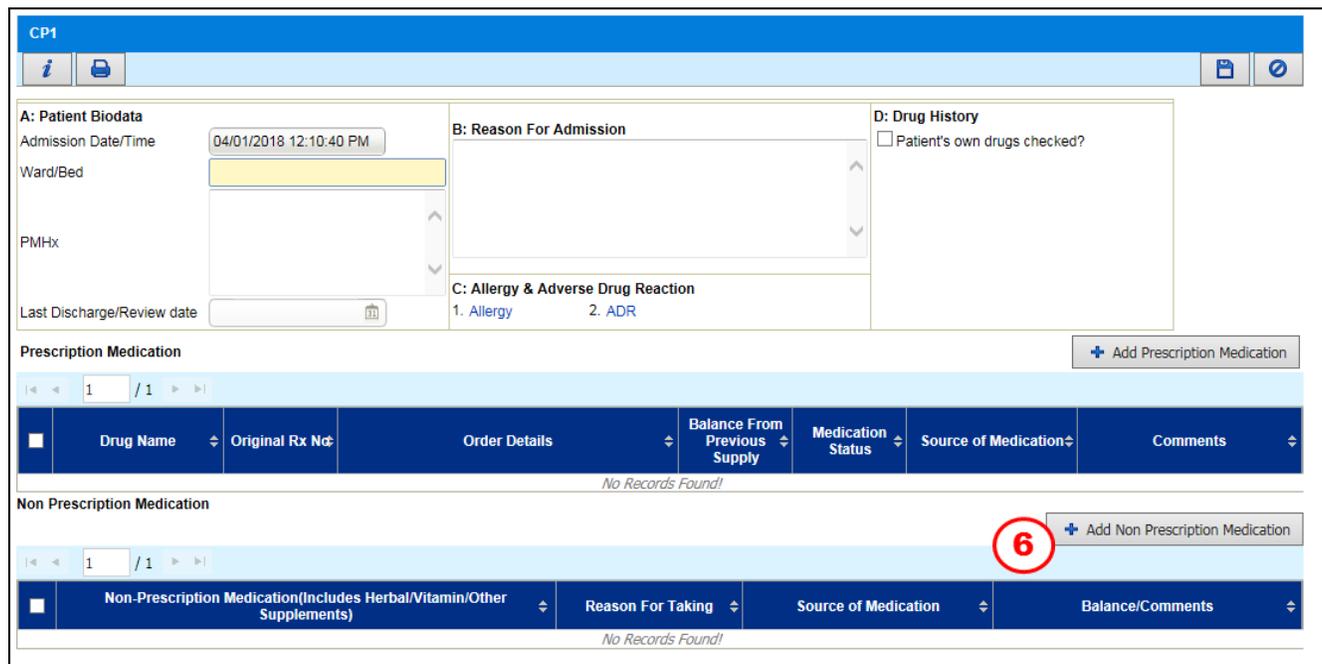


Figure 3.1.2-5 Confirmation alert

Note

- Click on  the button to save the record.



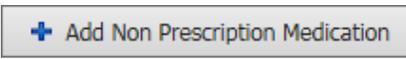
The screenshot shows the CP1 form with the following sections:

- A: Patient Biodata**: Admission Date/Time (04/01/2018 12:10:40 PM), Ward/Bed, PMHx, Last Discharge/Review date.
- B: Reason For Admission**: Text area for admission reason.
- C: Allergy & Adverse Drug Reaction**: 1. Allergy, 2. ADR.
- D: Drug History**: Patient's own drugs checked? (checkbox).
- Prescription Medication**: Table with columns: Drug Name, Original Rx No, Order Details, Balance From Previous Supply, Medication Status, Source of Medication, Comments. Below the table: "No Records Found!".
- Non Prescription Medication**: Table with columns: Non-Prescription Medication (Includes Herbal/Vitamin/Other Supplements), Reason For Taking, Source of Medication, Balance/Comments. Below the table: "No Records Found!".

A red circle with the number 6 highlights the "+ Add Non Prescription Medication" button in the Non Prescription Medication section.

Figure 3.1.2-6 CP1

STEP 6

Click on the  button to enter the information as Figure 3.1.2-7

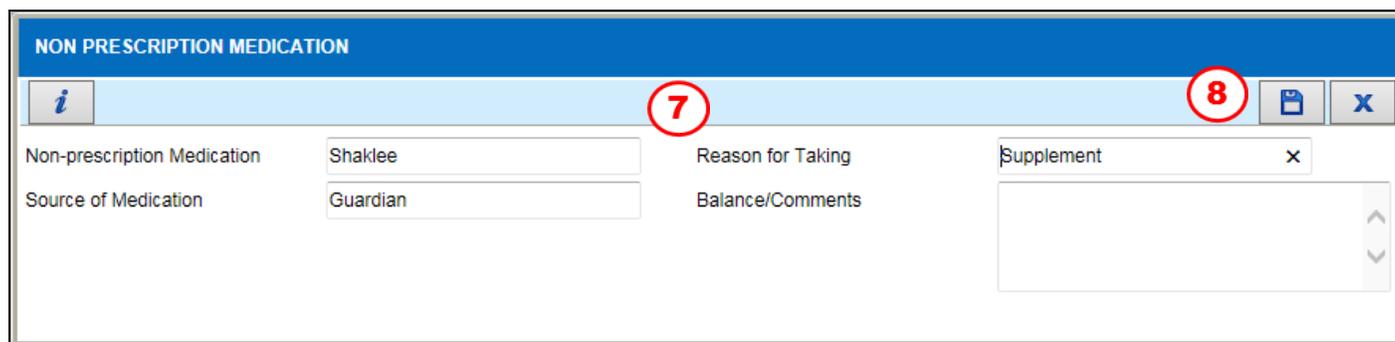


Figure 3.1.2-7 Non Prescription Medication

STEP 7

Fill in the necessary information

- Non-prescription Medication**
- Source of Medication**
- Reason for Taking**
- Balance/Comments**

STEP 8

Click on the  button to save record and system will display confirmation alert as figure 3.1.2-8

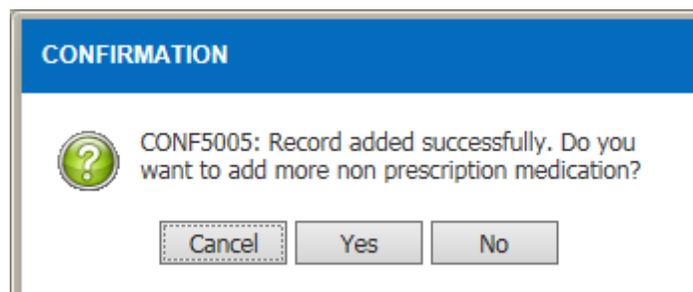
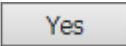
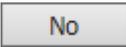


Figure 3.1.2-8 Confirmation Alert

Note

- Click on the  button will saved the record and allowed user to add more non prescription information without close the Non Prescription Medication screen.
- Click on the  button will saved the record and display the main screen
- Prescription Medication.
 - It has certain condition whereby the drug display at prescription medication come from the latest visit patient at that facility
 - User can add prescriptions medication from other facility too
- Non Prescription Medication.
 - User can add any none prescription medication that has been taken by patient in system

CP1

A: Patient Biodata
 Admission Date/Time: 04/01/2018 3:05:12 PM
 Ward/Bed:
 PMHx:
 Last Discharge/Review date:

B: Reason For Admission

C: Allergy & Adverse Drug Reaction
 1. Allergy 2. ADR

D: Drug History
 Patient's own drugs checked?

Prescription Medication + Add Prescription Medication

1 / 1 [1 - 3 / 3]

<input type="checkbox"/>	Drug Name	Original Rx N ^o	Order Details	Balance From Previous Supply	Medication Status	Source of Medication	Comments
<input checked="" type="checkbox"/>	Chlorpheniramine Maleate 2 mg/5 ml Syrup	40001087877	2 mg,OD (once daily),3 Days,04/01/2018 03:24 PM,07/01/2018 03:24 PM	60 ml	ORDERED	Hospital Pakar Sultanah Fatimah, Muar	Inpatient / 04-01-2018 / EncounterNo:0001
<input type="checkbox"/>	Lorazepam 1 mg Tablet	40001087880	1 mg,BD (twice daily),4 Days,04/01/2018 03:44 PM,08/01/2018 03:44 PM	8 tablet	ORDERED	Hospital Pakar Sultanah Fatimah, Muar	Inpatient / 04-01-2018 / EncounterNo:0001
<input checked="" type="checkbox"/>	Paracetamol 250 mg/5 ml Syrup	40001087876	120 mg,PRN,5 Days,04/01/2018 03:06 PM,09/01/2018 03:06 PM	60 ml	ORDERED	Hospital Pakar Sultanah Fatimah, Muar	Inpatient / 04-01-2018 / EncounterNo:0001

Non Prescription Medication + Add Non Prescription Medication

1 / 1

<input type="checkbox"/>	Non-Prescription Medication(Includes Herbal/Vitamin/Other Supplements)	Reason For Taking	Source of Medication	Balance/Comments
<input checked="" type="checkbox"/>	shaklee	Supplement	Guardians	

Figure 3.1.2-9 CP1

STEP 9

Click on the  button to save the CP1 record and confirmation alert will display as Figure 3.1.2-10

CONFIRMATION



CONF0151: Are you sure you want to save?

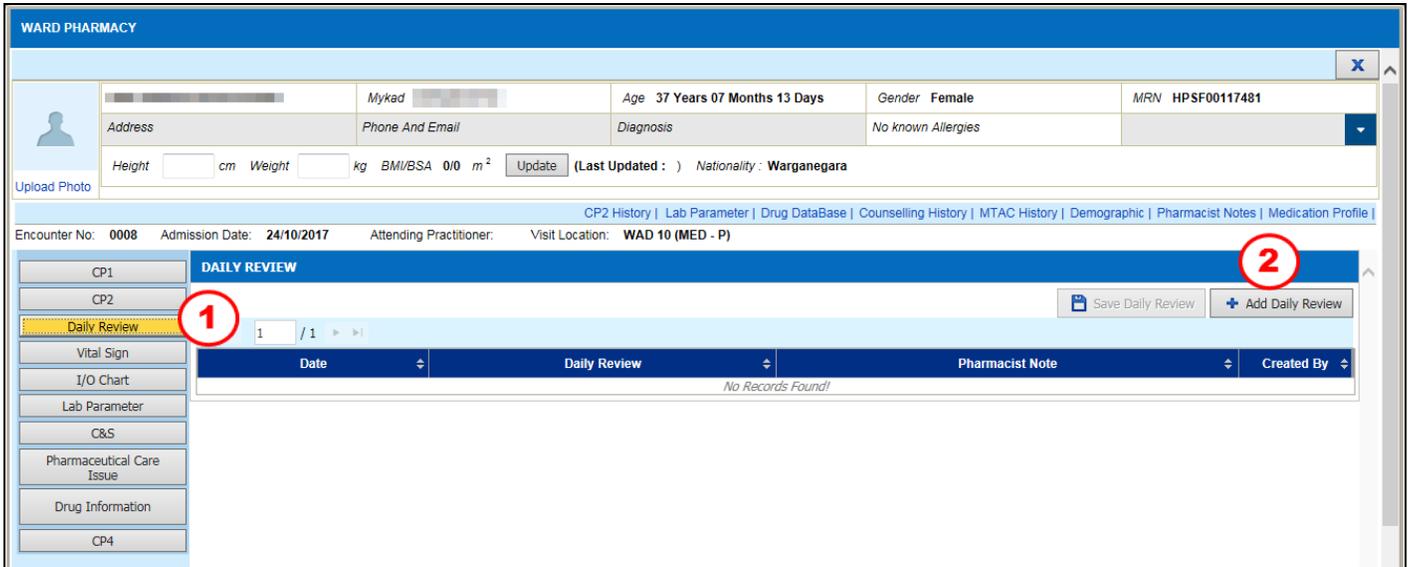
Figure 3.1.2-10 Confirmation Alert

Note

Information under Prescription Medication and Non Prescription will be display in the CP2 if user tick on the information checkbox.

3.1.3 Daily Review

To record Daily review, perform the step below:



WARD PHARMACY

Mykad: [REDACTED] Age: 37 Years 07 Months 13 Days Gender: Female MRN: HPSF00117481

Address: [REDACTED] Phone And Email: [REDACTED] Diagnosis: [REDACTED] No known Allergies

Height: [REDACTED] cm Weight: [REDACTED] kg BMI/BSA: 0/0 m² Update (Last Updated:) Nationality: Warganegara

Encounter No: 0008 Admission Date: 24/10/2017 Attending Practitioner: Visit Location: WAD 10 (MED - P)

CP1 CP2 CP3 CP4

DAILY REVIEW Save Daily Review + Add Daily Review

1 / 1

Date	Daily Review	Pharmacist Note	Created By
No Records Found!			

Figure 3.1.3-1 Daily Review

STEP 1

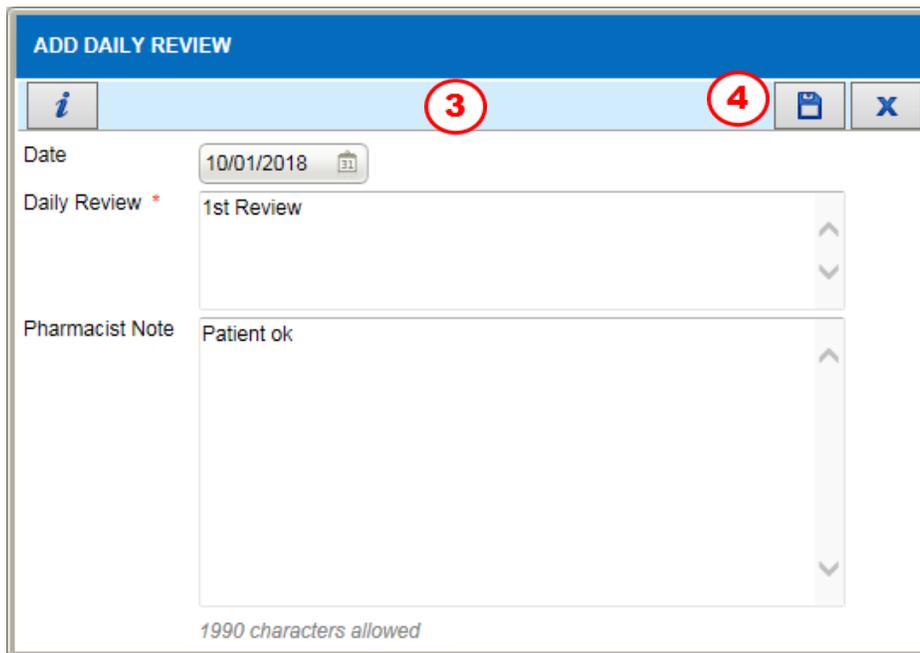
Click on the **Daily Review** tab on the left side

STEP 2

Click on the **+ Add Daily Review** button and Add Daily Review screen will be display as Figure 3.1.3-2

Note

Add Daily Review button only will be enable if user completed fill in CP2 information in the system



ADD DAILY REVIEW

i 3 4 Save X

Date: 10/01/2018

Daily Review *: 1st Review

Pharmacist Note: Patient ok

1990 characters allowed

Figure 3.1.3-2 Add Daily Review

STEP 3

Fill in necessary information

- a) **Date**
- b) **Daily Review**
- c) **Pharmacist Note**

STEP 4

Click on the  button to save the record and confirmation alert will displayed as Figure 3.1.3-3

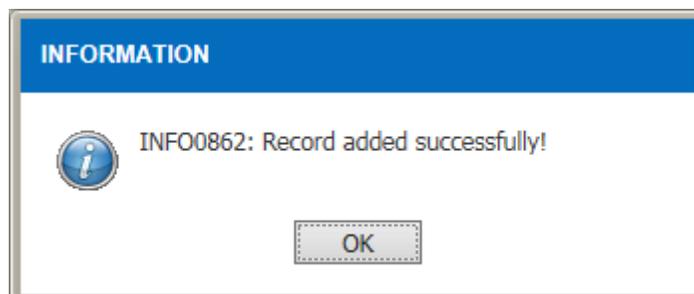


Figure 3.1.3-3 Confirmation Alert

Note

- Click on the  button to successfully save the record
- After save the record, the information will displayed in the main screen as Figure 3.1.3-4

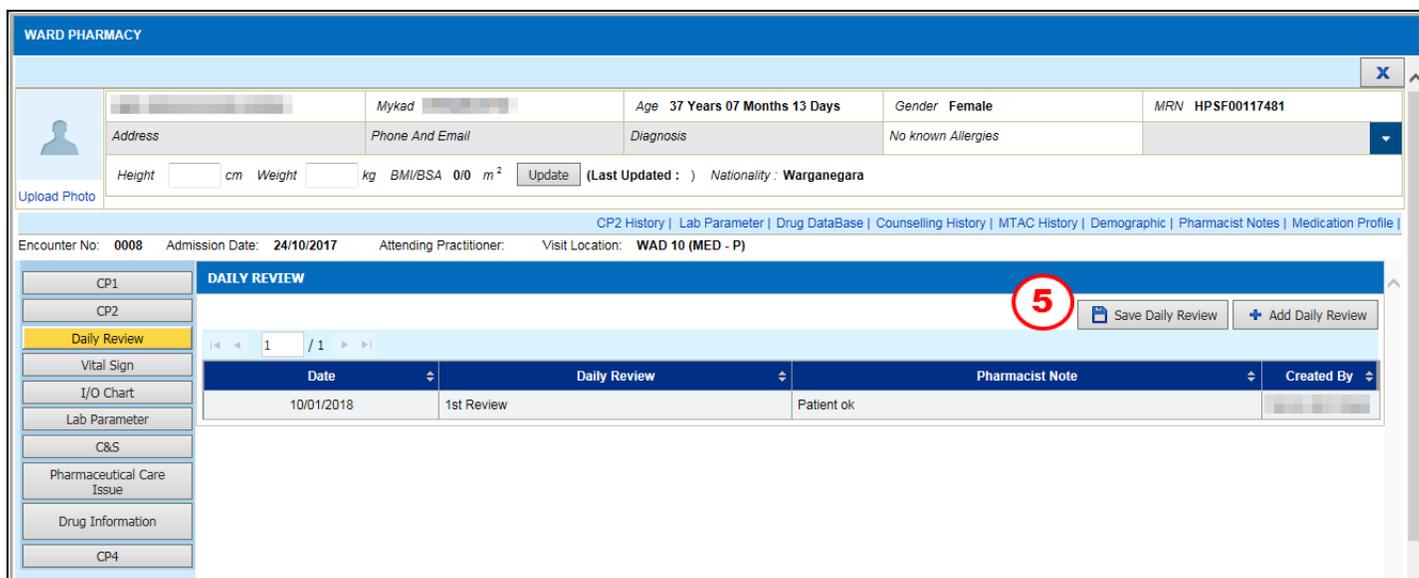


Figure 3.1.3-4 Daily Review

Note

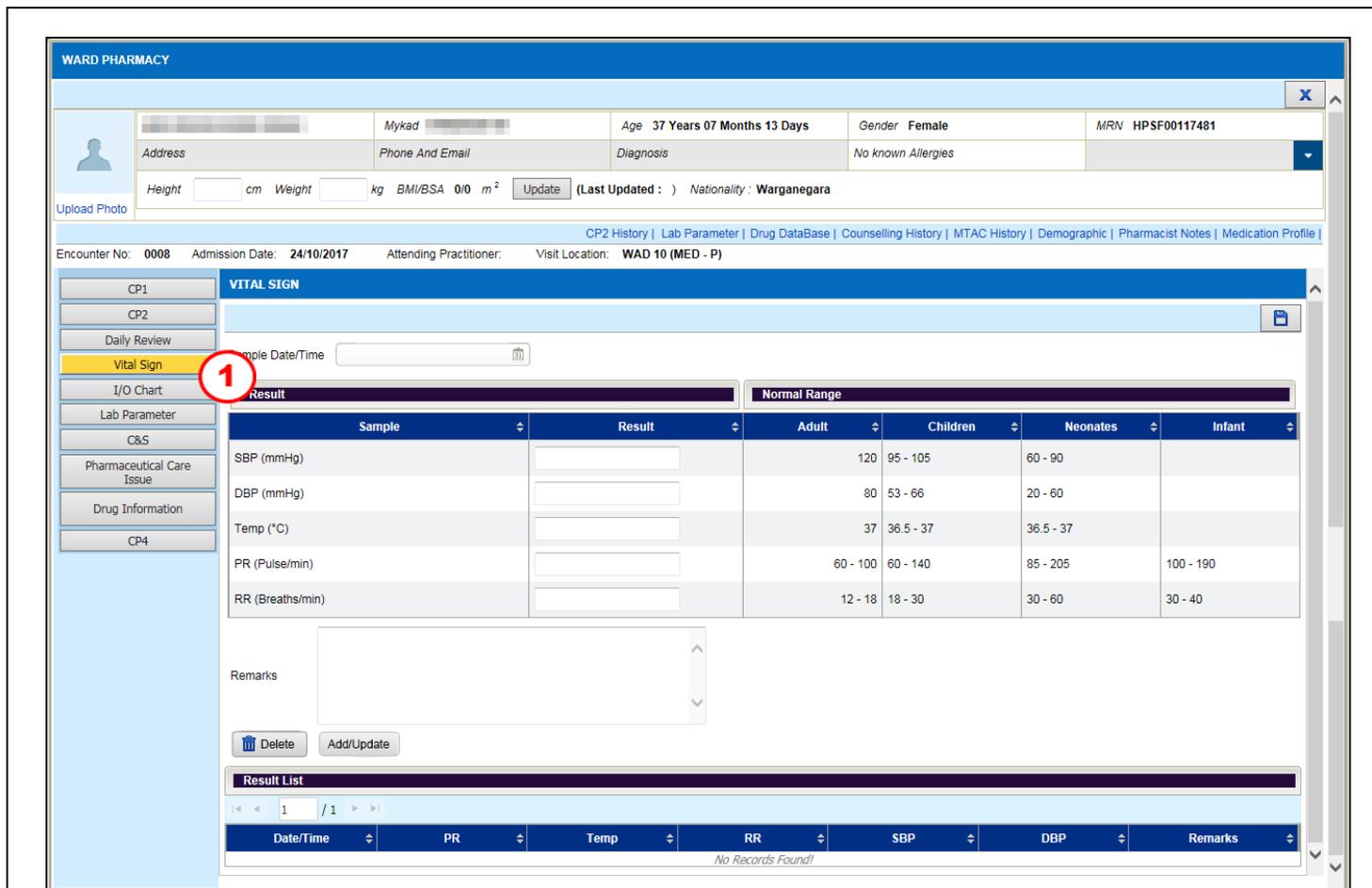
User is allowed to edit the record by double click on the information.

STEP 5

Click on the  button to save the Daily review record

3.1.4 Vital Sign

To record Vital Sign, perform the step below:



The screenshot shows the 'WARD PHARMACY' interface. At the top, there is a patient information summary including Mykad, Age (37 Years 07 Months 13 Days), Gender (Female), and MRN (HPSF00117481). Below this, there are fields for Address, Phone And Email, Diagnosis, and No known Allergies. A 'Vital Sign' tab is highlighted in yellow in the left-hand navigation menu, with a red circle and the number '1' next to it. The main content area shows a 'VITAL SIGN' form with a 'Sample Date/Time' field. Below this is a table with columns for 'Sample', 'Result', and 'Normal Range'. The 'Normal Range' column is further divided into 'Adult', 'Children', 'Neonates', and 'Infant'. The table lists parameters: SBP (mmHg), DBP (mmHg), Temp (°C), PR (Pulse/min), and RR (Breaths/min). Below the table is a 'Remarks' field with 'Delete' and 'Add/Update' buttons. At the bottom, there is a 'Result List' section with a table header: Date/Time, PR, Temp, RR, SBP, DBP, Remarks. The text 'No Records Found!' is displayed below the table.

Figure 3.1.4-1 Vital Sign

STEP 1

Click on the **Vital Sign** tab on the left side

VITAL SIGN

Sample Date/Time

2

Result	Normal Range				
Sample	Result	Adult	Children	Neonates	Infant
SBP (mmHg)	<input type="text" value="118"/>	120	95 - 105	60 - 90	
DBP (mmHg)	<input type="text" value="79"/>	80	53 - 66	20 - 60	
Temp (°C)	<input type="text" value="37"/>	37	36.5 - 37	36.5 - 37	
PR (Pulse/min)	<input type="text" value="80"/>	60 - 100	60 - 140	85 - 205	100 - 190
RR (Breaths/min)	<input type="text" value="14"/>	12 - 18	18 - 30	30 - 60	30 - 40

Remarks

Delete
 Add/Update
4

Result List

<< 1 / 1 >>

Date/Time	PR	Temp	RR	SBP	DBP	Remarks
02/01/2018 03:46 PM	80	37	14	118	79	

Figure 3.1.4-2 Vital Sign

STEP 2

Select **Sample Date/Time**

STEP 3

Fill in necessary information

- a) **SBP (mmHg)**
- b) **DBP (mmHg)**
- c) **Temp (°C)**
- d) **PR (Pulse/min)**
- e) **RR (Breaths/min)**
- f) **Remarks**

STEP 4

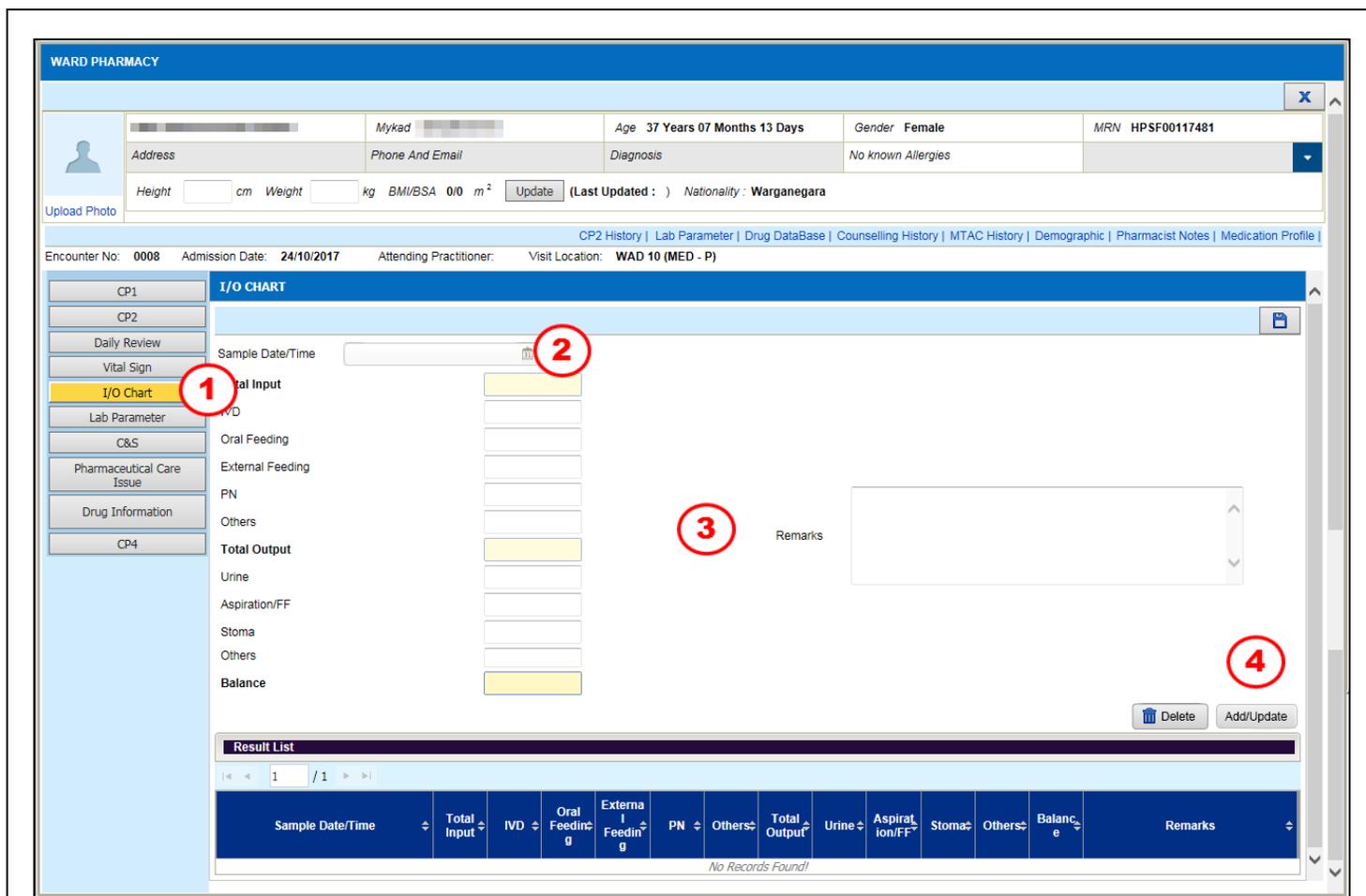
Click on the button to add the information in to Result List

Note

- User is allowed to delete the record by click on the button
- User is allowed to update the record by double click on the information in the Result List and edit the information if applicable

3.1.5 I/O Chart

To record I/O Chart, perform the step below:



WARD PHARMACY

Mykad: [Redacted] Age: 37 Years 07 Months 13 Days Gender: Female MRN: HPSF00117481

Address: [Redacted] Phone And Email: [Redacted] Diagnosis: [Redacted] No known Allergies

Height: [Redacted] cm Weight: [Redacted] kg BMI/BSA: 0/0 m² Update (Last Updated:) Nationality: Warganegara

CP2 History | Lab Parameter | Drug DataBase | Counselling History | MTAC History | Demographic | Pharmacist Notes | Medication Profile

Encounter No: 0008 Admission Date: 24/10/2017 Attending Practitioner: Visit Location: WAD 10 (MED - P)

I/O CHART

Sample Date/Time: [Redacted] **2**

1 Total Input: [Redacted]

IVD: [Redacted]

Oral Feeding: [Redacted]

External Feeding: [Redacted]

PN: [Redacted]

Others: [Redacted]

3 Total Output: [Redacted] Remarks: [Redacted]

Urine: [Redacted]

Aspiration/FF: [Redacted]

Stoma: [Redacted]

Others: [Redacted]

Balance: [Redacted]

4

Delete Add/Update

Result List

Sample Date/Time	Total Input	IVD	Oral Feeding	External Feeding	PN	Others	Total Output	Urine	Aspiration/FF	Stoma	Others	Balance	Remarks
No Records Found!													

Figure 3.1.5-1 I/O Chart

STEP 1

Click on the **I/O Chart** tab on the left side

STEP 2

Select **Sample Date/Time**

STEP 3

Fill in all necessary information

- IVD
- Oral Feeding
- External Feeding
- PN
- Others
- Urine
- Aspiration/FF
- Stoma
- Others
- Balance
- Remarks

STEP 4

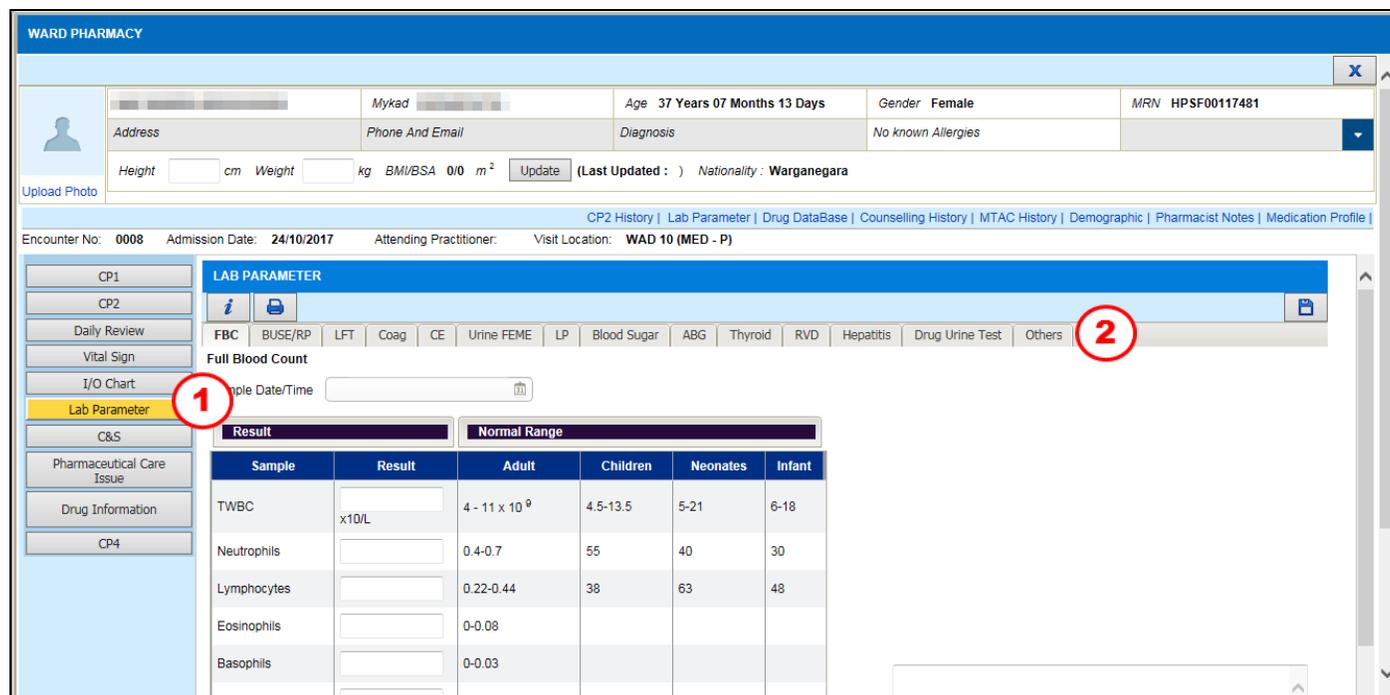
Click on the  button to add the information in to Result List

Note

- *User is allowed to delete the record by click on the  button*
- *User is allowed to update the record by double click on the information in the Result List and edit the information if applicable*

3.1.6 Lab Parameter

To record Lab Parameter, perform the step below:



WARD PHARMACY

Mykad: [Redacted] Age: 37 Years 07 Months 13 Days Gender: Female MRN: HPSF00117481

Address: [Redacted] Phone And Email: [Redacted] Diagnosis: [Redacted] No known Allergies

Height: [Redacted] cm Weight: [Redacted] kg BMI/BSA: 0/0 m² Update (Last Updated:) Nationality: Warganegara

CP2 History | Lab Parameter | Drug DataBase | Counselling History | MTAC History | Demographic | Pharmacist Notes | Medication Profile

Encounter No: 0008 Admission Date: 24/10/2017 Attending Practitioner: Visit Location: WAD 10 (MED - P)

LAB PARAMETER

FBC BUSE/RP LFT Coag CE Urine FEME LP Blood Sugar ABG Thyroid RVD Hepatitis Drug Urine Test Others

Full Blood Count

Sample Date/Time

Sample	Result	Normal Range			
		Adult	Children	Neonates	Infant
TWBC	x10/L	4 - 11 x 10 ⁹	4.5-13.5	5-21	6-18
Neutrophils		0.4-0.7	55	40	30
Lymphocytes		0.22-0.44	38	63	48
Eosinophils		0-0.08			
Basophils		0-0.03			

Figure 3.1.6-1 Lab Parameter

STEP 1

Click on the **Lab Parameter** tab on the left side

STEP 2

Select Lab Parameter that consist of:

- FBX**
- BUSE/RP**
- LFT**
- Coug**
- CE**
- Urine FEME**
- LP**
- Blood Sugar**
- ABG**
- Thyroid**
- RVD**
- Hepatitis**
- Drug Urine Test**
- Others**

LAB PARAMETER

i
📄

FBC
BUSE/RP
LFT
Coag
CE
Urine FEME
LP
Blood Sugar
ABG
Thyroid
RVD
Hepatitis
Drug Urine Test
Others

Full Blood Count

Sample Date/Time

Result		Normal Range			
Sample	Result	Adult	Children	Neonates	Infant
TWBC	<input type="text"/> x10 ⁹ /L	4 - 11 x 10 ⁹	4.5-13.5	5-21	6-18
Neutrophils	<input type="text"/>	0.4-0.7	55	40	30
Lymphocytes	<input type="text"/>	0.22-0.44	38	63	48
Eosinophils	<input type="text"/>	0-0.08			
Basophils	<input type="text"/>	0-0.03			
RBC (/L)	<input type="text"/> x10 ⁶	4.5- 6.3 x 10 ¹²	3.7 - 6.5 x 10 ¹²	3.7 - 6.5 x 10 ¹²	
Monocytes	<input type="text"/>				
Hb (g/dL)	<input type="text"/> g	Male 13.5 - 17.5 Female 12 - 16			
HCT	<input type="text"/>	Male 0.41 - 0.53 Female 0.36 - 0.46	0.31 - 0.37	0.28 - 0.55	0.33 - 0.39
Platelet (/L)	<input type="text"/> x	150 - 400 x 10 ⁹			
MPV	<input type="text"/>				
MCV (fL)	<input type="text"/> fL	80 - 100	76 - 80		70 - 74
MCH (pg/cell)	<input type="text"/>	26 - 34	26-32	29	27
MCHC (g/L)	<input type="text"/>	310 - 370	310 - 370	290 - 380	

🗑️ Delete
Add/Update

Remarks

Result List

1 / 1

Sample Date/Time	TWBC	Neutrophils	Lymphocytes	Eosinophils	Basophils	RBC	Monocytes	MCV	Mpv	Hb	HCT	Mch	Mchc	Platelet	Remarks
No Records Found!															

Figure 3.1.6-2 Lab Parameter

STEP 3

Fill in all necessary information

STEP 4

Click on the Add/Update button to add the information in to Result List

Note

- User is allowed to delete the record by click on the 🗑️ Delete button
- User is allowed to update the record by double click on the information in the Result List and edit the information if applicable
- The step is the same for all other Lab Parameter

3.1.7 C&S

To record C&S, perform the step below:

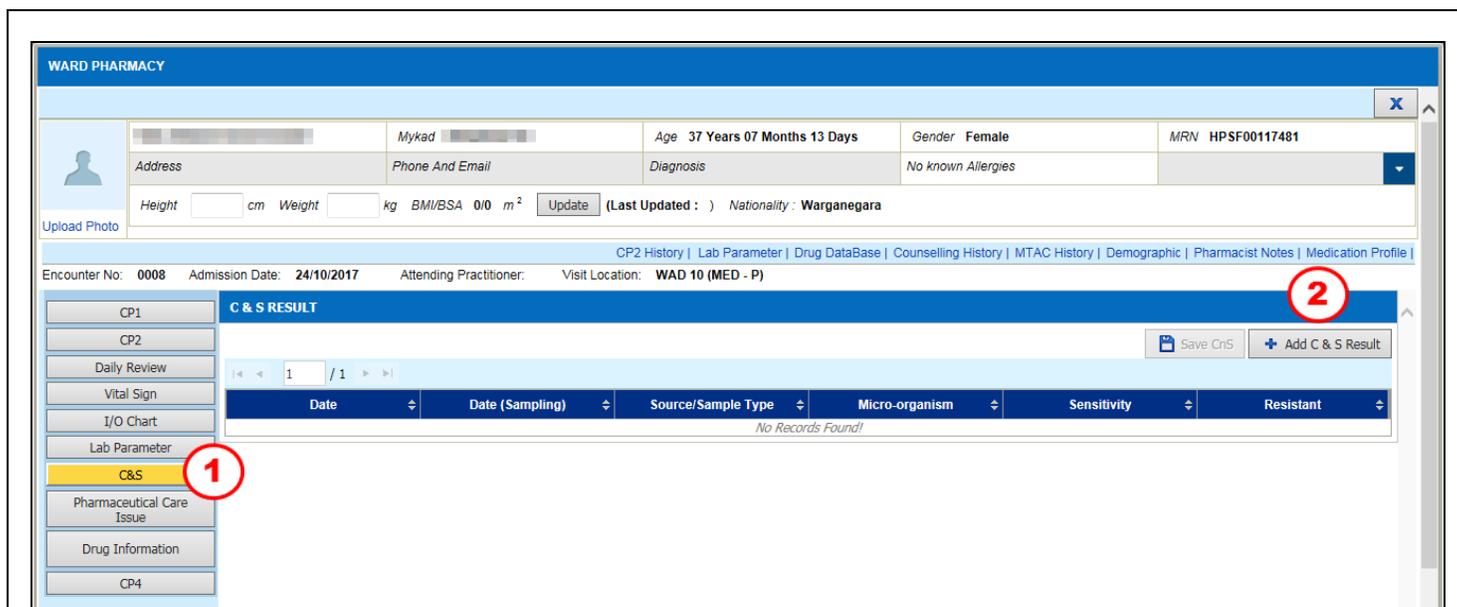


Figure 3.1.7-1 C&S

STEP 1

Click on the **C&S** tab on the left side

STEP 2

Click on the **+ Add C & S Result** button and C&S Result screen will displayed as Figure 3.1.7-2

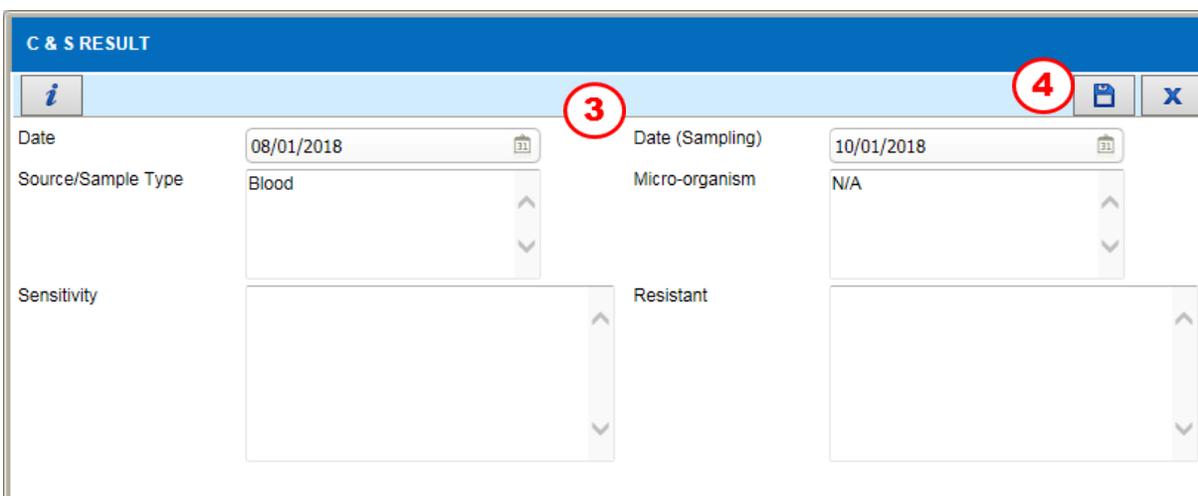


Figure 3.1.7-2 C&S Result

STEP 3

Fill in all the necessary information

- Date**
- Date (Sampling)**
- Source/Sample Type**
- Micro-organism**

- e) **Sensitivity**
- f) **Resistant**

Note

user is allow to edit **Date** with the condition of 5 days backdated

STEP 4

Click on the  button to save the record and system will display information alert as Figure 3.1.7-3

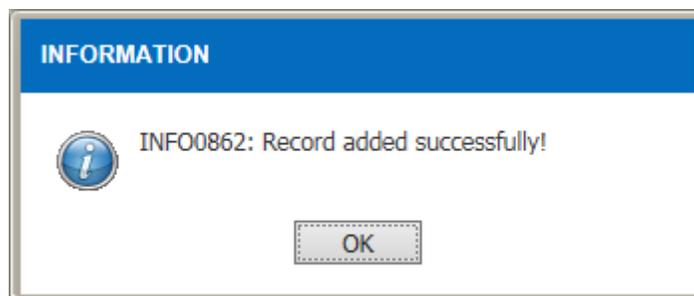
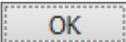
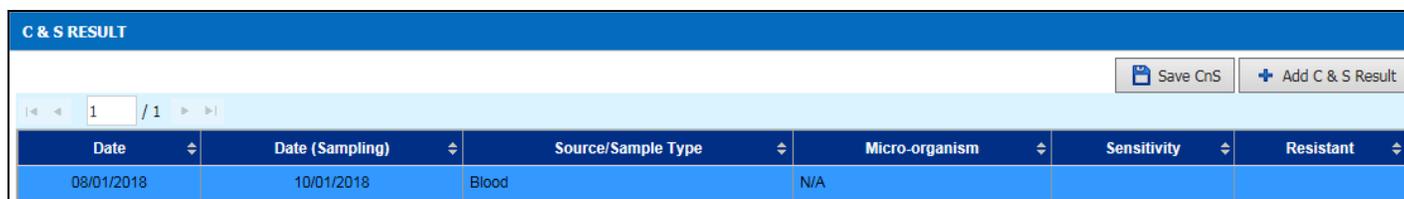


Figure 3.1.7-3 Information Alert

Note

- Click on the  button to successfully save the record
- After saved, the information will be display at the C&S main screen as Figure 3.1.7-4



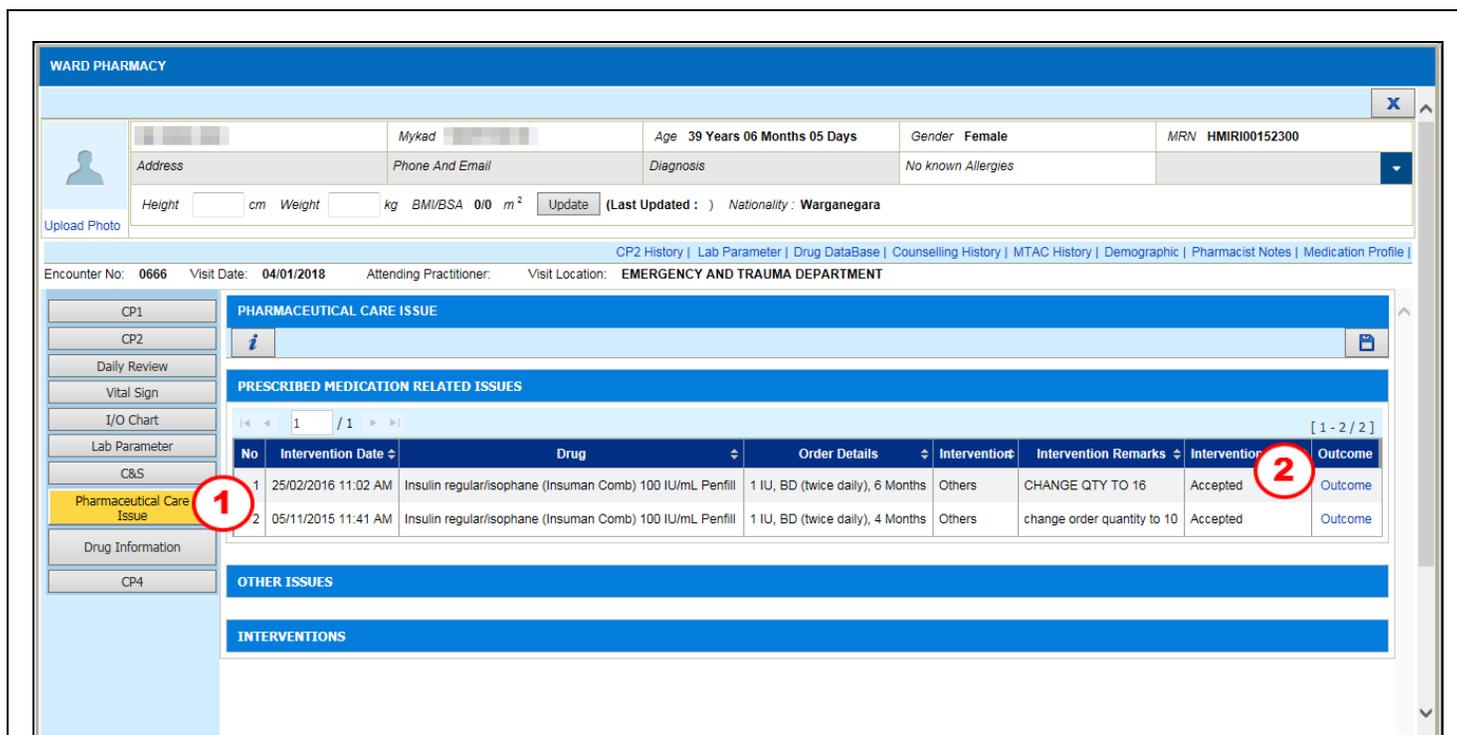
The image shows a screenshot of the "C & S RESULT" screen. At the top right, there are two buttons: "Save CnS" and "+ Add C & S Result". Below these is a pagination control showing "1 / 1". The main part of the screen is a table with the following data:

Date	Date (Sampling)	Source/Sample Type	Micro-organism	Sensitivity	Resistant
08/01/2018	10/01/2018	Blood	N/A		

Figure 3.1.7-4 C&S Result

3.1.8 Pharmaceutical Care Issue

To record Pharmaceutical Care Issue, perform the step below:



WARD PHARMACY

Mykad: [REDACTED] Age: 39 Years 06 Months 05 Days Gender: Female MRN: HMIRI00152300

Address: [REDACTED] Phone And Email: [REDACTED] Diagnosis: [REDACTED] No known Allergies

Height: [REDACTED] cm Weight: [REDACTED] kg BMI/BSA: 0/0 m² Update (Last Updated:) Nationality: Warganegara

Encounter No: 0666 Visit Date: 04/01/2018 Attending Practitioner: [REDACTED] Visit Location: EMERGENCY AND TRAUMA DEPARTMENT

CP1 CP2 Daily Review Vital Sign I/O Chart Lab Parameter C&S **Pharmaceutical Care Issue** Drug Information CP4

PHARMACEUTICAL CARE ISSUE

PRESCRIBED MEDICATION RELATED ISSUES

No	Intervention Date	Drug	Order Details	Intervention	Intervention Remarks	Intervention	Outcome
1	25/02/2016 11:02 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 6 Months	Others	CHANGE QTY TO 16	Accepted	Outcome
2	05/11/2015 11:41 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 4 Months	Others	change order quantity to 10	Accepted	Outcome

OTHER ISSUES

INTERVENTIONS

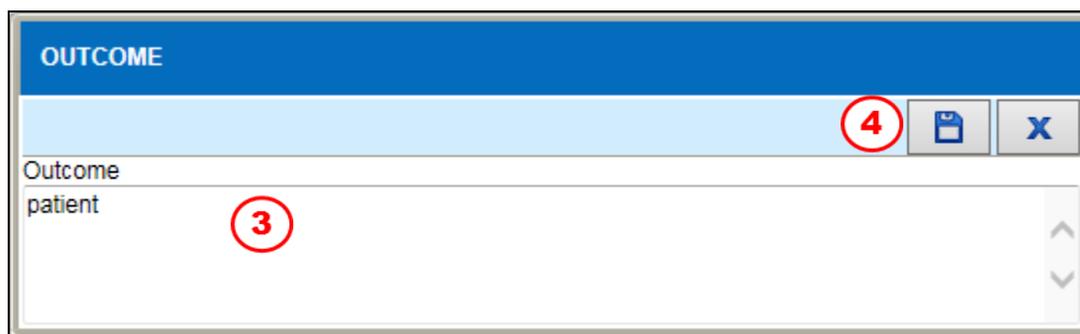
Figure 3.1.8-1 Pharmaceutical Care Issue

STEP 1

Click on the **C&S** tab on the left side

STEP 2

Enter the **Prescribed Medication Related Issues** if applicable by click on the **Outcome** hyperlink



OUTCOME

Outcome patient

Figure 3.1.8-2 Outcome

STEP 3

Enter the information **outcome**

STEP 4

Click on the  button to save the record

Note
Prescribed Medication Related Issues is only available if pharmacists do the prescription intervention during dispensing stage

OTHER ISSUES

Date: 5

Interventions/Requests Encountered

Type of Intervention: *

Description: *

PCI:

Status of Intervention *
 Accepted
 Not Accepted

Pharmacist Recommendation:

Outcome:

6

INTERVENTIONS

<< 1 / 1 >>

Date	Type of Intervention	Description	PCI	Pharmacist Recommendation	Status of Intervention	Outcome	Follow-up	Checklist
No Records Found!								

Figure 3.1.8-3 Other Issues

STEP 5

Enter 'Other Issues' if applicable

- a) Date
- b) Type of Intervention
- c) PCI
- d) Pharmacist Recommendation
- e) Description
- f) Status of Intervention
 - Accepted
 - Not Accepted
- g) Outcome

Note

This section is use for ward pharmacist to record other PCI issue that is not related to dispensing intervention.

STEP 6

Click on the button to add the record and it will display in Interventions section as Figure 3.1.8-4

INTERVENTIONS

<< 1 / 1 >>

Date	Type of Intervention	Description	PCI	Pharmacist Recommendation	Status of Intervention	Outcome	Follow-up	Checklist
10/01/2018	Incomplete Prescriptions	Dose			Accepted			<input type="checkbox"/>

Figure 3.1.8-4 Interventions

Note

- To edit information in **'Interventions'** section, double click on the data then click on the  button. Change the information that display in the **'Other Issue'** section.
- To delete information in **'Interventions'** section, click on the information checkbox then click on the  button.

PHARMACEUTICAL CARE ISSUE								
								 7
PRESCRIBED MEDICATION RELATED ISSUES								
[1 - 2 / 2]								
No	Intervention Date	Drug	Order Details	Intervention	Intervention Remarks	Intervention Status	Outcome	
1	25/02/2016 11:02 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 6 Months	Others	CHANGE QTY TO 16	Accepted	Outcome	
2	05/11/2015 11:41 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 4 Months	Others	change order quantity to 10	Accepted	Outcome	

Figure 3.1.8-5 Pharmaceutical Care Issue

STEP 7

Click on the  button to save the record and system will displayed confirmation alert as Figure 3.1.8-6

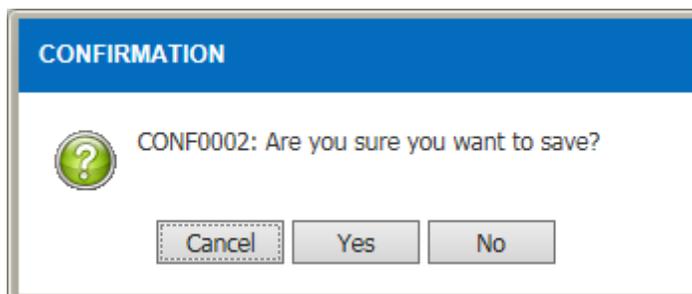
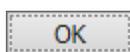


Figure 3.1.8-6 Confirmation Alert

Note

Click on the  button to save the record and system will display information alert as Figure 3.1.8-7

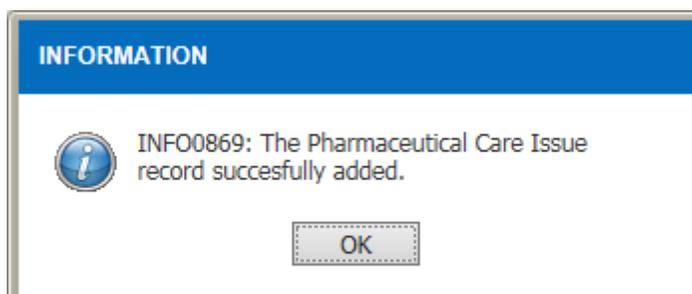
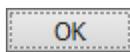


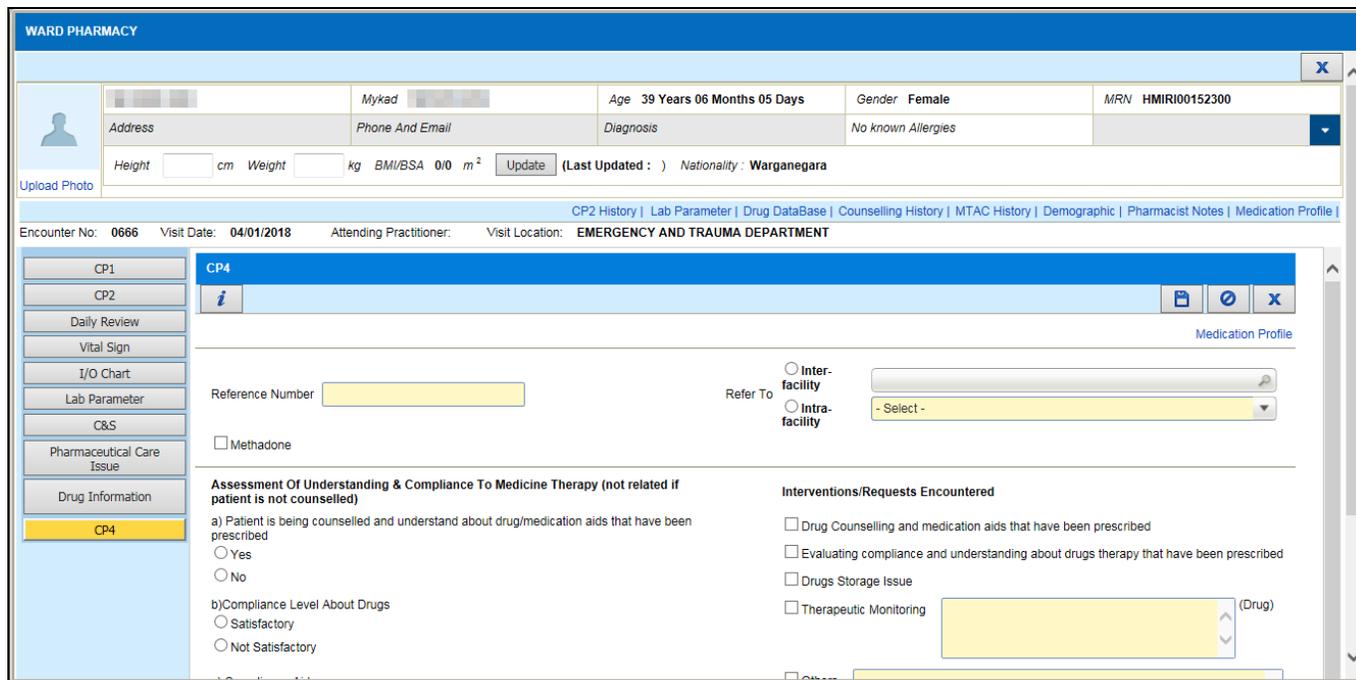
Figure 3.1.8-7 Information Alert

Note

Click on the  button to successfully save

3.1.9 CP4

To record CP4, perform the step below:



WARD PHARMACY

Mykad: [Redacted] Age: 39 Years 06 Months 05 Days Gender: Female MRN: HMIRI00152300

Address: [Redacted] Phone And Email: [Redacted] Diagnosis: [Redacted] No known Allergies

Height: [Redacted] cm Weight: [Redacted] kg BMI/BSA: 0/0 m² Update (Last Updated:) Nationality: Warganegara

Encounter No: 0666 Visit Date: 04/01/2018 Attending Practitioner: [Redacted] Visit Location: EMERGENCY AND TRAUMA DEPARTMENT

CP4

Reference Number: [Redacted]

Refer To: Inter-facility Intra-facility

Methadone

Assessment Of Understanding & Compliance To Medicine Therapy (not related if patient is not counselled)

a) Patient is being counselled and understand about drug/medication aids that have been prescribed

Yes No

b) Compliance Level About Drugs

Satisfactory Not Satisfactory

Interventions/Requests Encountered

Drug Counselling and medication aids that have been prescribed

Evaluating compliance and understanding about drugs therapy that have been prescribed

Drugs Storage Issue

Therapeutic Monitoring [Redacted] (Drug)

Figure 3.1.9-1 CP4

STEP 1

Click on the **CP4** tab on the left side

To Record CP4

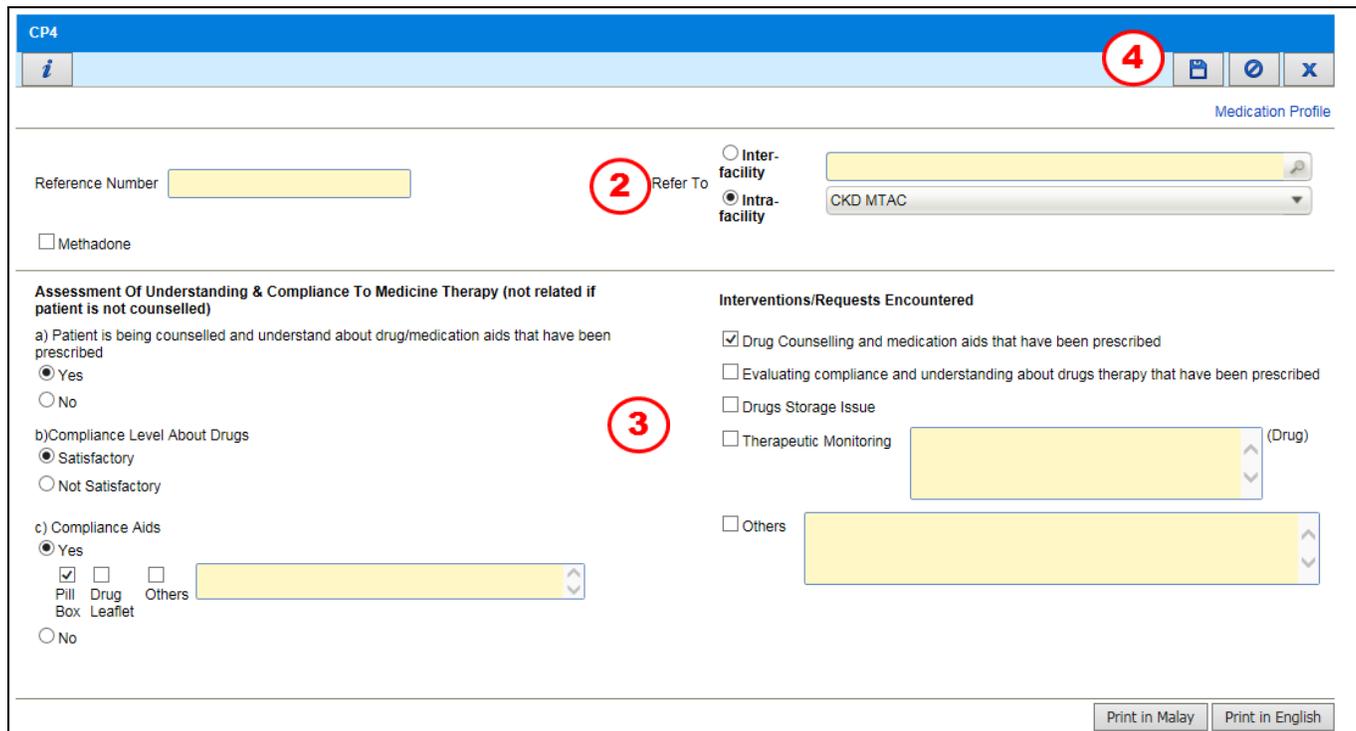


Figure 3.1.9-2 CP4

STEP 2

Select **Refer To**

- a) **Inter-facility**
- b) **Intra-facility**

STEP 3

Fill up the question

STEP 4

Click on the  button to save the record

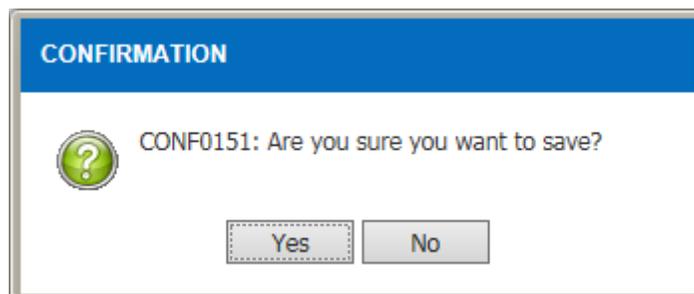
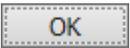
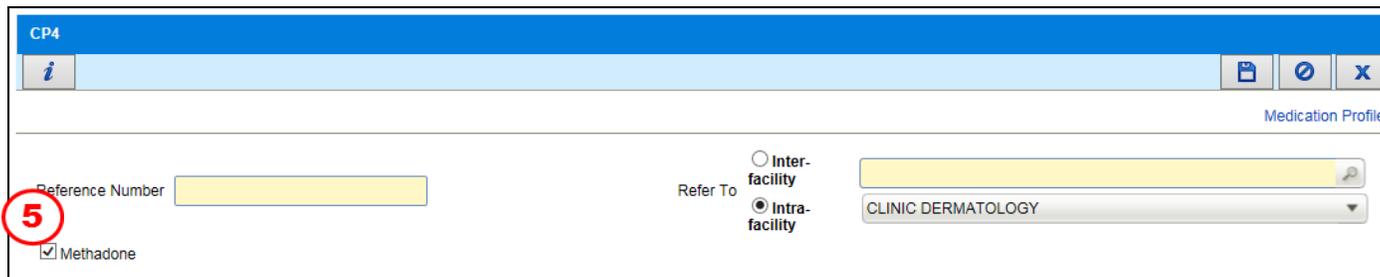


Figure 3.1.9-3 Confirmation Alert

Note

Click on the  button to save the record

To Record CP4 Methadone



CP4

Reference Number

Methadone

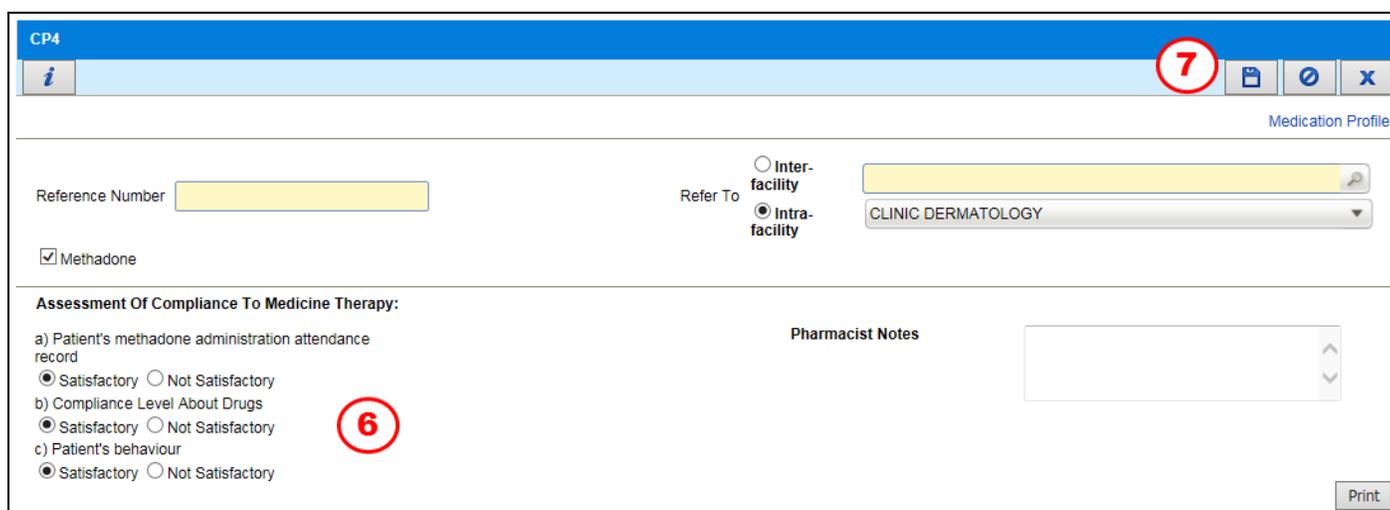
Refer To Inter-facility Intra-facility

CLINIC DERMATOLOGY

Figure 3.1.9-4 CP4 Methadone

STEP 5

Click on the **Methadone** checkbox



CP4

Reference Number

Methadone

Assessment Of Compliance To Medicine Therapy:

a) Patient's methadone administration attendance record
 Satisfactory Not Satisfactory

b) Compliance Level About Drugs
 Satisfactory Not Satisfactory

c) Patient's behaviour
 Satisfactory Not Satisfactory

Pharmacist Notes

Print

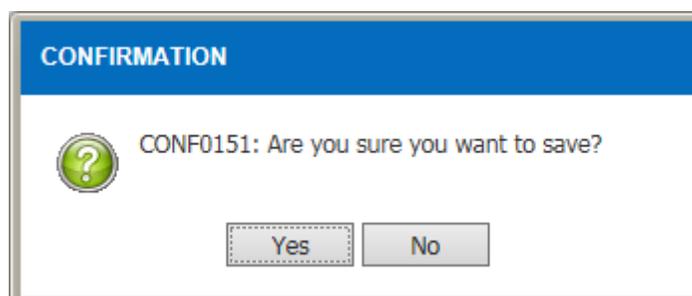
Figure 3.1.9-5 CP4 Methadone

STEP 6

Fill up the question

STEP 7

Click on the  button to save the record



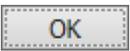
CONFIRMATION

CONF0151: Are you sure you want to save?

Yes No

Figure 3.1.9-6 Confirmation Alert

Note

Click on the  button to save the record

4.0 Acronyms

Abbreviation	Definition
PhIS	Pharmacy Information System
CPS	Clinical Pharmacy System
PM	Patient Management
eGL	Electronic Guarantee Letter
HRMIS	Human Resource Management System
MRN	Medical Record Number
MOH	Ministry of Health

5.0 Links to Clinical Modules

No	Module	PDF Links	No	Module	PDF Links
1	<i>Inpatient</i>	Click Here	12	<i>CDR Dispensing</i>	Click Here
2	<i>CDR Order</i>	Click Here	13	<i>Methadone Dispensing</i>	Click Here
3	<i>TDM Order</i>	Click Here	14	<i>PN Dispensing</i>	Click Here
4	<i>PN Order</i>	Click Here	15	<i>Order Management</i>	Click Here
5	<i>IV Order</i>	Click Here	16	<i>Patient Management</i>	Click Here
6	<i>Prepacking</i>	Click Here	17	<i>Radiopharmaceuticals</i>	Click Here
7	<i>Galenical</i>	Click Here	18	<i>Outpatient</i>	Click Here
8	<i>MTAC</i>	Click Here	19	<i>Special Drug Request</i>	Click Here
9	<i>ADR & DAC</i>	Click Here	20	<i>MAR</i>	Click Here
10	<i>Medication Counselling</i>	Click Here	21	<i>DICE</i>	Click Here
11	<i>Ward Pharmacy</i>	Click Here	22		