



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

Pharmacy Based

**User Manual
Ward Pharmacy**

Version	: 10th EDITION
Document ID	: PB_U. MANUAL_WARD PHARMACY



PhIS & CPS Project
User Manual – Ward Pharmacy



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Reference ID : PB_U. MANUAL_WARD PHARMACY-10th EDITION

Application reference: PhIS & CPS v2.1 & v2.2

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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)



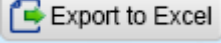
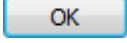

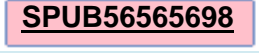






1.3 Organised Sections

These are the sections within this document:

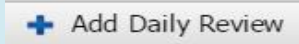

- Section 1: Introduction
- Section 2: Application Standard Features
- Section 3: Ward Pharmacy
- Section 4: Acronyms
- Section 5: Links to Clinical Modules

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		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

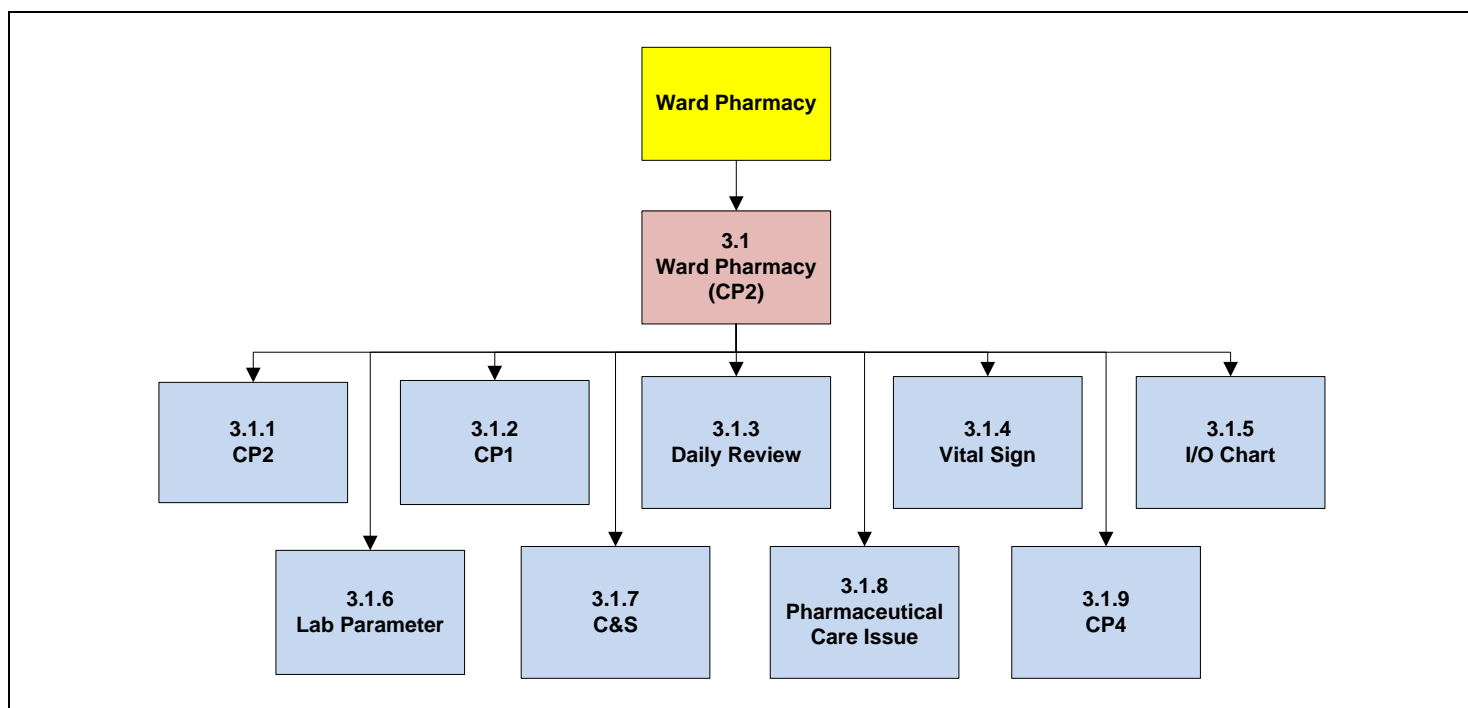


Figure 3.1

Functional Description

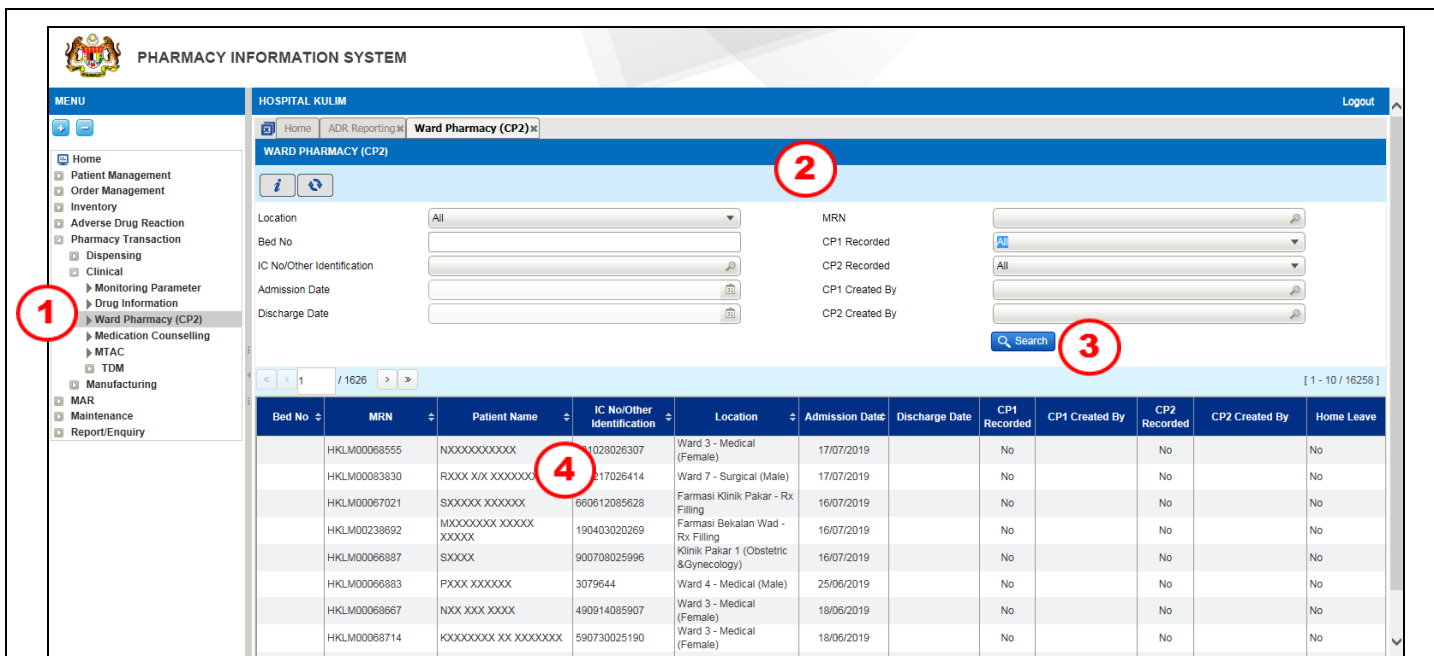
Ward Pharmacy comprises of nine (9) functions:

- 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.



Bed No	MRN	Patient Name	IC No/Other Identification	Location	Admission Date	Discharge Date	CP1 Recorded	CP1 Created By	CP2 Recorded	CP2 Created By	Home Leave
	HKLM00068555	NXXXXXXXXX	1028026307	Ward 3 - Medical (Female)	17/07/2019		No		No		No
	HKLM00083830	RXXX XX XXXXXX	17026414	Ward 7 - Surgical (Male)	17/07/2019		No		No		No
	HKLM00067021	SXXXXX XXXXXX	660612085628	Farmasi Klinik Pakar - Rx Filling	16/07/2019		No		No		No
	HKLM00238692	MXXXXXXXX XXXX XXXX	190403020269	Farmasi Bekalan Wad - Rx Filling	16/07/2019		No		No		No
	HKLM00066887	SXXXX	900708025996	Klinik Pakar 1 (Obstetric & Gynecology)	16/07/2019		No		No		No
	HKLM00066883	PXXX XXXXXX	3079644	Ward 4 - Medical (Male)	25/06/2019		No		No		No
	HKLM00068667	NXX XXX XXXX	490914085907	Ward 3 - Medical (Female)	18/06/2019		No		No		No
	HKLM00068714	KXXXXXXXX XX XXXXXX	590730025190	Ward 3 - Medical (Female)	18/06/2019		No		No		No

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: <ul style="list-style-type: none"> - 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	IC No/Other Identification	IC No/Other Identification	Allow to search by patient full or partial IC No/Other Identification
e	CP1 Recorded?	<ul style="list-style-type: none"> - All - Yes - No 	All-Allow to search by status 'Yes' and 'No' Yes-Allow to search by status 'Yes' No-Allow to search by status 'No'
f	CP2 Recorded?	<ul style="list-style-type: none"> - All 	All-Allow to search by status 'Yes' and 'No'

		– Yes – No	Yes-Allow to search by status 'Yes' No-Allow to search by status 'No'
G	CP1 Created By	CP1 Created By	Allow to search CP1 created by
h	CP2 Created By	CP2 Created By	Allow to search CP2 created by
i	Admission Date	Date Enter Ward	Allow to search by date enter to ward
j	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

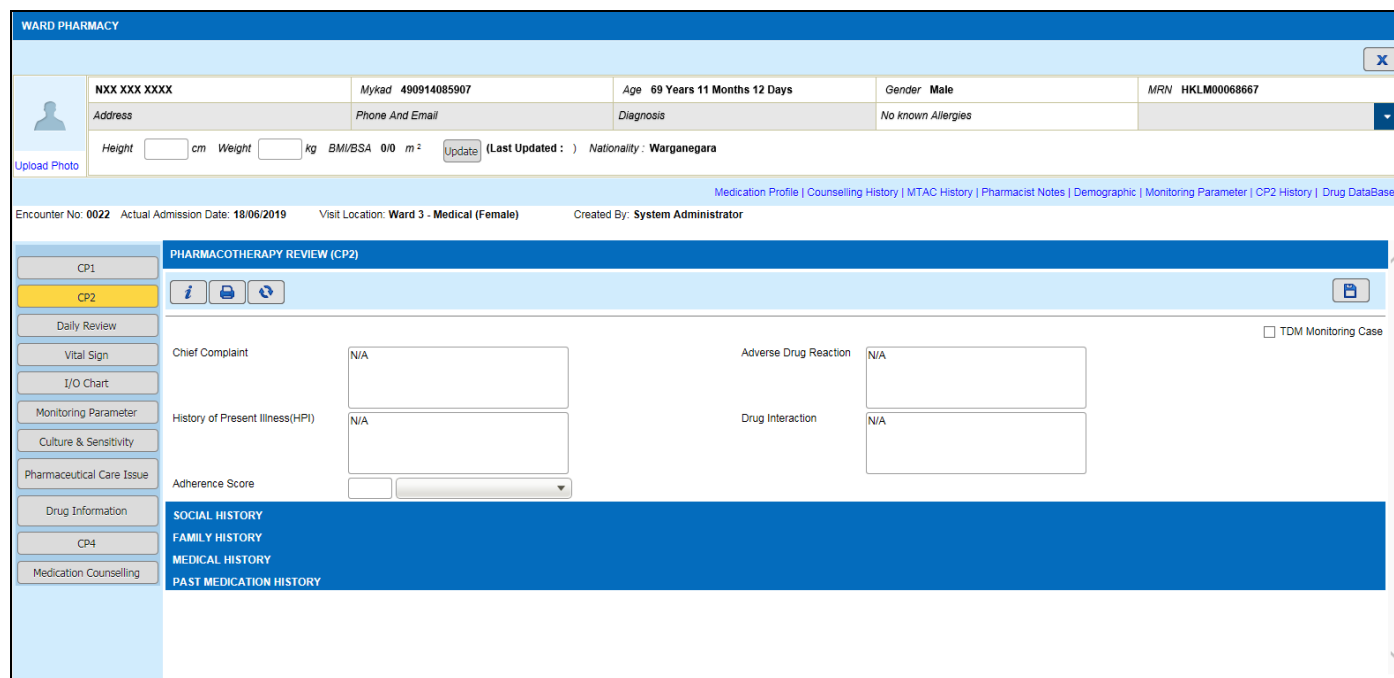
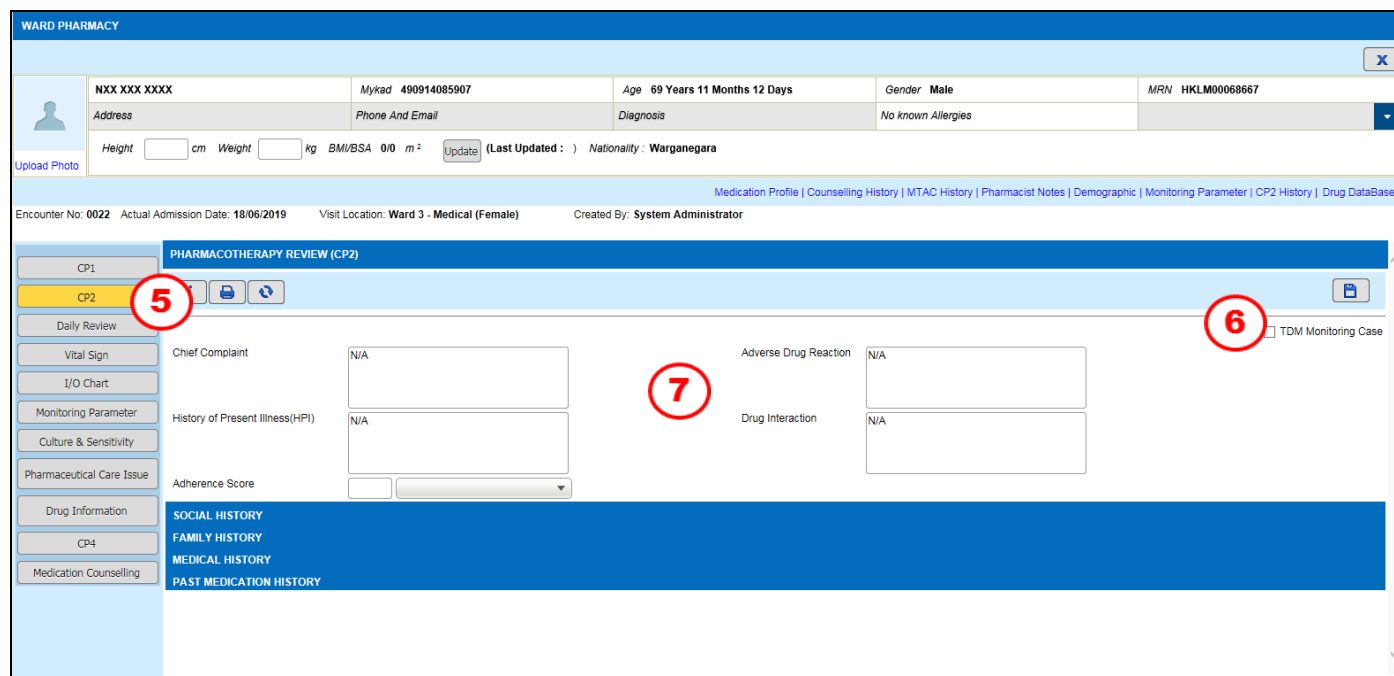


Figure 3.1.1-2 Ward Pharmacy

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
 - Monitoring Parameter
 - Culture & Sensitivity

- *Pharmaceutical Care Issue*
- *Drug Information*
- *CP4*
- *Medication Counseling*



WARD PHARMACY

Encounter No: 0022 Actual Admission Date: 18/06/2019 Visit Location: Ward 3 - Medical (Female) Created By: System Administrator

PHARMACOTHERAPY REVIEW (CP2)

CP1 CP2 Daily Review Vital Sign I/O Chart Monitoring Parameter Culture & Sensitivity Pharmaceutical Care Issue Drug Information CP4 Medication Counseling

Chief Complaint: N/A

History of Present Illness (HPI): N/A

Adverse Drug Reaction: N/A

Drug Interaction: N/A

Adherence Score: [] []

SOCIAL HISTORY

FAMILY HISTORY

MEDICAL HISTORY

PAST MEDICATION HISTORY

☐ TDM Monitoring Case

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*

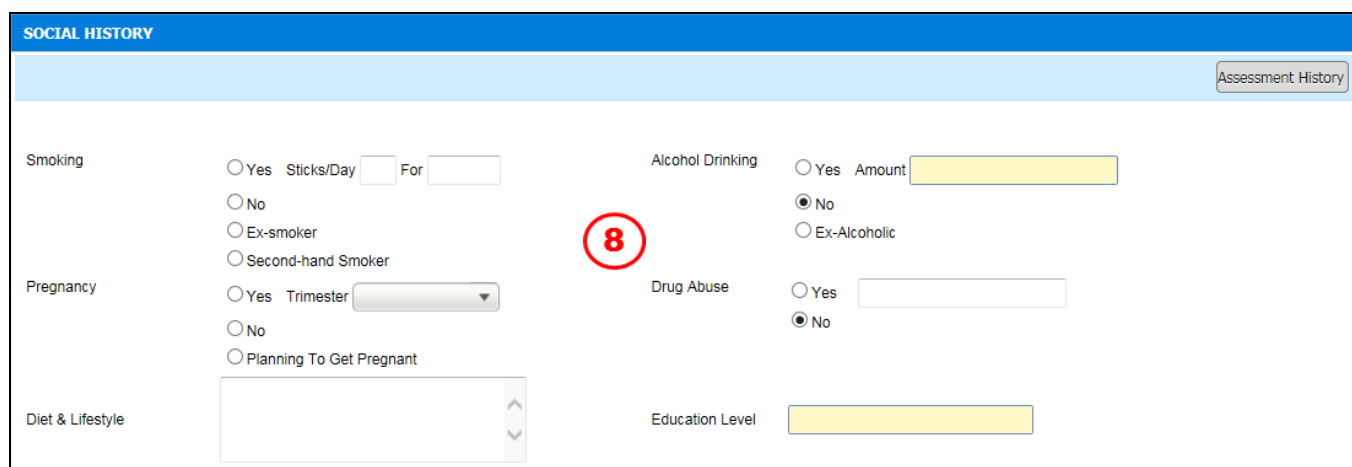
STEP 6

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

STEP 7

Enter the necessary information

- Chief Complaint**
- HPI**
- ADR**
- Drug Information**
- Adherence Score**



SOCIAL HISTORY

Assessment History

Smoking: ☐ Yes Sticks/Day For ☐ No ☐ Ex-smoker ☐ Second-hand Smoker

Pregnancy: ☐ Yes Trimester ☐ No ☐ Planning To Get Pregnant

Diet & Lifestyle:

Alcohol Drinking: ☐ Yes Amount ☒ No ☐ Ex-Alcoholic

Drug Abuse: ☐ Yes ☒ No

Education Level:

Figure 3.1.1-4 Social History

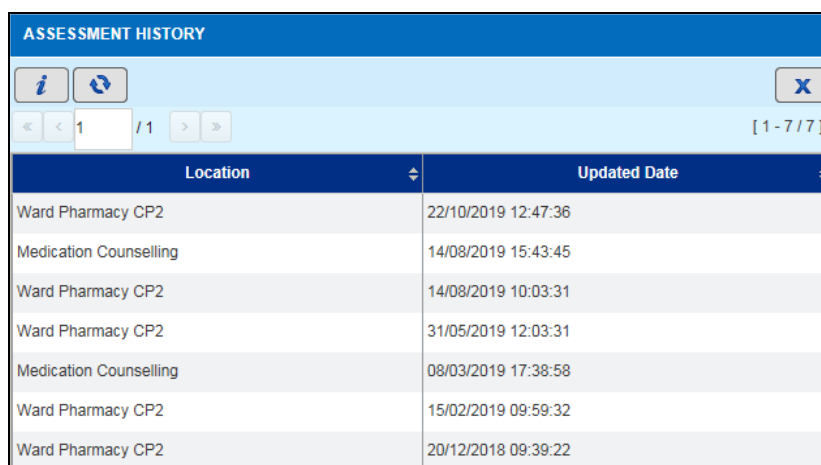
STEP 8

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

- Smoking**
- Pregnancy**
- Diet & Lifestyle**
- Alcohol Drinking**
- Drug Abuse**

Note

- Pregnancy** field is disable if the patient gender is male
- Education** is retrieved from **Patient Registration** function
- Click on the **Assessment History** button to view Assessment History as shown in Figure 3.1.1-5



ASSESSMENT HISTORY	
Location	Updated Date
Ward Pharmacy CP2	22/10/2019 12:47:36
Medication Counselling	14/08/2019 15:43:45
Ward Pharmacy CP2	14/08/2019 10:03:31
Ward Pharmacy CP2	31/05/2019 12:03:31
Medication Counselling	08/03/2019 17:38:58
Ward Pharmacy CP2	15/02/2019 09:59:32
Ward Pharmacy CP2	20/12/2018 09:39:22

Figure 3.1.1-5 Assessment History

- User is allowed to copy information of Assessment History by double click on the selected record and the information will be updated into the Social History

FAMILY HISTORY	
Marital Status	Family History Of Illness
No. Of Children	
Lives With	
- Select -	

Figure 3.1.1-6 Family History

STEP 9

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

- Marital Status**
- No Of Children**
- Lives With**
- Family History Of Illness**

Note

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

MEDICAL HISTORY	
+ Add	
Comorbidity	History
No Records Found!	
Surgical History	
<input type="radio"/> Yes	
<input type="radio"/> No	
Diagnostic Test	

Figure 3.1.1-7 Medical History

STEP 10

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

- Comorbidity**
- Surgical History**
- Diagnostic Test**

Note

User can add patient comorbidity by click on the  button

PAST MEDICATION HISTORY			
Prescription Medication			
[1 - 2 / 2]			
Drug Name	Dosage	Frequency	Remarks
Betahistine Dihydrochloride 24mg Tablet	24 mg	BD (twice daily)	Inpatient / 14-07-2016 / EncounterNo:0762
Metformin 500 mg and Glibenclamide 2.5 mg Tablet	2 tablet	BD (twice daily)	Inpatient / 14-07-2016 / EncounterNo:0762
Non Prescription Medication			
[1 - 2 / 2]			
Non-Prescription Medication(Includes Herbal/Vitamin/Other Supplements)	Balance/Comments	Source Of Medication	Reason For Taking
No Records Found!			

Figure 3.1.1-8 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 CP1 screen.

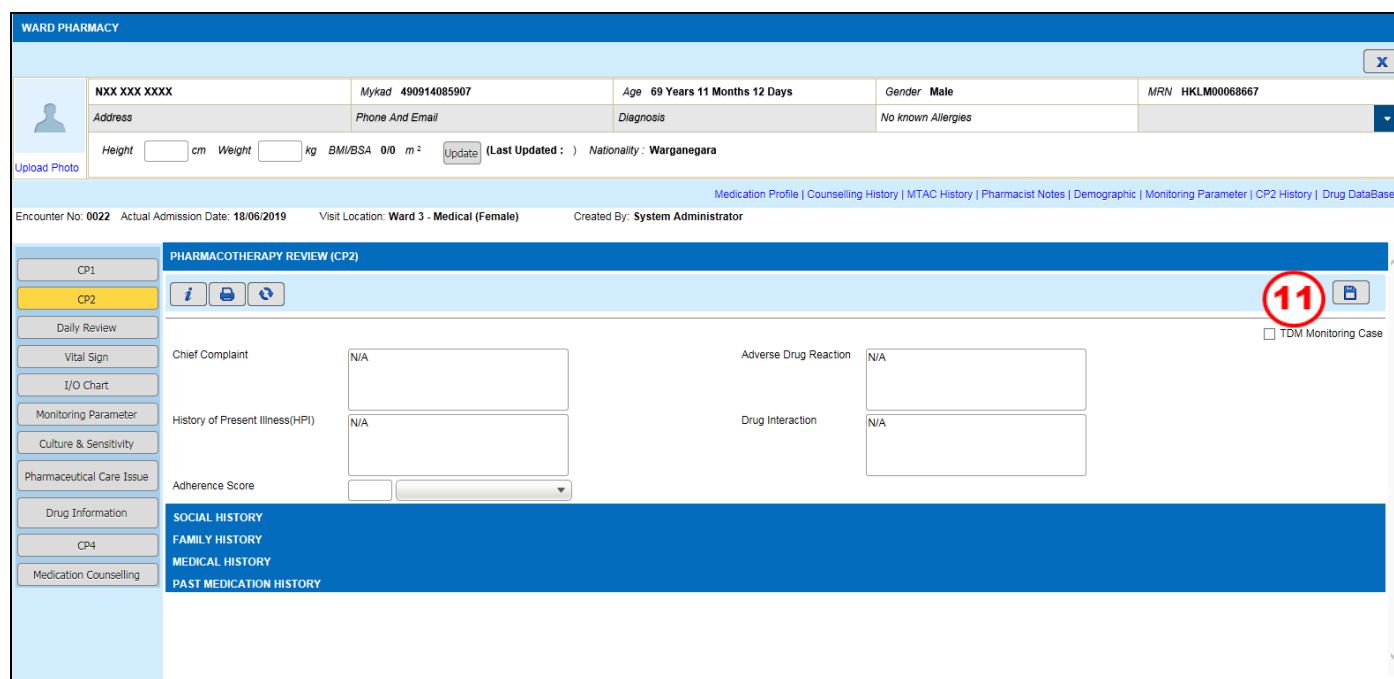



Figure 3.1.1-9 Ward Pharmacy (CP2)

STEP 11

Click on the  button to save the CP2 record and system will display confirmation alert as figure 3.1.1-10

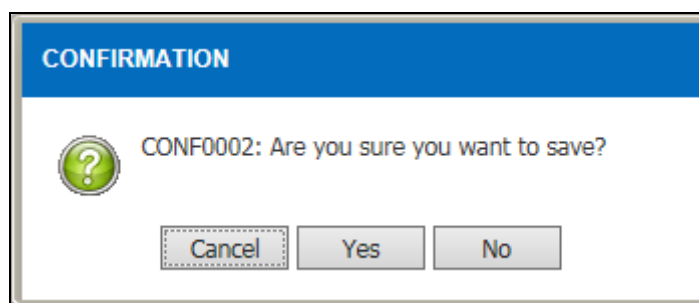


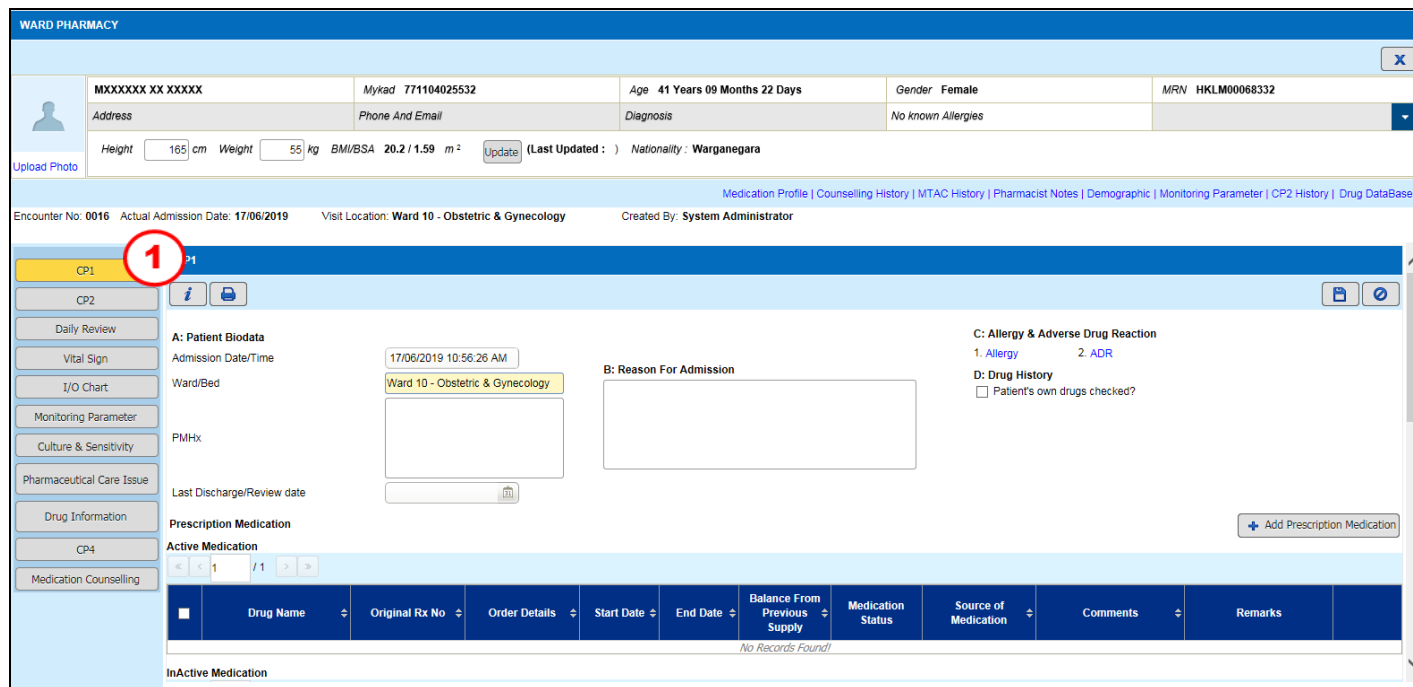
Figure 3.1.1-10 Confirmation Alert

Note

- Click on Yes 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.



WARD PHARMACY

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

CP1 (Highlighted with red circle 1)

A: Patient Biodata

Admission Date/Time: 17/06/2019 10:56:26 AM

Ward/Bed: Ward 10 - Obstetric & Gynecology

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

Active Medication

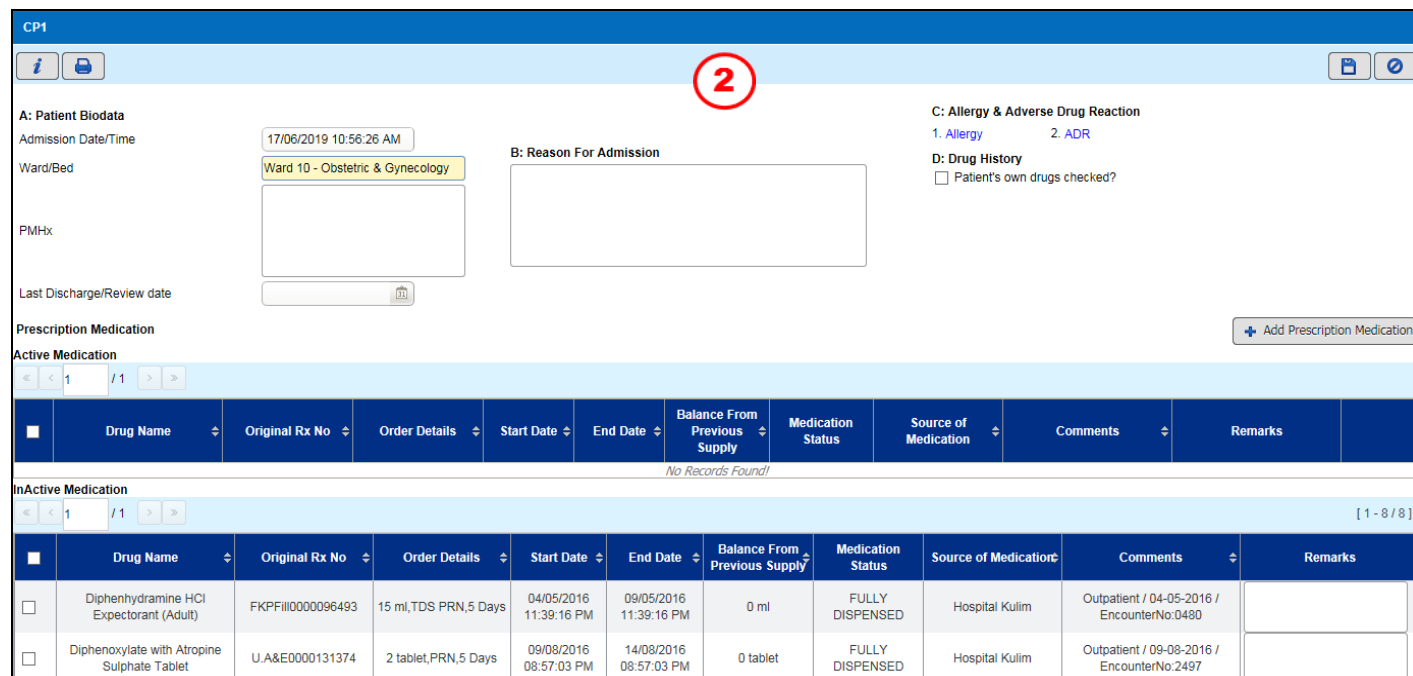
Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
No Records Found!									

InActive Medication

Figure 3.1.2-1 CP1 Button

STEP 1

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



CP1 (Highlighted with red circle 2)

A: Patient Biodata

Admission Date/Time: 17/06/2019 10:56:26 AM

Ward/Bed: Ward 10 - Obstetric & Gynecology

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

Active Medication

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
No Records Found!									

InActive Medication

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/> Diphenhydramine HCl Expectorant (Adult)	FKPFI0000096493	15 ml,TDS PRN,5 Days	04/05/2016 11:39:16 PM	09/05/2016 11:39:16 PM	0 ml	FULLY DISPENSED	Hospital Kulim	Outpatient / 04-05-2016 / EncounterNo:0480	
<input type="checkbox"/> Diphenoxylate with Atropine Sulphate Tablet	U.A&E0000131374	2 tablet,PRN,5 Days	09/08/2016 08:57:03 PM	14/08/2016 08:57:03 PM	0 tablet	FULLY DISPENSED	Hospital Kulim	Outpatient / 09-08-2016 / EncounterNo:2497	

Figure 3.1.2-2 CP1

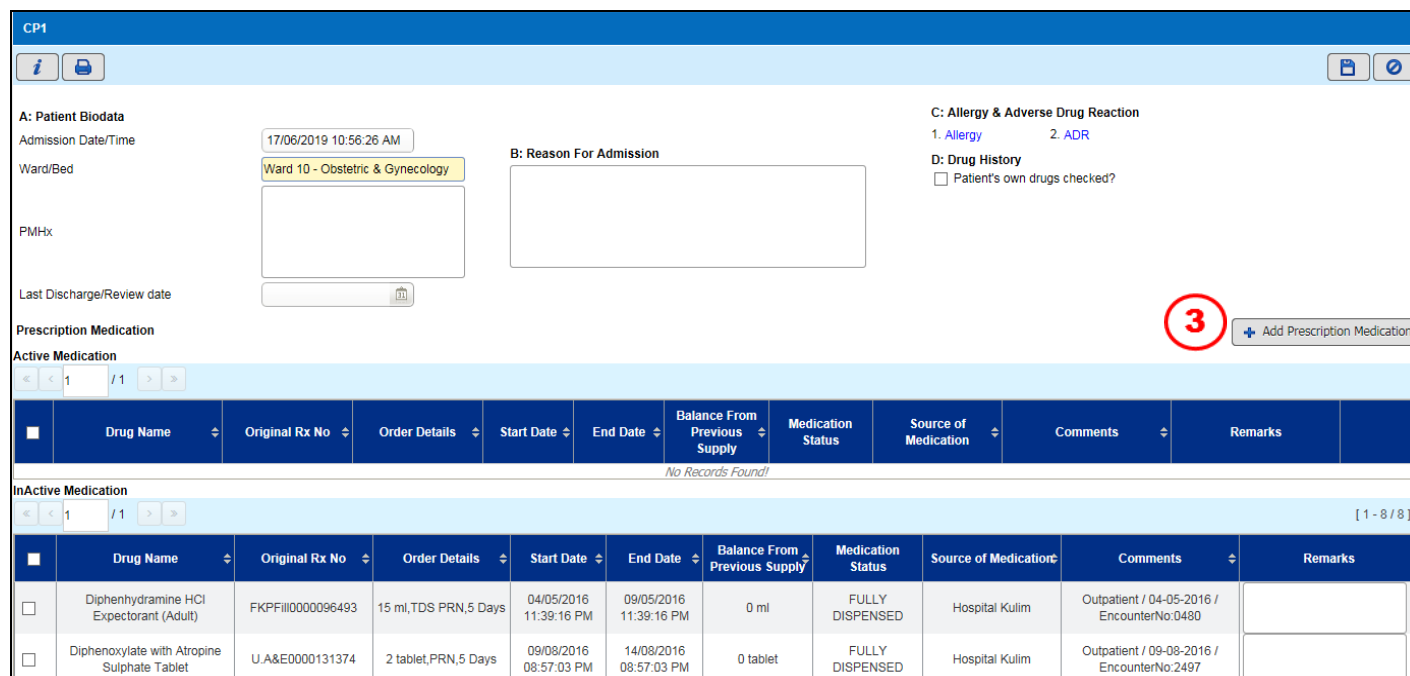
STEP 2

Enter the necessary information

- A: Patient Biodata**
- B: Reason For Admission**
- D: Drug history**

Note

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



CP1

A: Patient Biodata
 Admission Date/Time: 17/06/2019 10:56:26 AM
 Ward/Bed: Ward 10 - Obstetric & Gynecology
 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

Active Medication

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
No Records Found!									

InActive Medication

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
Diphenhydramine HCl Expectorant (Adult)	FKPF110000096493	15 ml, TDS, PRN, 5 Days	04/05/2016 11:39:16 PM	09/05/2016 11:39:16 PM	0 ml	FULLY DISPENSED	Hospital Kulim	Outpatient / 04-05-2016 / EncounterNo:0480	
Diphenoxylate with Atropine Sulphate Tablet	U.A&E000131374	2 tablet, PRN, 5 Days	09/08/2016 08:57:03 PM	14/08/2016 08:57:03 PM	0 tablet	FULLY DISPENSED	Hospital Kulim	Outpatient / 09-08-2016 / EncounterNo:2497	

Figure 3.1.2-3 CP1

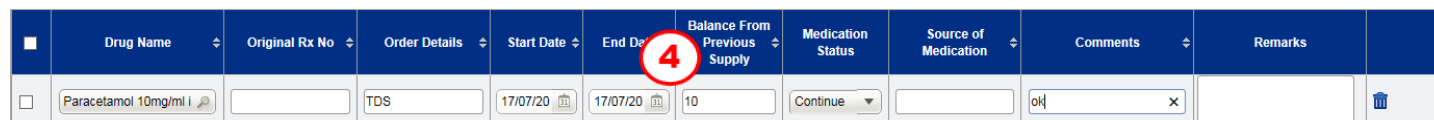
Note

Active Medication : prescription with Current Medication and Partially Supply

InActive Medication : prescription with fully supply and it is past 1 year from order date including Stop drug except Cancel drug

STEP 3

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



Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
Paracetamol 10mg/ml		TDS	17/07/20	17/07/20	10	Continue		ok	

Figure 3.1.2-4 Prescription Medication


STEP 4

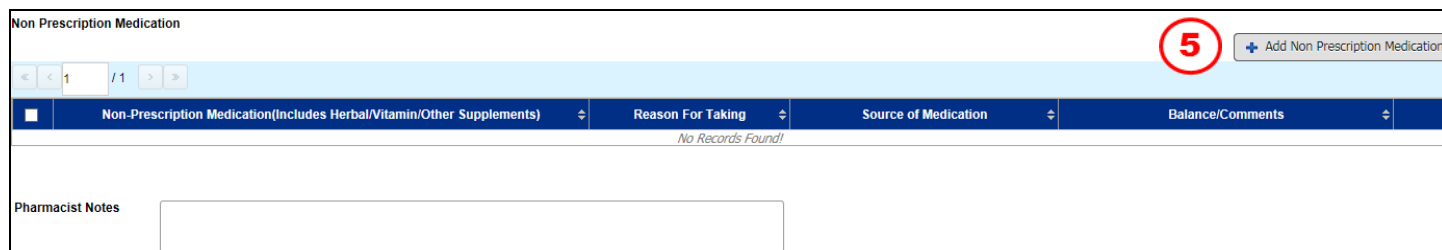
Fill in all the necessary information

- Drug Name**
- Original Rx No**
- Order Details**
- Start Date**
- End Date**

- f) **Balance From Previous Supply**
- g) **Medication Status**
- h) **Source of Medication**
- i) **Comments**
- j) **Remarks**

Note

- User is allowed to enter multiple of Medication by following **STEP 3** to **STEP 4**
- User is allowed to delete the information by click on the  button



Non Prescription Medication

1 / 1

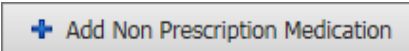
+ Add Non Prescription Medication

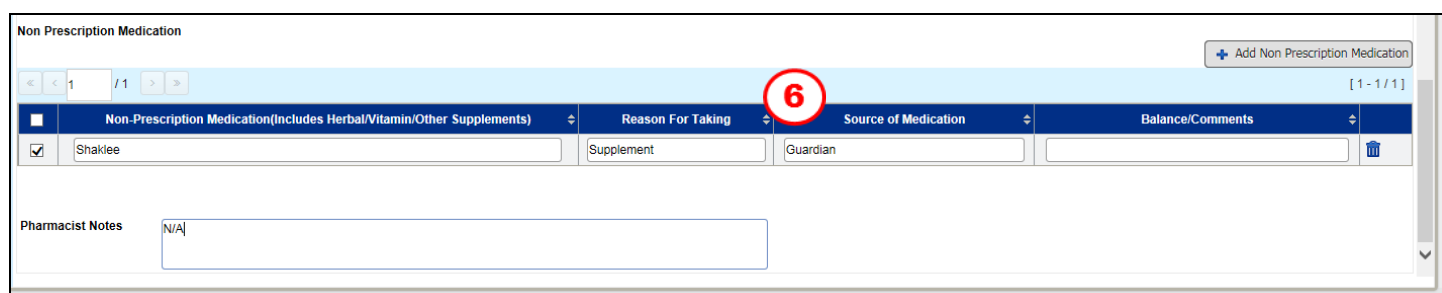
Non-Prescription Medication(Includes Herbal/Vitamin/Other Supplements)	Reason For Taking	Source of Medication	Balance/Comments
No Records Found!			

Pharmacist Notes

Figure 3.1.2-6 CP1

STEP 5

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



Non Prescription Medication

1 / 1 [1 - 1 / 1]

+ Add Non Prescription Medication

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

Pharmacist Notes

N/A

Figure 3.1.2-7 Non Prescription Medication

STEP 6

Fill in the necessary information

- a) **Non-prescription Medication (Includes Herbal/Vitamin/Other Supplemets)**
- b) **Source of Medication**
- c) **Reason for Taking**
- d) **Balance/Comments**

CP1
7

A: Patient Biodata

Admission Date/Time:

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?

+ Add Prescription Medication

Prescription Medication

Active Medication

<
1
/ 1
>

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/> Benzydamine 3mg/ml throat spray						Continue			

InActive Medication


<
1
/ 1
>

[1 - 8 / 8]


Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/> Diphenhydramine HCl Expectorant (Adult)	FKPFI0000096493	15 ml,TDS PRN,5 Days	04/05/2016 11:39:16 PM	09/05/2016 11:39:16 PM	0 ml	FULLY DISPENSED	Hospital Kulim	Outpatient / 04-05-2016 / EncounterNo:0480	
<input type="checkbox"/> Diphenoxylate with Atropine Sulphate Tablet	U.A&E0000131374	2 tablet,PRN,5 Days	09/08/2016 08:57:03 PM	14/08/2016 08:57:03 PM	0 tablet	FULLY DISPENSED	Hospital Kulim	Outpatient / 09-08-2016 / EncounterNo:2497	

Figure 3.1.2-9 CP1

STEP 7

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?

Yes
No

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:

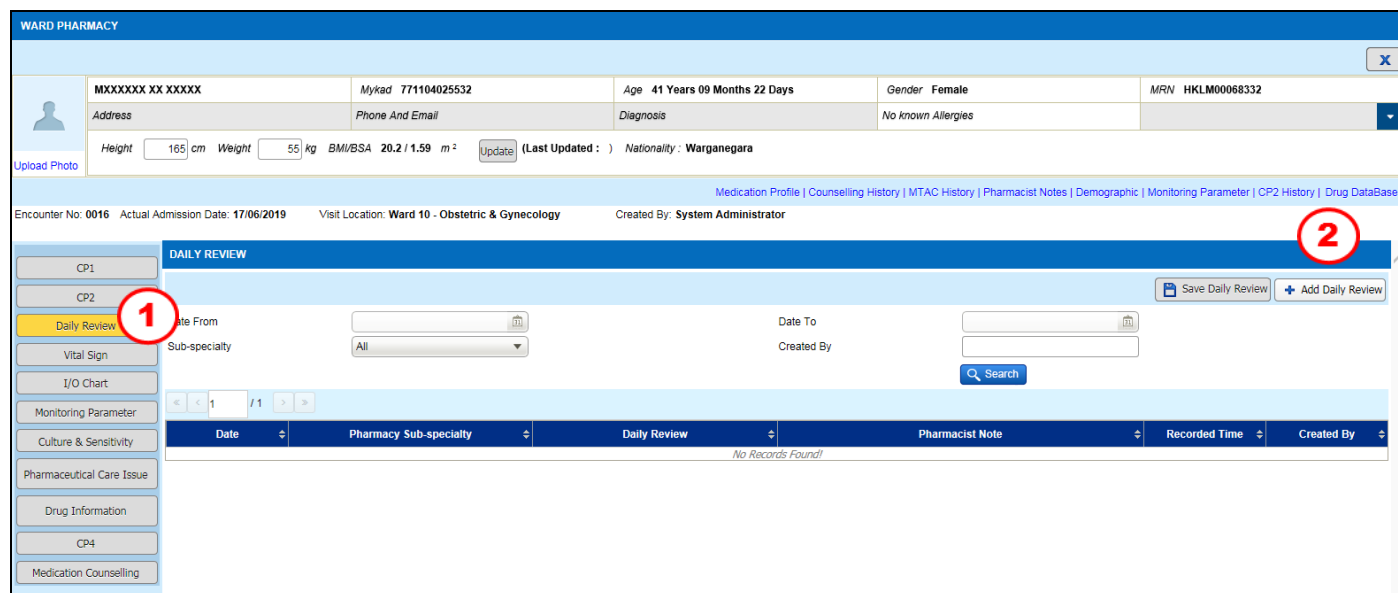


Figure 3.1.3-1 Daily Review

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

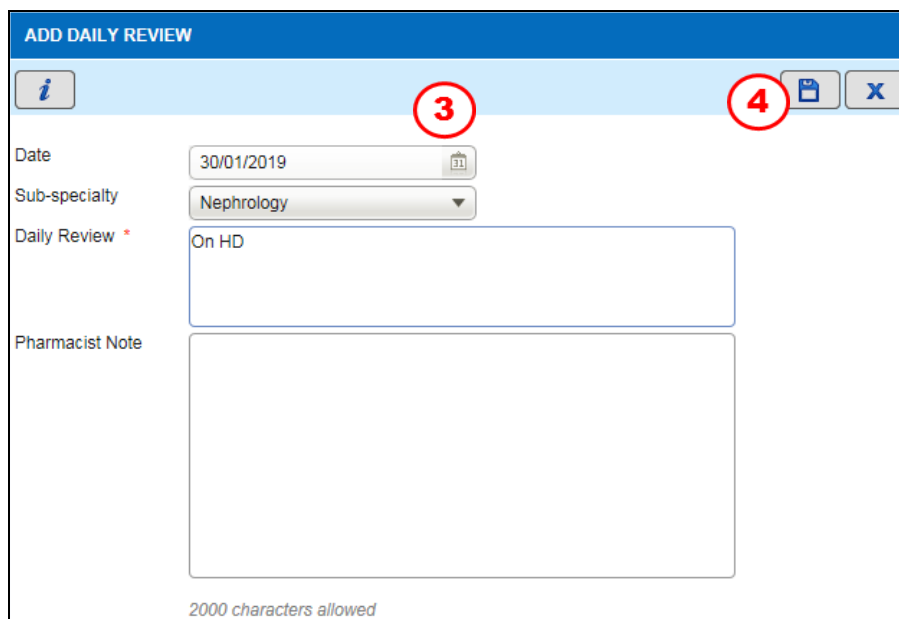



Figure 3.1.3-2 Add Daily Review

STEP 3

Fill in necessary information

- Date**
- Sub-specialty**
- Daily Review (mandatory)**
- Pharmacist Note**

STEP 4

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

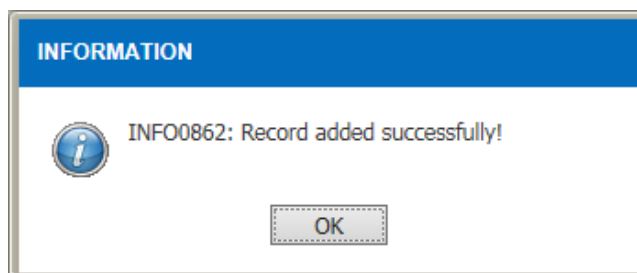
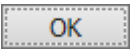
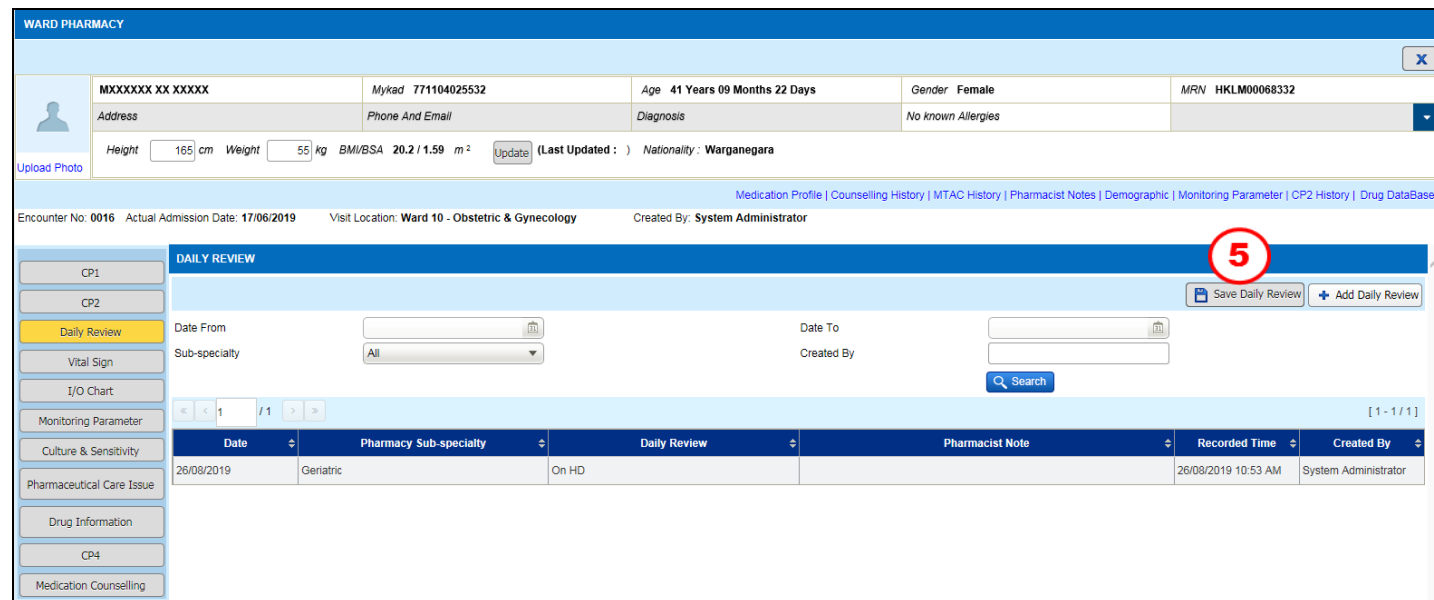


Figure 3.1.3-3 Confirmation Alert

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



WARD PHARMACY

MXXXXXX XX XXXXX Mykad 771104025532 Age 41 Years 09 Months 22 Days Gender Female MRN HKLM00068332

Address Phone And Email Diagnosis No known Allergies

Height 165 cm Weight 55 kg BMI/BSA 20.2 / 1.59 m² Update (Last Updated :) Nationality : Warganegara

Upload Photo

Medication Profile | Counseling History | MTAC History | Pharmacist Notes | Demographic | Monitoring Parameter | CP2 History | Drug DataBase |

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

DAILY REVIEW

Save Daily Review Add Daily Review

Date From Date To Sub-specialty Created By Search

Date	Pharmacy Sub-specialty	Daily Review	Pharmacist Note	Recorded Time	Created By
26/08/2019	Geriatric	On HD		26/08/2019 10:53 AM	System Administrator

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:

WARD PHARMACY

XXXXXX XX XXXX

Mykad 771104025532

Age 41 Years 09 Months 22 Days

Gender Female

MRN HKLM00068332

Address

Phone And Email

Diagnosis

No known Allergies

Height 165 cm Weight 55 kg BMI/BSA 20.2 / 1.59 m²

Update (Last Updated :)

Nationality : Warganegara

Upload Photo

[Medication Profile](#) | [Counselling History](#) | [MTAC History](#) | [Pharmacist Notes](#) | [Demographic](#) | [Monitoring Parameter](#) | [CP2 History](#) | [Drug DataBase](#)

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

CP1

CP2

Daily Review

Vital Sign

I/O Chart

Monitoring Parameter

Culture & Sensitivity

Pharmaceutical Care Issue

Drug Information

CP4

Medication Counselling

VITAL SIGN

Date/Time

Result

Normal Range

Vital Sign	Result	Adult	Children	Neonates	Infant
SBP (mmHg)		120	95 - 105	60 - 90	
DBP (mmHg)		80	53 - 66	20 - 60	
Temp (°C)		37	36.5 - 37	36.5 - 37	
PR (Pulse/min)		60 - 100	60 - 140	85 - 205	100 - 190
RR (Breaths/min)		12 - 18	18 - 30	30 - 60	30 - 40
Pain Score		0 - 10	0 - 10	0 - 10	0 - 10

Remarks

Figure 3.1.4-1 Vital Sign

STEP 1

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

VITAL SIGN

Date/Time

26/08/2019 10:59 AM

Result	Normal Range																																										
<table> <thead> <tr> <th>Vital Sign</th> <th>Result</th> <th>Adult</th> <th>Children</th> <th>Neonates</th> <th>Infant</th> </tr> </thead> <tbody> <tr> <td>SBP (mmHg)</td> <td>118</td> <td>120</td> <td>95 - 105</td> <td>60 - 90</td> <td></td> </tr> <tr> <td>DBP (mmHg)</td> <td>79</td> <td>80</td> <td>53 - 66</td> <td>20 - 60</td> <td></td> </tr> <tr> <td>Temp (*C)</td> <td>37</td> <td>7</td> <td>36.5 - 37</td> <td>36.5 - 37</td> <td></td> </tr> <tr> <td>PR (Pulse/min)</td> <td>80</td> <td>60 - 100</td> <td>60 - 140</td> <td>85 - 205</td> <td>100 - 190</td> </tr> <tr> <td>RR (Breaths/min)</td> <td>14</td> <td>12 - 18</td> <td>18 - 30</td> <td>30 - 60</td> <td>30 - 40</td> </tr> <tr> <td>Pain Score</td> <td>9</td> <td>0 - 10</td> <td>0 - 10</td> <td>0 - 10</td> <td>0 - 10</td> </tr> </tbody> </table>	Vital Sign	Result	Adult	Children	Neonates	Infant	SBP (mmHg)	118	120	95 - 105	60 - 90		DBP (mmHg)	79	80	53 - 66	20 - 60		Temp (*C)	37	7	36.5 - 37	36.5 - 37		PR (Pulse/min)	80	60 - 100	60 - 140	85 - 205	100 - 190	RR (Breaths/min)	14	12 - 18	18 - 30	30 - 60	30 - 40	Pain Score	9	0 - 10	0 - 10	0 - 10	0 - 10	
Vital Sign	Result	Adult	Children	Neonates	Infant																																						
SBP (mmHg)	118	120	95 - 105	60 - 90																																							
DBP (mmHg)	79	80	53 - 66	20 - 60																																							
Temp (*C)	37	7	36.5 - 37	36.5 - 37																																							
PR (Pulse/min)	80	60 - 100	60 - 140	85 - 205	100 - 190																																						
RR (Breaths/min)	14	12 - 18	18 - 30	30 - 60	30 - 40																																						
Pain Score	9	0 - 10	0 - 10	0 - 10	0 - 10																																						

Remarks

Delete

Add/Update

Result List

<

>

1

/ 1

Date/Time	SBP	DBP	Temp	PR	RR	Pain Score	Remarks
No Records Found!							

Figure 3.1.4-2 Vital Sign

STEP 2

Select **Sample Date/Time**

STEP 3

Fill in necessary information

- SBP (mmHg)**
- DBP (mmHg)**
- Temp (*C)**
- PR (Pulse/min)**
- RR (Breaths/min)**
- Pain Score**
- Remarks**

STEP 4

Click on the **Add/Update** button to add the information in to Result List as shown in Figure 3.1.4-3

Result List							
<div> <div><</div> <div>></div> <div>1</div> <div>/ 1</div> </div> <div>[1 - 1 / 1]</div>							
Date/Time	SBP	DBP	Temp	PR	RR	Pain Score	Remarks
26/08/2019 10:59 AM	118	79	37	80	14	9	

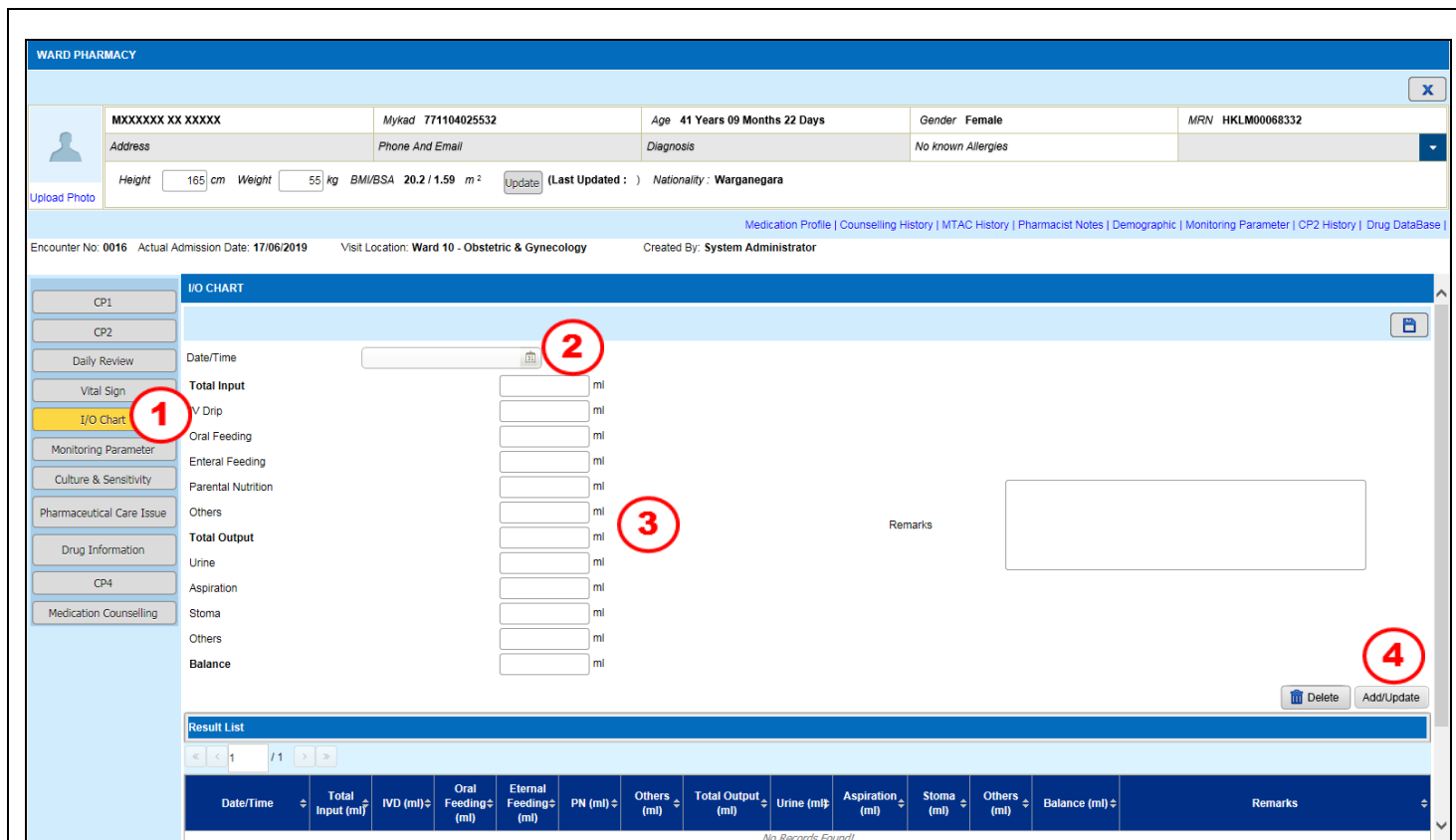
Figure 3.1.4-3 Vital Sign

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

MXXXXX XX XXXXX Mykad 771104025532 Age 41 Years 09 Months 22 Days Gender Female MRN HKLM00068332

Address Phone And Email Diagnosis No known Allergies

Height 165 cm Weight 55 kg BMI/BSA 20.2 / 1.59 m² Update (Last Updated :) Nationality : Warganegara

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

I/O CHART

CP1 CP2 Daily Review Vital Sign **I/O Chart** Monitoring Parameter Culture & Sensitivity Pharmaceutical Care Issue Drug Information CP4 Medication Counselling

Date/Time **2**

Total Input ml

IV Drip ml

Oral Feeding ml

Enteral Feeding ml

Parental Nutrition ml

Others ml **3**

Total Output ml

Urine ml

Aspiration ml

Stoma ml

Others ml

Balance ml

Remarks

Delete Add/Update **4**

Result List

Date/Time	Total Input (ml)	IVD (ml)	Oral Feeding (ml)	Enteral Feeding (ml)	PN (ml)	Others (ml)	Total Output (ml)	Urine (ml)	Aspiration (ml)	Stoma (ml)	Others (ml)	Balance (ml)	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 **Add/Update** 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

MONITORING PARAMETER

FBC

BUSE/RP

LFT

Coag

CE

Urine FEME

LP

Blood Sugar

ABG

Thyroid

RVD

Hepatitis

Drug Urine Test

Others

Full Blood Count

Date/Time

Result		Normal Range			
Sample	Result	Adult	Children	Neonates	Infant
TWBC	<input type="text"/> x10/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/100ml	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"/> x10 ⁹	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	

Remarks

Delete

Add/Update

Result List

<<

1

/ 1

>>

Date/Time	TWBC	Neutrophils	Lymphocytes	Eosinophils	Basophils	RBC (/L)	Monocytes	Hb (g/dL)	HCT	Platelet (/L)	MPV	MCV (fL)	MCH (pg/cell)	MCHC (g/L)	Remarks
No Records Found!															

Figure 3.1.6-2 Lab Parameter

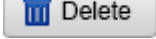
STEP 3

Fill in all necessary information

STEP 4

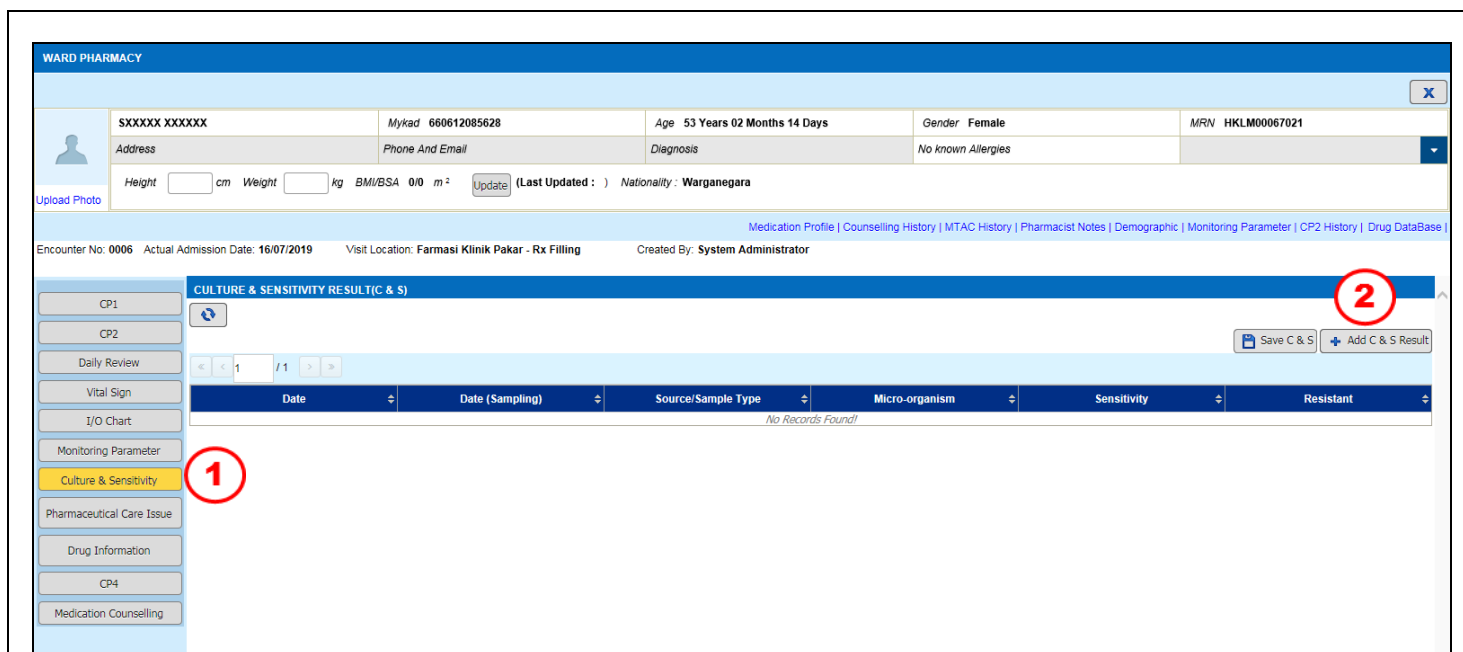
Click on the  button to add the information in to Result List

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
- The step is the same for all other Lab Parameter

3.1.7 Culture & Sensitivity

To record C&S, perform the step below:



WARD PHARMACY

XXXXXX XXXXXX Mykad 660612085628 Age 53 Years 02 Months 14 Days Gender Female MRN HKLM00067021

Address Phone And Email Diagnosis No known Allergies

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

Encounter No: 0006 Actual Admission Date: 16/07/2019 Visit Location: Farmasi Klinik Pakar - Rx Filling Created By: System Administrator

CULTURE & SENSITIVITY RESULT(C & S)

Save C & S Add C & S Result

Date	Date (Sampling)	Source/Sample Type	Micro-organism	Sensitivity	Resistant
No Records Found!					

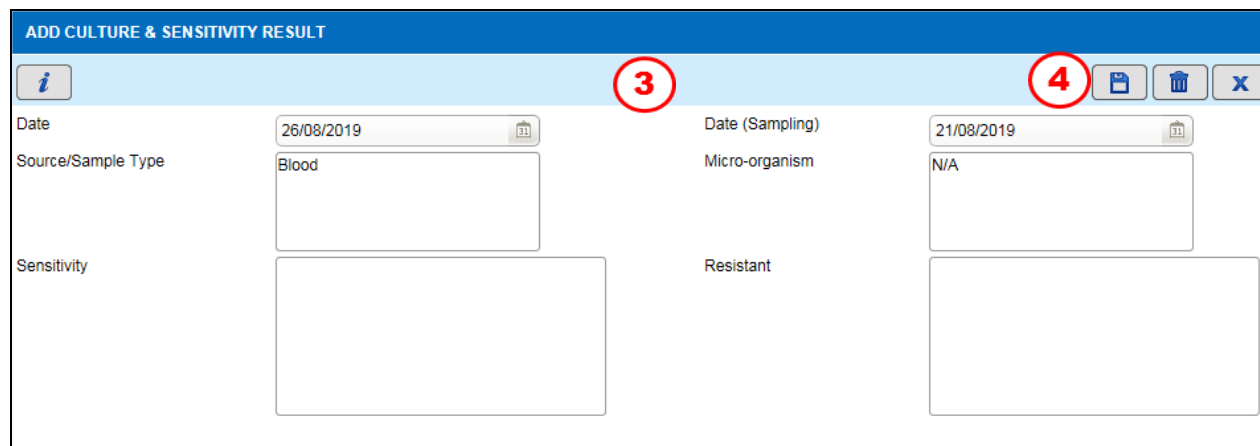
Figure 3.1.7-1 Culture & Sensitivity

STEP 1

Click on the **Culture & Sensitivity** 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



ADD CULTURE & SENSITIVITY RESULT

Date 26/08/2019 Date (Sampling) 21/08/2019

Source/Sample Type Blood Micro-organism N/A

Sensitivity Resistant

Figure 3.1.7-2 Culture & Sensitivity

STEP 3

Fill in all the necessary information


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

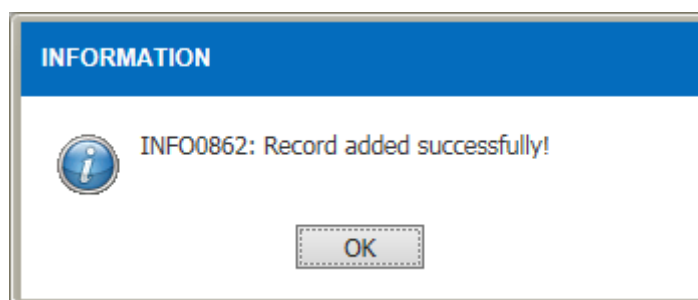
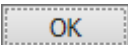


Figure 3.1.7-3 Information Alert

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


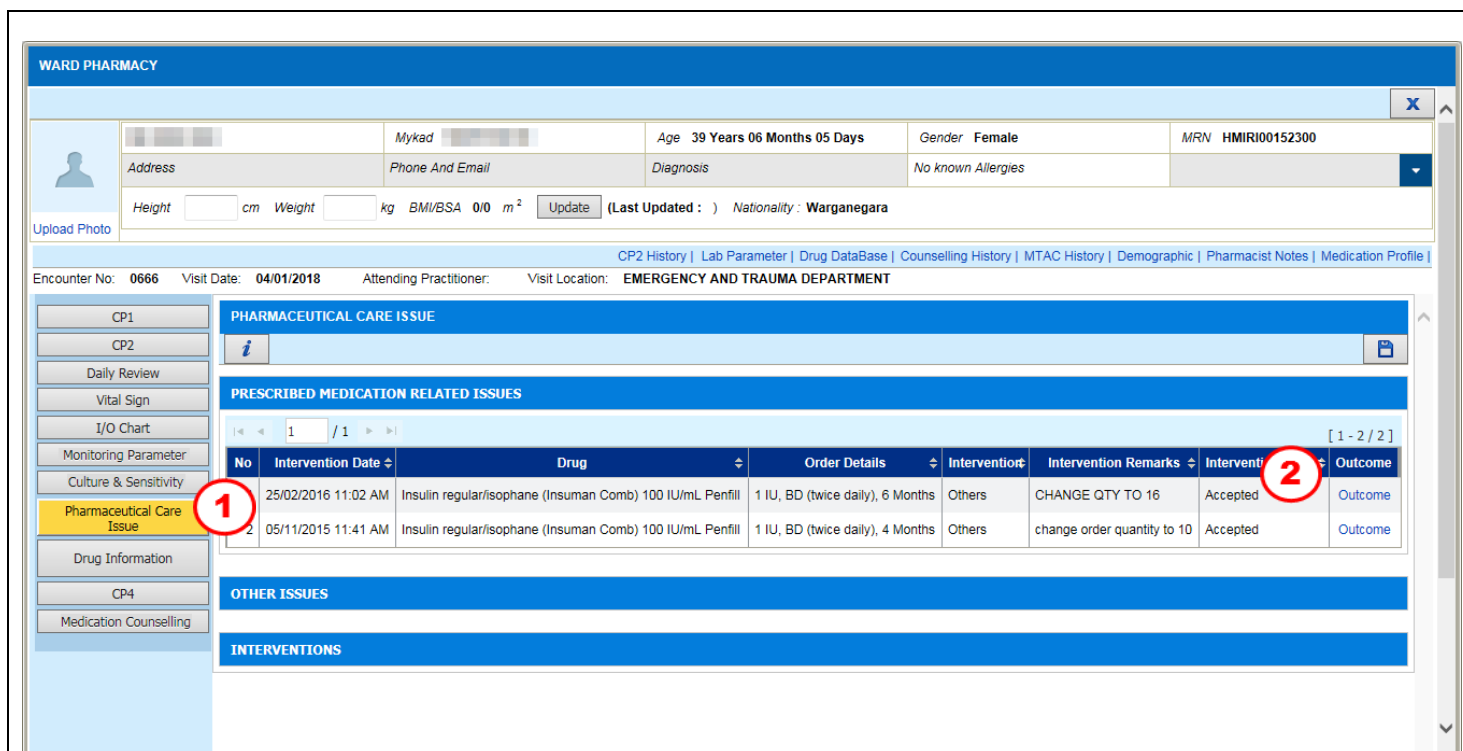
CULTURE & SENSITIVITY RESULT(C & S)					
<div>  <div>Save C & S</div> <div>Add C & S Result</div> </div>					
<div> <div>< 1 / 1 ></div> <div>[1 - 1 / 1]</div> </div>					
Date	Date (Sampling)	Source/Sample Type	Micro-organism	Sensitivity	Resistant
26/08/2019	21/08/2019	Blood	N/A		

Figure 3.1.7-4 Culture & Sensitivity

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

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

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

PHARMACEUTICAL CARE ISSUE

PRESCRIBED MEDICATION RELATED ISSUES

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

OTHER ISSUES

INTERVENTIONS

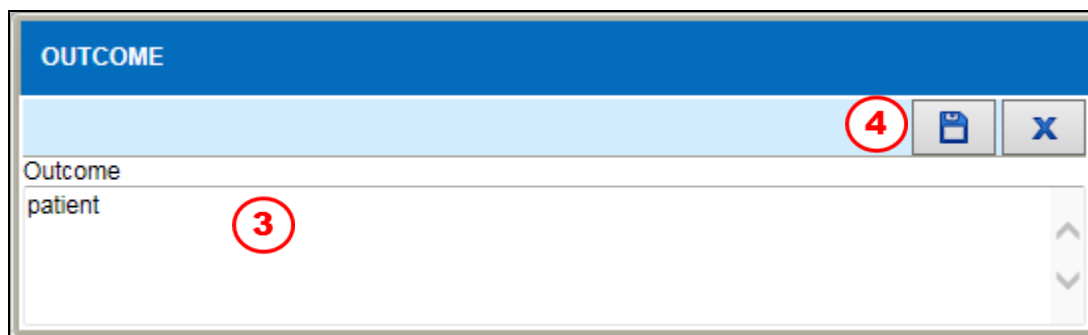
Figure 3.1.8-1 Pharmaceutical Care Issue

STEP 1

Click on the **Pharmaceutical Care Issue** 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

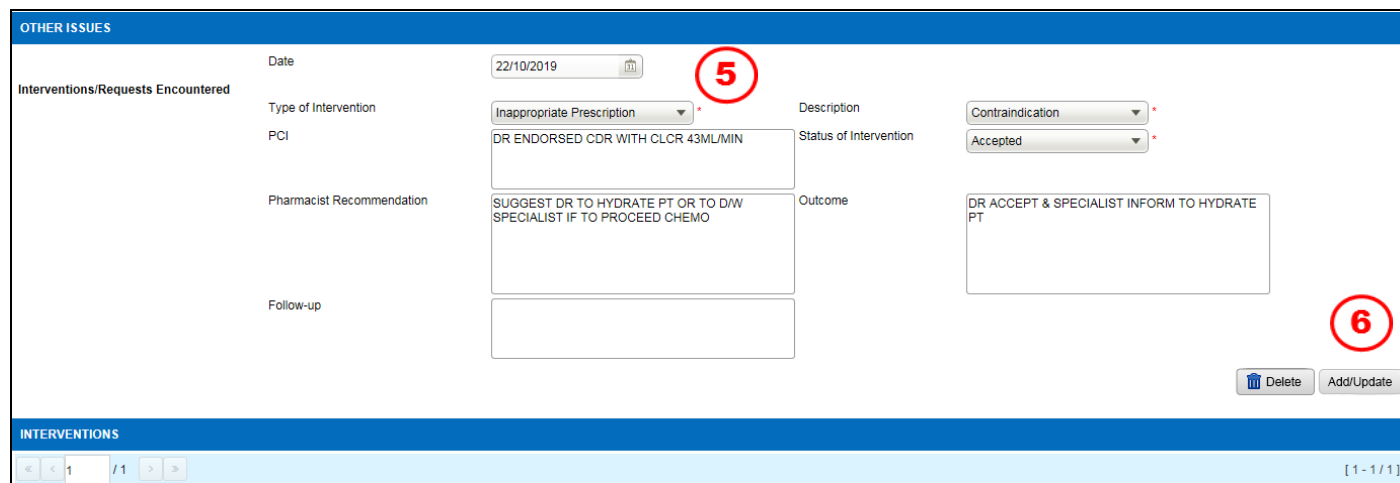


Figure 3.1.8-3 Other Issues

STEP 5

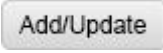
Enter '**Other Issues**' if applicable

- a) **Date**
- b) **Type of Intervention**
 - **Inappropriate Prescription**
 - **Incomplete Prescriptions**
 - **Incorrect/Inappropriate/Inadequate Regimen**
 - **Miscellaneous**
- c) **PCI**
- d) **Pharmacist Recommendation**
- e) **Description**
 - **Contraindication**
 - **Drug Interaction**
 - **Incompatibility**
 - **Polypharmacy**
- f) **Status of Intervention**
 - **Accepted**
 - **Not Accepted**
 - **Not Available**
- g) **Outcome**
- h) **Follow-up**

Note

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

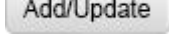

STEP 6

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

INTERVENTIONS								
<div> <div>1 / 1</div> <div>[1 - 1 / 1]</div> </div>								
Date	Type of Intervention	Description	PCI	Pharmacist Recommendation	Status of Intervention	Outcome	Follow-up	Check list
22/10/2019	Inappropriate Prescription	Contraindication	DR ENDORSED CDR WITH CLCR 43ML/MIN	SUGGEST DR TO HYDRATE PT OR TO D/W SPECIALIST IF TO PROCEED CHEMO	Accepted	DR ACCEPT & SPECIALIST INFORM TO HYDRATE PT		<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

i

7

PRESCRIBED MEDICATION RELATED ISSUES

1 / 1

[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

OTHER ISSUES

INTERVENTIONS

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

CONFIRMATION

?

CONF0002: Are you sure you want to save?

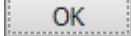
Cancel

Yes

No

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

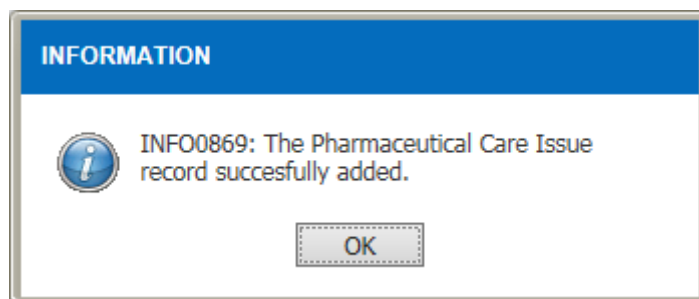


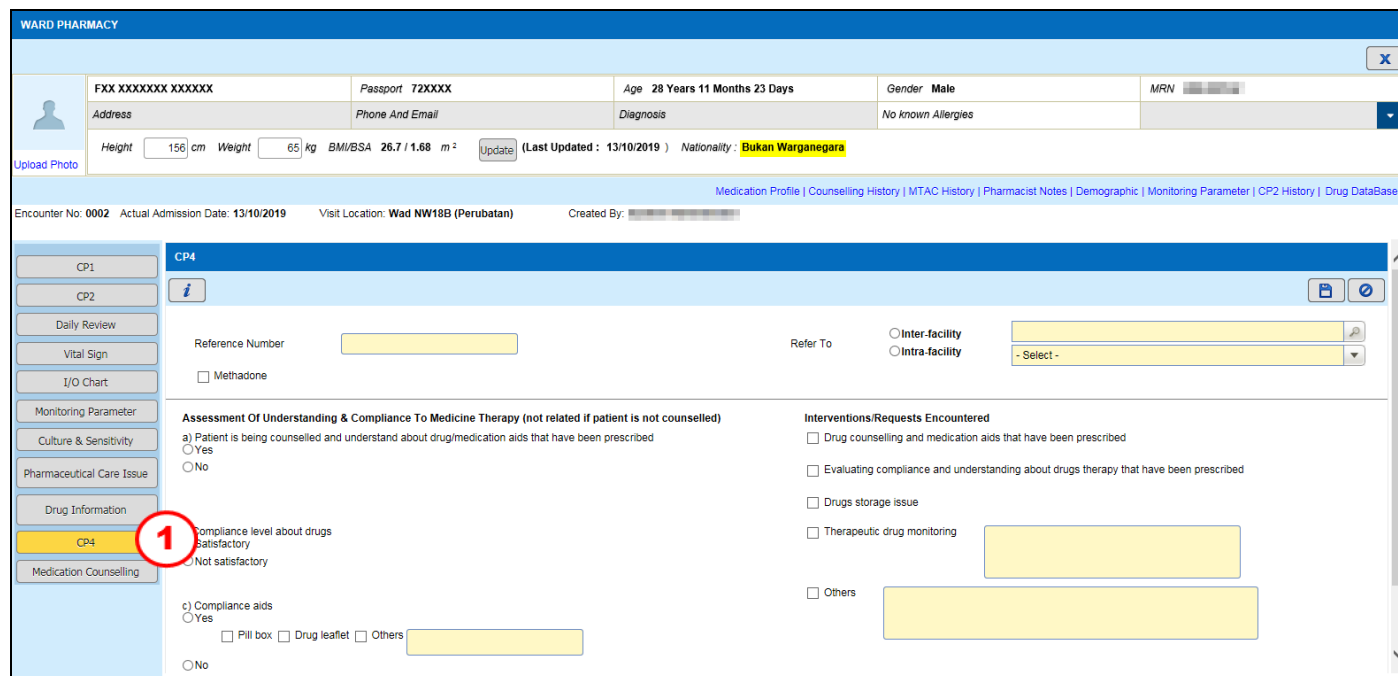
Figure 3.1.8-7 Information Alert

Note

Click on the  button to successfully save

3.1.9 CP4

To record CP4, perform the step below:



WARD PHARMACY

Encounter No: 0002 Actual Admission Date: 13/10/2019 Visit Location: Wad NW18B (Perubatan) Created By: [User Name]

CP4

Reference Number: [Field]
☐ 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

c) Compliance aids
☐ Yes
☐ Pill box ☐ Drug leaflet ☐ Others [Field]
☐ No

Interventions/Requests Encountered

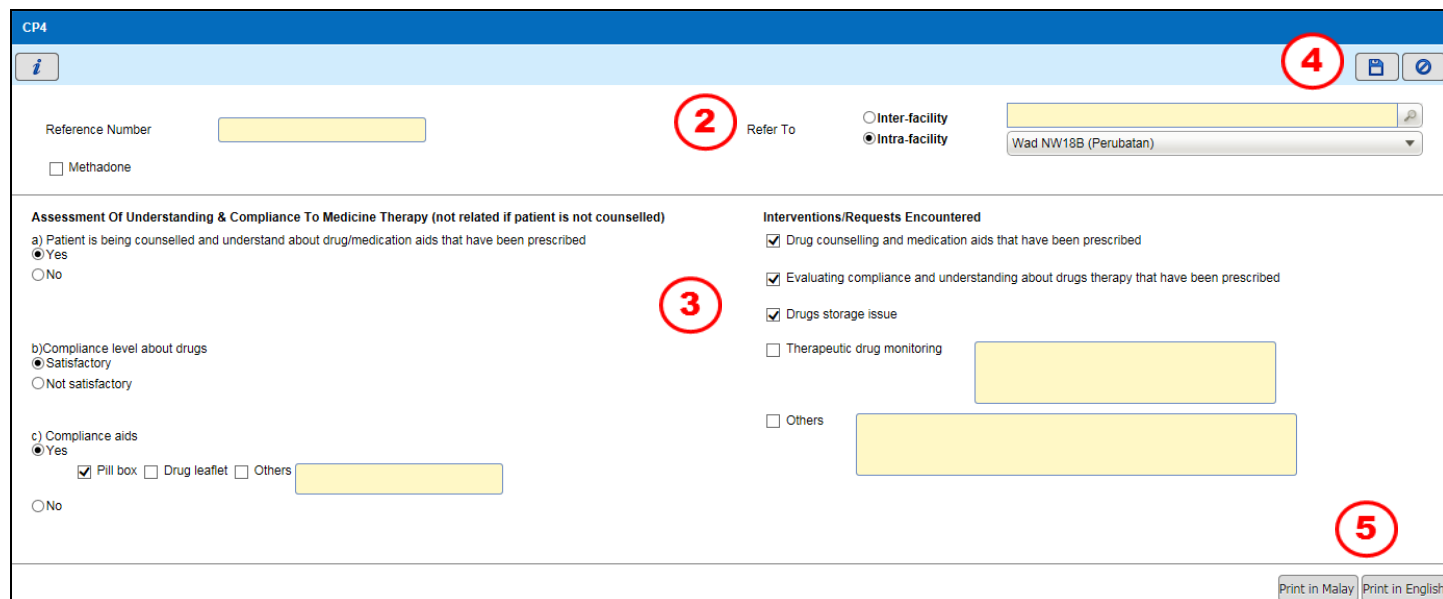
☐ Drug counselling and medication aids that have been prescribed
☐ Evaluating compliance and understanding about drugs therapy that have been prescribed
☐ Drugs storage issue
☐ Therapeutic drug monitoring [Field]
☐ Others [Field]

Figure 3.1.9-1 CP4

STEP 1

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

To Record CP4



The screenshot shows the CP4 form interface. Callout 2 points to the 'Refer To' section with radio buttons for 'Inter-facility' and 'Intra-facility'. Callout 3 points to the 'Assessment Of Understanding & Compliance To Medicine Therapy' section, which includes questions about patient counselling, compliance level, and compliance aids. Callout 4 points to the top right of the form, and callout 5 points to the 'Print in Malay' and 'Print in English' buttons at the bottom right.

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

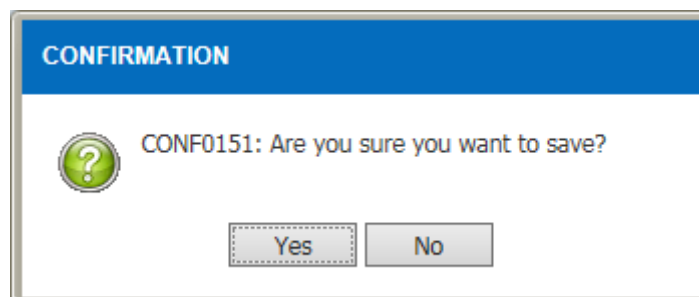


Figure 3.1.9-3 Confirmation Alert

Note

Click on the  button to save the record

STEP 5

Click on  the button to print in Malay and  button to print in English

KEMENTERIAN KESIHATAN MALAYSIA
HOSPITAL KUALA LUMPUR
Jabatan Farmasi

NOTA RUJUKAN

CP4/411

KEPADA:
Pegawai Perubatan/Pegawai Farmasi : Wad SW26 (Perubatan)
PER: RUJUKAN PESAKIT

MXXXXXXX XXXX
 NAMA

/ / /
 MRN

/ / /
 NO. KP

Pesakit ini TELAH / ~~BEUM~~ DIBERI KAUNSELING UBAT-UBATAN untuk dinilai tahap kefahaman/kepatuhan terhadap terapi ubat yang ditetapkan. Diharapkan pihak tuan/puan dapat memberi kaunseling dan penilaian susulan yang diperlukan untuk meningkatkan keberkesanan rawatan.

2. DIAGNOSIS :
None

3. SENARAI UBAT SEMASA:

Nama Ubat	Dos	Frekuensi	Tarikh Mula	Tarikh Tamat	Jangkamasa Bekalan

4. PENILAIAN KEFAHAMAN & KEPATUHAN TERHADAP TERAPI UBAT
(Tidak berkenaan jika pesakit belum dikaunsel)

a) Pesakit telah dikaunsel dan faham tentang ubat/alat bantuan pengubatan yang ditetapkan ☒ Ya ☐ Tidak

b) Tahap kepatuhan terhadap ubat - ubatan ☒ Memuaskan ☐ Tidak Memuaskan

c) Alat bantuan kepatuhan ☐ Pill Box ☐ Risalah Ubat ☐ Lain - lain ☒ Tidak

5. TINDAKAN SUSULAN YANG DIPERLUKAN
[Sila tandakan (☒) di kotak yang disediakan]

<input checked="" type="checkbox"/>	Kaunseling ubat - ubat dan alat bantuan pengubatan yang ditetapkan
<input type="checkbox"/>	Menilai kepatuhan dan kefahaman terhadap terapi ubat yang ditetapkan
<input type="checkbox"/>	Pemantauan ubat terapeutik:
<input type="checkbox"/>	Isu penyimpanan ubat - ubatan
<input type="checkbox"/>	Lain - lain:

Sekian, terima kasih.



 PF44
 0326155555
 30/10/2019

Figure 3.1.9-4 Print In Malay

KEMENTERIAN KESIHATAN MALAYSIA
HOSPITAL KUALA LUMPUR
Pharmacy Department

REFERRAL NOTE
CP4/413

TO:
Medical Officer / Pharmacist : Wad SW27 (Perubatan)

RE: PATIENT REFERRAL

NX XXXX XXXX
 Name

/ **MRN**

/ **IC No**

This patient HAS / ~~NOT~~ BEEN GIVEN MEDICATION COUNSELING for understanding of the treatment that have been prescribed. We expect that you can give the counselling & further evaluation that needed to increase the effectiveness of the treatment.

2. DIAGNOSIS :
None

3. LIST OF CURRENT DRUG :

Drug Name	Dose	Frequency	Start Date	End Date	Supply Period

4. UNDERSTANDING ASSESSMENT & COMPLIANCE TO DRUG
(not applicable if the patient has not been counseled):

a) The patient has been counseled and understand the drug/medication aids prescribed ☒ Yes ☐ No

b) Compliance level about Drugs ☐ Satisfactory ☐ Not-Satisfactory

c) Compliance Aids ☐ Pill Box ☐ Drug Message ☐ Others ☐ No

5. INFORMATION / REQUESTS ENCOUNTERED :
[Please tick (☒) In the box provided]

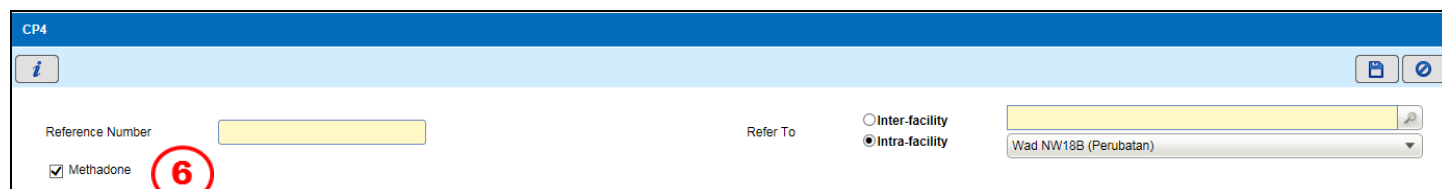
	Drug counselling and medication aids that have been prescribed
<input checked="" type="checkbox"/>	Evaluate compliance with and understanding of the prescribed drug therapy
	Therapeutic drug monitoring:
	Drug storage issues
	Other:

Thank You,

PF44
0326155555
30/10/2019

Figure 3.1.9-5 Print In English

To Record CP4 Methadone



CP4

Reference Number

Refer To ☐ Inter-facility ☒ Intra-facility

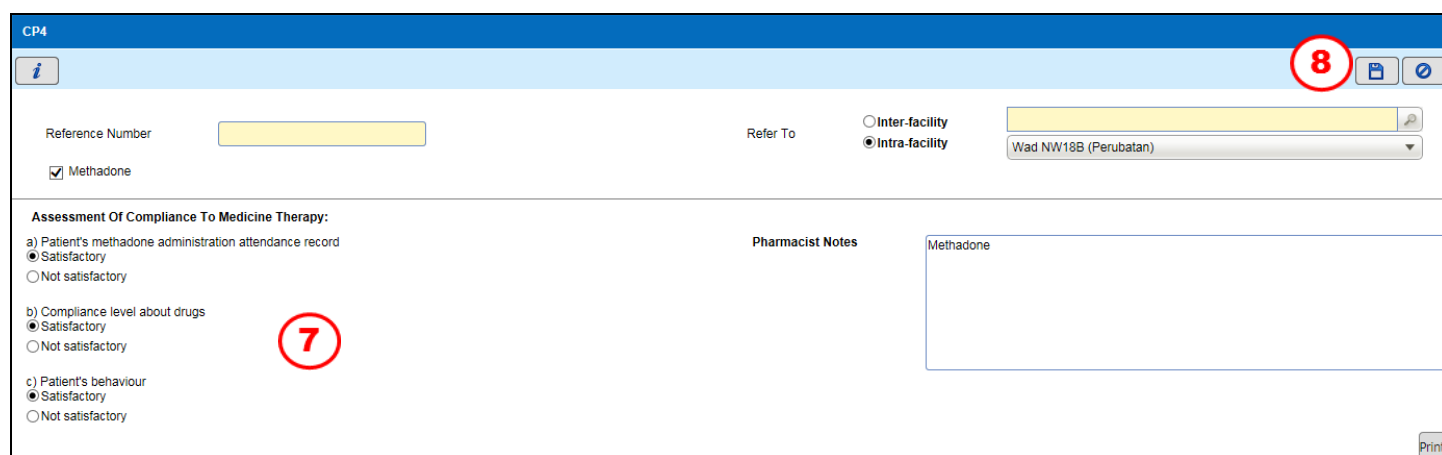
☒ Methadone

Wad NW18B (Perubatan)

Figure 3.1.9-6 CP4 Methadone

STEP 6

Click on the **Methadone** checkbox



CP4

Reference Number

Refer To ☐ Inter-facility ☒ Intra-facility

☒ Methadone

Wad NW18B (Perubatan)

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

Methadone

Print

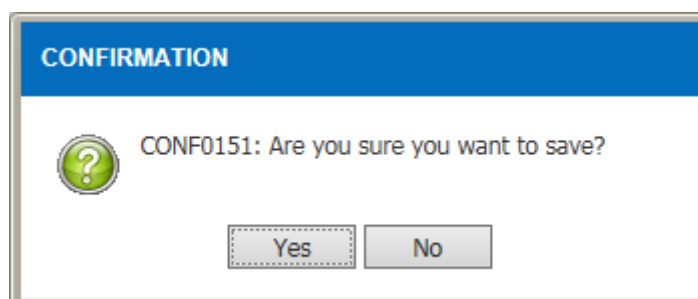
Figure 3.1.9-7 CP4 Methadone

STEP 7

Fill up the question

STEP 8

Click on the  button to save the record



CONFIRMATION

CONF0151: Are you sure you want to save?

Yes No

Figure 3.1.9-8 Confirmation Alert

Note

- Click on the  button to save the record

- Click on  the button to vie/print report

KEMENTERIAN KESIHATAN MALAYSIA
HOSPITAL KUALA LUMPUR
Jabatan Farmasi

NOTA RUJUKAN: METHADONE CP4/413

KEPADA:
Pegawai Perubatan/Pegawai Farmasi : Wad SW27 (Perubatan)

PER: RUJUKAN

NX XXXX XXXX
 NAMA

/
 MRN

/
 NO.KP

Pesakit ini TELAH/BELUM DIBERI KAUNSELING UBAT-UBATAN untuk dinilai tahap kefahaman/kepatuhan terhadap terapi ubat yang dipreskripsikan. Diharapkan pihak tuan/puan dapat memberi kaunseling dan penilaian susulan yang diperlukan untuk meningkatkan keberkesanan rawatan.

2. SENARAI UBAT / REKOD-REKOD UBATAN LAIN:

NAMA UBAT	DOS	TEMPOH BEKALAN

3. KEPATUHAN TERHADAP TERAPI UBAT

a) Rekod kedatangan pesakit mengambil	<input checked="" type="checkbox"/>	Memuaskan	<input type="checkbox"/>	Tidak Memuaskan
b) Tahap kepatuhan terhadap ubat-ubatan	<input checked="" type="checkbox"/>	Memuaskan	<input type="checkbox"/>	Tidak Memuaskan
c) Tingkahlaku pesakit	<input checked="" type="checkbox"/>	Memuaskan	<input type="checkbox"/>	Tidak Memuaskan

CATATAN PEGAWAI FARMASI
 None

Cop & Tandatangan Pegawai Farmasi

No. Tel:

Tarikh : 30/10/2019 BAHAGIAN PERKHIDMATAN FARMASI, KKM

Figure 3.1.9-9 CP4 Report

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	Inpatient	Click Here	12	CDR Dispensing	Click Here
2	CDR Order	Click Here	13	Methadone Dispensing	Click Here
3	TDM Order	Click Here	14	PN Dispensing	Click Here
4	PN Order	Click Here	15	Order Management	Click Here
5	IV Order	Click Here	16	Patient Management	Click Here
6	Prepacking	Click Here	17	Radiopharmaceuticals	Click Here
7	Galenical	Click Here	18	Outpatient	Click Here
8	MTAC	Click Here	19	Special Drug Request	Click Here
9	ADR & DAC	Click Here	20	MAR	Click Here
10	Medication Counselling	Click Here	21	DICE	Click Here
11	Ward Pharmacy	Click Here	22		