

BIL 02 / 2022

PHARMACY BULLETIN

HOSPITAL SERI MANJUNG



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April 2022-June 2022	



You are your Priority

Sexual Harrassment at Work

By: Nurul Najihah binti Bahrin



WHAT IS SEXUAL HARRASMENT AT WORKPLACE ? [1,2,4,5].

Sexual harassment in the workplace refers to verbal or physical act with a sexual nature, performed in recruitment or in the workplace by a boss, manager, employee, client or customer of a working unit, that is unwelcomed by the person receiving it and has caused the person to feel violated, insulted, and being in an unbearable hostile environment. Workplace covers any place under the direct or indirect control of the employer that an employee needs to be present or go to in order to carry out work. [1,2,4,5]



PREVALENCE OF SEXUAL HARRASMENT [1].

- In the U.S, 5.6% of women (almost 7 million) and 2.5% of men (nearly 3 million) reported some type of sexual violence by a workplace-related perpetrator.
- For women, the most commonly reported sexual violence type was unwanted sexual contact (3.5% of women); for men, it was noncontact unwanted sexual experiences (1.3% of men)

EXAMPLE OF SEXUAL HARRASMENT AT WORKPLACE [2,3,5].

- joking or teasing with a sexual nature;
- continuous invitation to dinner or date despite rejection
- intentional dissemination of hearsay with a sexual nature
- enquiring for or sharing sexual experience
- spreading and displaying a nude or image with apparent sexual contents
- request for sexual intercourse
- unnecessary physical contact
- forced sexual intercourse

What is sexual harassment based on the Employment Act 1955? [5]

Sexual harassment is defined in the Employment Act 1955 ("EA 1955") as "any unwanted conduct of a sexual nature, whether verbal, nonverbal, visual, gestural or physical, directed at a person which is offensive or humiliating or is a threat to his well-being, arising out of and in the course of his employment."

The following are examples which may come within the definition in the EA 1955:

- Making indecent or derogatory jokes about a colleague of the same/opposite gender;
- Touching a colleague's thighs; and
- Constantly asking a colleague out on a date despite being rejected multiple times.



CODE OF PRACTICE [5]

The Ministry of Human Resources, Malaysia has published a Code of Practice on the Prevention and Eradication of Sexual Harassment in the Workplace in 1999 ("**Code of Practice**") as a guide for both employers and employees alike.

The **Code of Practice** further divides this definition into two categories: "sexual coercion" and "sexual annoyance" which, briefly, means the following:

- **Sexual Coercion** - Where the sexual harassment act/conduct results in some direct consequence to the victim's employment. An example of sexual coercion includes a situation where a superior threatens to deny job benefits to a subordinate if the subordinate refuses the superior's request for a date.
- **Sexual Annoyance** - Where the sexually-related conduct is offensive, hostile and/or intimidating to the recipient, but nonetheless has no direct link to any job benefits. This definition also extends to sexually-related conduct by the company's clients towards employees. An example of sexual coercion includes a situation where a colleague constantly makes suggestive and offensive sexual remarks to another colleague of similar rank.



WHAT CAN I DO IF I'M SEXUALLY HARASSED AT MY WORKPLACE? [3,4,5]

- **Document the incident.** Include details such as place, date, time, nature of harassment, the harasser and your relationship to that person. Save any evidence that you may have from the incident (notes, messages, photos, audio recordings, videos etc).
- **Lodge a written complaint to your Human Resources (HR) Department.** Include all incident details and evidence that you have collected in the written complaint. You have all the rights to ask for an inquiry, as per Part XVA of the Employment Act 1955.
- If your employer fails to take action, you can **refer the matter to the Director-General of Labour (DGL)** - <http://jtksm.mohr.gov.my/index.php/en> . Do ensure that a copy of this complaint is sent to your employer as well, so that they will be aware of the seriousness of this matter.
- If you are dismissed due to sexual harassment, you can **lodge a complaint with the Industrial Relations Department (IRD)** within 60 days of the dismissal citing unfair dismissal and requesting to be reinstated, as per Section 20 of the Industrial Relations Act. The IRD will call for a meeting between you and your employer, whereby the employer will be required to prove that the dismissal was justified.



Malaysia has taken progressive steps to raise awareness surrounding the severity of sexual harassment. Allegations or complaints of sexual harassment in a professional environment should no longer be ignored or dismissed lightly. Employers should take a proactive action in promoting awareness and handling cases regarding sexual harassment. Employers should take the initiative to understand and identify what sexual harassment amounts to in the Malaysian workplace, and to implement internal policies and measures to assist with the prevention of the occurrence of encounters of this nature. It is best to ensure that a company's policy and grievance procedure sufficiently address the issue of sexual harassment in order to create a safe workspace, and that the company's human resource department is equipped to properly handle complaints of sexual harassment in the workplace.



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New Medication In HSM Formulary

JKUT BIL. 1/2022

By: Arni Zafirah Binti Zaminudin

1. Erythropoietin Beta Human Recombinant 4000 IU Injection (Recormon)

Indications:

- i) Treatment of anaemia associated with chronic renal failure. Dialysis patients who have haemoglobin <10 g/dL or are exhibiting symptoms of anaemia although haemoglobin >10 g/dL and pre-transplant cases
- ii) Anaemia in cancer (non-myeloid malignancies) with concomitant chemotherapy.

Dosage: EPO Beta: 450IU/kg once weekly or 30,000 IU once weekly.

Prescriber Category: A (MOPD)

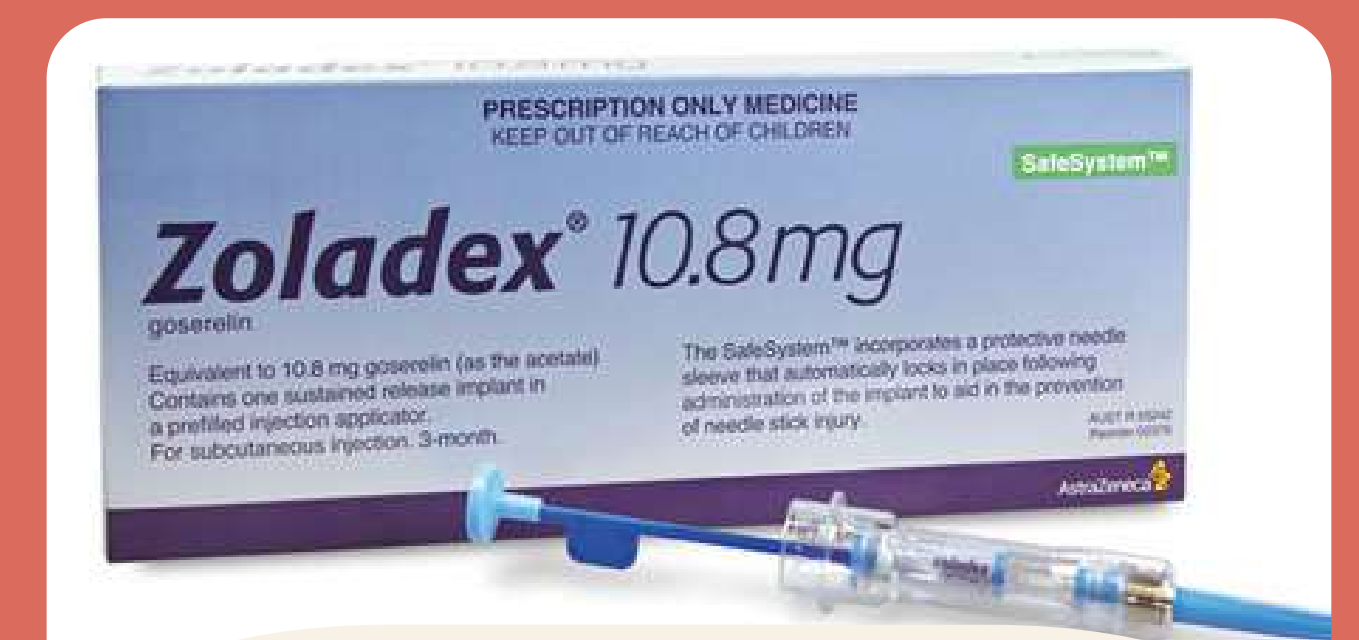


2. Goserelin 10.8mg Depot Injection (Zoladex)

Indications: Androgen deprivation therapy in prostate cancer.

Dosage: One 10.8 mg depot is injected subcutaneously into the anterior abdominal wall, every 12 weeks.

Prescriber Category: A (SOPD)



KUOTA SOPD

3. Levodopa 100mg, Carbidopa 25mg, Entacapone 200mg Tablet (Stalevo 100/25/200)

Indications: Idiopathic Parkinson's disease

Dosage:

- The optimum daily dosage must be determined by careful titration of levodopa in each patient.
- The daily dose should preferably be optimised using 1:4 available tablet strengths. Patients should be instructed to take only 1 tablet administration. While the experience with total daily dosage >200 mg carbidopa is limited, the maximum recommended daily dose of entacapone is 2000 mg and therefore the maximum dose, for the strengths of 50/12.5/200 mg, 100/25/200 mg and 150/37.5/200 mg, is 10 tablets/day.
- Ten (10) tablets of the strength 150/37.5/200 mg equal carbidopa 375 mg/day. Therefore, using a maximum recommended daily dose of carbidopa 375 mg, the maximum daily dose of 200/50/200 mg is 7 tablets per day. The maximum total daily levodopa dose administered should not exceed 1500 mg.

Prescriber category: A* (MOPD)



4. Rituximab 500mg/50ml Injection

Indications: Primary Membranous Nephropathy (Off-label by FUKKM)

Dosage: 1g once every 2 weeks for 2 doses; alternative dosing regimens include 375 mg/m² once weekly for 4 doses or 375 mg/m² once followed by a second dose of 375 mg/m² if ≥ 5 circulating B cells per mL are detected by flow cytometry 1 week after the initial dose.

Prescriber Category: A*



KPK

5. Natamycin 5% Ophthalmic Suspension

Indications: Fungal keratitis in patients not responding to standard treatment.

Dosage: Instill 1 drop in conjunctival sac every 1-2 hours, after 3-4 days reduce to one drop 6 to 8 times daily; usual course of therapy is 2 to 3 weeks or until resolution of active fungal keratitis (may be useful to gradually reduce dosage at 4- to 7-day intervals to assure elimination of organism).

Prescriber Category: A* (OPHTHAL)



KPK

6. Ursodeoxycholic acid 250mg capsule

Indications: Cholestatic liver diseases (eg. primary biliary cirrhosis, primary cholangitis)

Dosage: 10-15 mg/kg daily in 2 to 4 divided doses usually for 3 months to 2 years. If there is no decrease in stone size after 18 months, further treatment seems not to be useful

Prescriber Category: A (MOPD)



7. Cholestyramine Resin 4g

Indications: i) Hypercholesterolemia, ii) Familial hypercholesterolemia - heterozygous, iii) Generalized atherosclerosis, iv) Diarrhoea due to bile acid malabsorption, v) Pruritus of skin associated with partial biliary obstruction

Dosage: Hypercholesterolemia: Adjunct: initial, 4 g orally 1-2 times daily, maintenance, 8 to 16 g in divided doses, **max 24 g daily** CHILD: 50 - 150 mg/kg 6 - 8 hourly oral

Prescriber Category: A (MOPD)



KPK

8. Domperidone 1mg/ml Suspension (60ml) (MOTILIUM)

Indications: Nausea, vomiting, dyspepsia, gastro-oesophageal reflux

Dosage: Adults & adolescents ≥ 12 years of age & weighing ≥ 35 kg & children < 12 years of age & weighing ≥ 35 kg: 10ml 3-4 times per day. Maximum dose: 40mg/day. Adults & adolescents (≥ 12 years of age) weighing < 35 kg: 0.25mg/kg 3-4 times per day. **Maximum dose: 35mg/day.**

Prescriber Category: B



9. Paracetamol 250mg/5ml Syrup

Indications: Mild to moderate pain and pyrexia

Dosage: CHILD: 6 - 12 years: 250 - 500 mg per dose. Repeat every 4 - 6 hours when necessary. Maximum of 4 doses in 24 hours

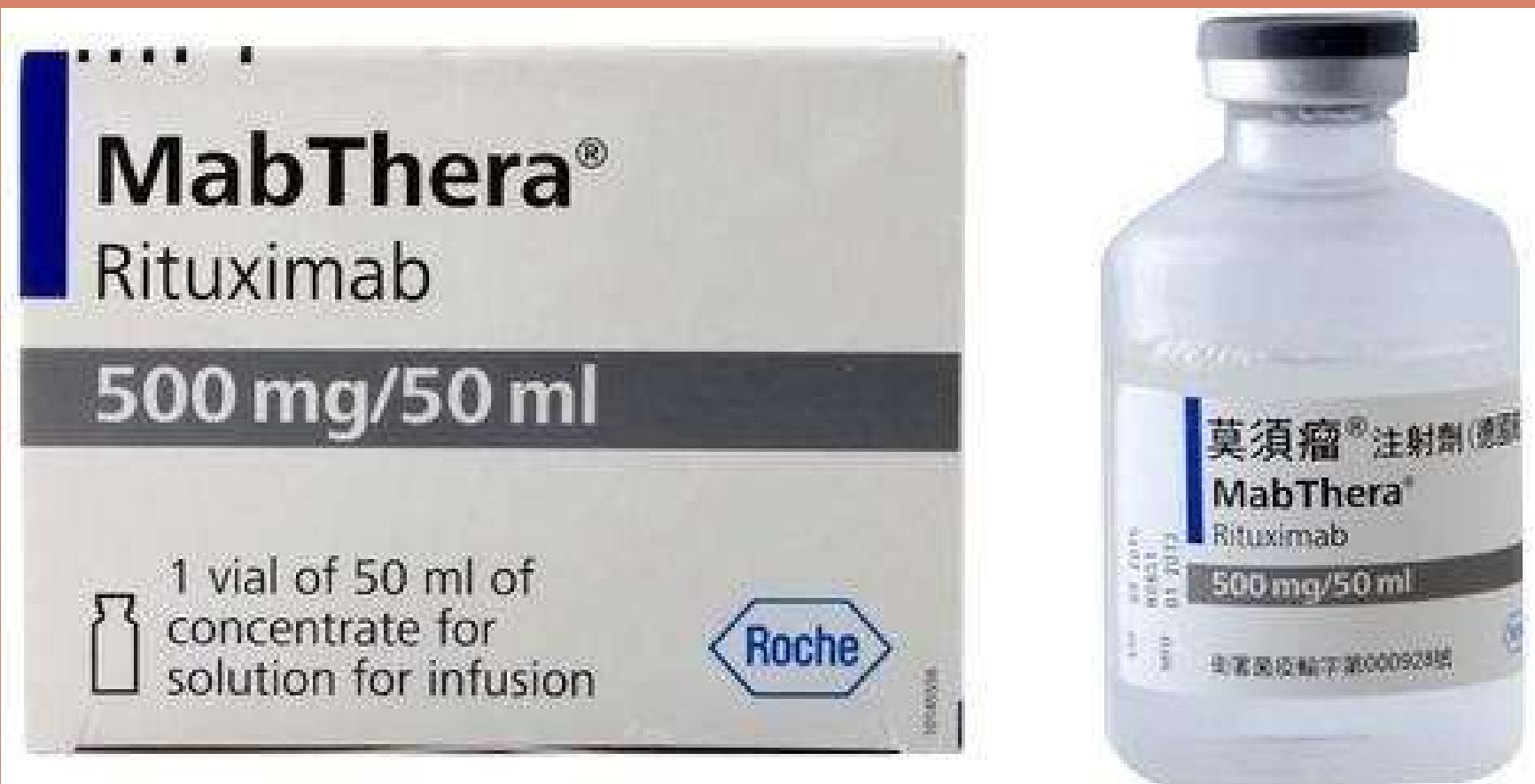
Prescriber Category: C+





Injection Rituximab 500mg/50mL

By: Nurul Balqis Binti Zainal Azim



Rituximab is a type of protein called a “monoclonal antibody”. It sticks to the surface of a type of white blood cell called B-cells. B-cells in the body are an important part of our immune system but can produce harmful autoantibodies which attack the body’s own tissues causing illness. Rituximab works by depleting the B-cells for several months to reduce inflammation and improve symptoms.



In Rheumatoid Arthritis (RA), Rituximab is used in patients who have not met treatment goals despite maximally tolerated methotrexate therapy, inadequate response to TNF inhibitor therapy or a history of lymphoproliferative disorder for which rituximab is an approved therapy. It may be administered in combination with methotrexate, another conventional synthetic disease-modifying antirheumatic drug, or as monotherapy if other treatment options are not tolerated. Rituximab works by inducing apoptosis in DHL 4 human B cell lymphoma cells and inhibits rheumatoid factor production, antigen presentation, T-cell activation and proinflammatory cytokine production in rheumatoid arthritis (1)

Dilution and Administration

- Dilute 500mg/50ml up to 125 - 500 ml diluent to give a concentration of 1 - 4 mg/ml
- Diluent: Normal Saline, Dextrose 5%
- 1st infusion: administer at a rate of 50 mg/hr, can be escalated in 50 mg/hr increments every 30 min (max: 400 mg/hr)
- Subsequent infusions: administer at a rate of 100 mg/hr, can be escalated in 100 mg/hr increments every 30 min (max: 400 mg/hr)
- Do not administer as IV push or bolus
- Gently invert the bag to mix the solution. Do not shake (2)

Side Effects

Infusion reactions are more likely during the first infusion, occurring in up to 20 to 30 percent of patients with rheumatoid arthritis (RA) treated with rituximab. Examples of reactions include:

- headache
- fever
- chills
- sweats
- skin rash
- dyspnea
- throat swelling
- mild hypotension
- nausea
- rhinitis
- pruritus
- asthenia
- back pain
- bronchospasm



Dose

Indication: Rheumatoid arthritis, In combination with methotrexate, in patients with an inadequate response to methotrexate

- **Low dose**

500 mg IV once and repeat in 2 weeks OR 1000 mg IV as a single dose; give with methotrexate and folic acid; premedicate with methylprednisolone 100 mg IV (or prednisone equivalent); repeated doses of rituximab permitted after 24 weeks (off-label dosage)

- **High dose**

1000 mg IV once and repeat in 2 weeks; give with methotrexate and folic acid; premedicate with methylprednisolone 100 mg IV (or prednisone equivalent); repeated doses of rituximab permitted after 24 weeks (off-label dosage) (3)

Indication: Rheumatoid arthritis (Moderate to Severe), In combination with methotrexate, in patients who had an inadequate response to one or more tumor-necrosis-factor antagonist therapies

- 1000 mg IV followed by a second 1000-mg IV dose 2 weeks later in combination with methotrexate every 24 weeks or based on clinical evaluation; no more often than every 16 weeks (FDA dosage)
- 500 mg IV followed by a second 500 mg IV dose 2 weeks later or a single 1000 mg IV dose; in combination with methotrexate (off-label dosage)
- Premedication, give acetaminophen, an antihistamine, and a glucocorticoid (methylprednisolone 100 mg IV or its equivalent) **30 minutes before each rituximab infusion** (FDA dosage) (3)

Counselling Points

- Avoid vaccines before and during therapy due to drug-induced immunosuppression. Administration of non-live vaccines should take place at least 4 weeks prior to a course of rituximab treatment.
- Tell patient to report infusion-related reactions or severe mucocutaneous reactions.
- Recommend women of childbearing age the use reliable contraception to avoid pregnancy during therapy and at least 12 months post-treatment.
- Advise patient to report symptoms of hepatitis or tumor lysis syndrome.

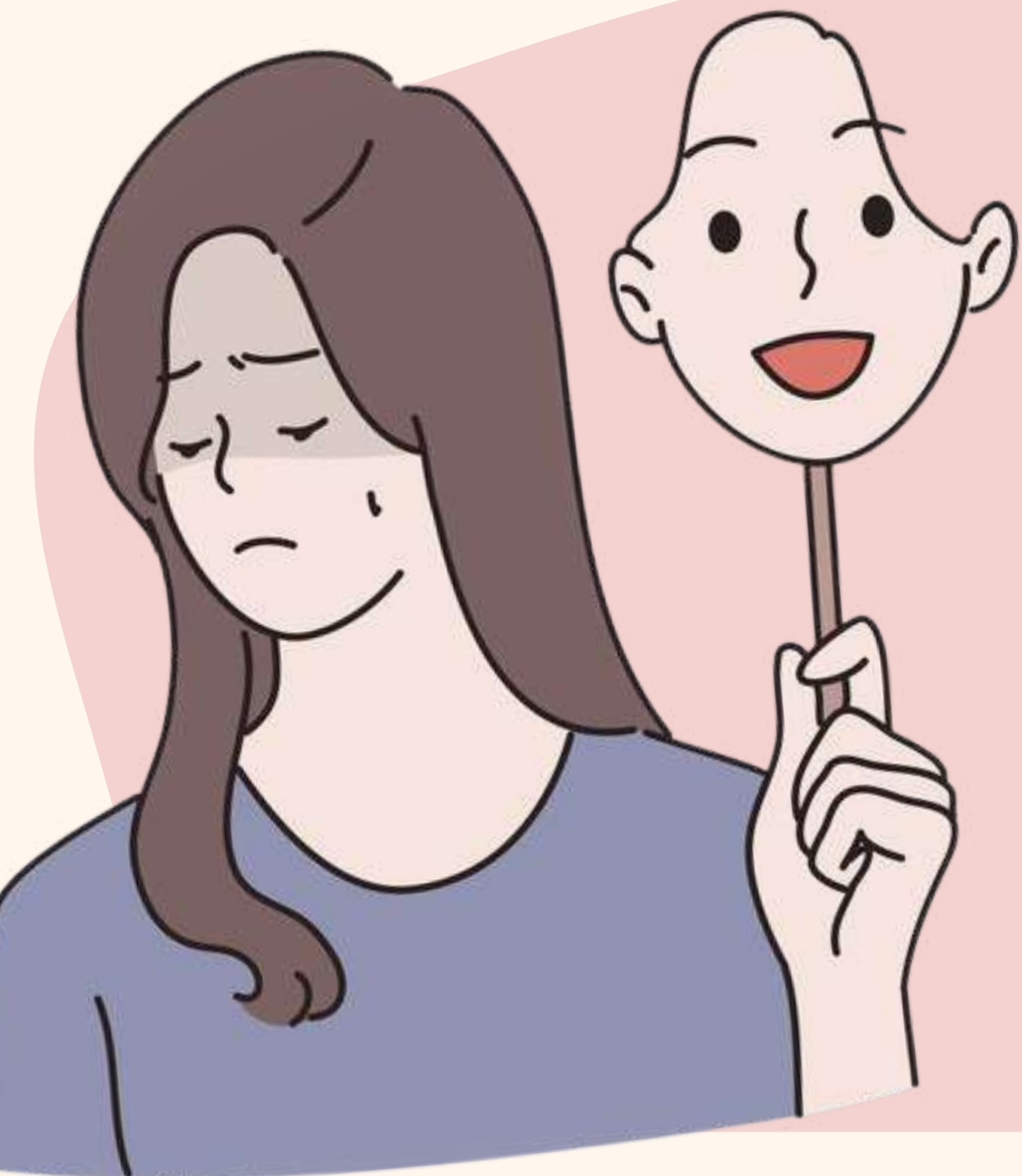


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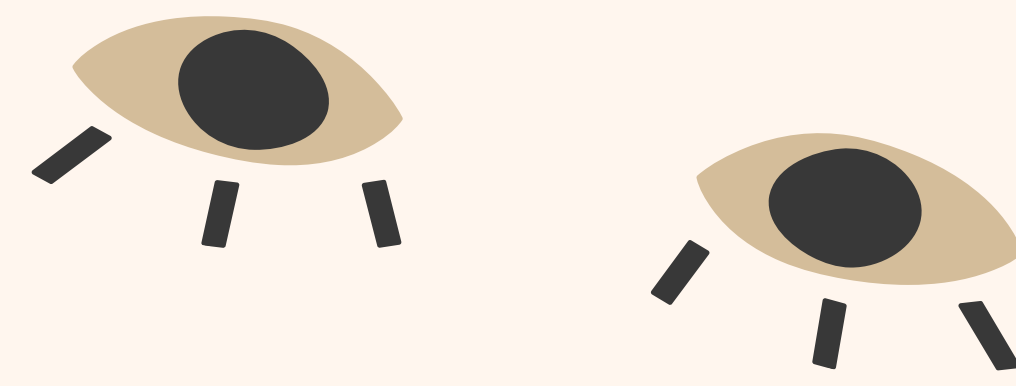


Epidemiology



According to the National Mental Health Registry (NMHR), a total of 7351 schizophrenia cases has been reported from 2003-2005. Schizophrenia recorded higher prevalence in males (60%) than females (40%), urban and migrant populations. Schizophrenia distribution by races is as such: Malays (54%), Chinese (28%), Indians (9%) and others ethnicities (9%). The onset age for schizophrenia is between 15 to 35 years old. Males was found to develop the disease earlier than females (1,2,4).

Pathophysiology



The exact pathophysiology of schizophrenia is unknown but may involve neurotransmitter imbalances in the brain. Abnormalities of the neurotransmitters serotonin, norepinephrine, and dopamine could play a role in this disorder. Reduced hippocampal volumes, thalamic abnormalities, and white-matter abnormalities have been noted in patients with schizoaffective disorder. Exposure to viruses, malnutrition, or even birth complications may also play a role. (7)

Signs & Symptoms (2,3,6)

Schizophrenia patients exhibit signs and symptoms which can be categorized into **THREE** categories:

Positive symptoms are highly exaggerated ideas, perceptions, or actions that show the person can't tell what's real from what isn't. Here the word "positive" means the presence (rather than absence) of symptoms. **Negative symptoms** refer to an absence or lack of normal mental function involving thinking, behavior, and perception. **Cognitive symptoms** reflect how well the person's brain learns, stores, and uses information. (2,3)



Positive Symptoms

- Hallucinations
- Delusions
- Disorganized speech & thoughts

Negative Symptoms

- Anhedonia
- Avolition
- Blunted affect

Cognitive Symptoms

- Memory issues
- Inability to process social cues
- Impaired sensory perception

Pharmacotherapy

Medications for schizophrenia can be classified into **TWO** groups.

1st generation antipsychotics or also known as **typical antipsychotics** include Sulpiride, Perphenazine, Trifluoperazine, Chlorpromazine, Haloperidol, and Zuclopenthixol. On top of that, Fluphenazine, Flupenthixol, and Zuclopenthixol is available as injection. Typical antipsychotics have higher risk of causing neurological side effects, namely extrapyramidal symptoms (EPS). Common examples of EPS include dystonia (uncontrolled muscular spasm), pseudoparkinsonism (bradykinesia, tremor), akathisia (restlessness) and tardive dyskinesia (abnormal involuntarily movement).

2nd generation antipsychotics or also known as **atypical antipsychotics** include Risperidone, Paliperidone, Quetiapine, Amisulpride, Aripiprazole, Olanzapine, Clozapine while Paliperidone is available as injection. These medications have higher risk of causing metabolic side effects such as central obesity, hypertension, dyslipidaemia and glucose intolerance. These newer, second-generation medications are generally preferred because they pose a lower risk of serious side effects than do first-generation antipsychotics. (3)

Non-Pharmacotherapy

In addition to drug therapy, **psychological and social (psychosocial) interventions** are essential. These may include **psychotherapy** which aims to help to normalize patient's thought patterns, cope with stress and identify early warning signs of relapse so that schizophrenia patients can better manage their illness. There is also **Social skills training** which focuses on improving patient's communication skill, social interactions, and patient's ability to participate in daily activities. On top of that, **family therapy** can provide support and education to families dealing with schizophrenia patients. **Vocational rehabilitation and supported employment** is also available to help schizophrenia patients prepare for, find and keep jobs. Some Non-Governmental Organizations (NGOs) also offer support services to these patients through **community programs** such as skill trainings and self-care training. With appropriate treatment, most people with schizophrenia can manage their illness and live a functional life. Electroconvulsive therapy (ECT) may also be considered for schizophrenia patients who do not respond to drug therapy (8).



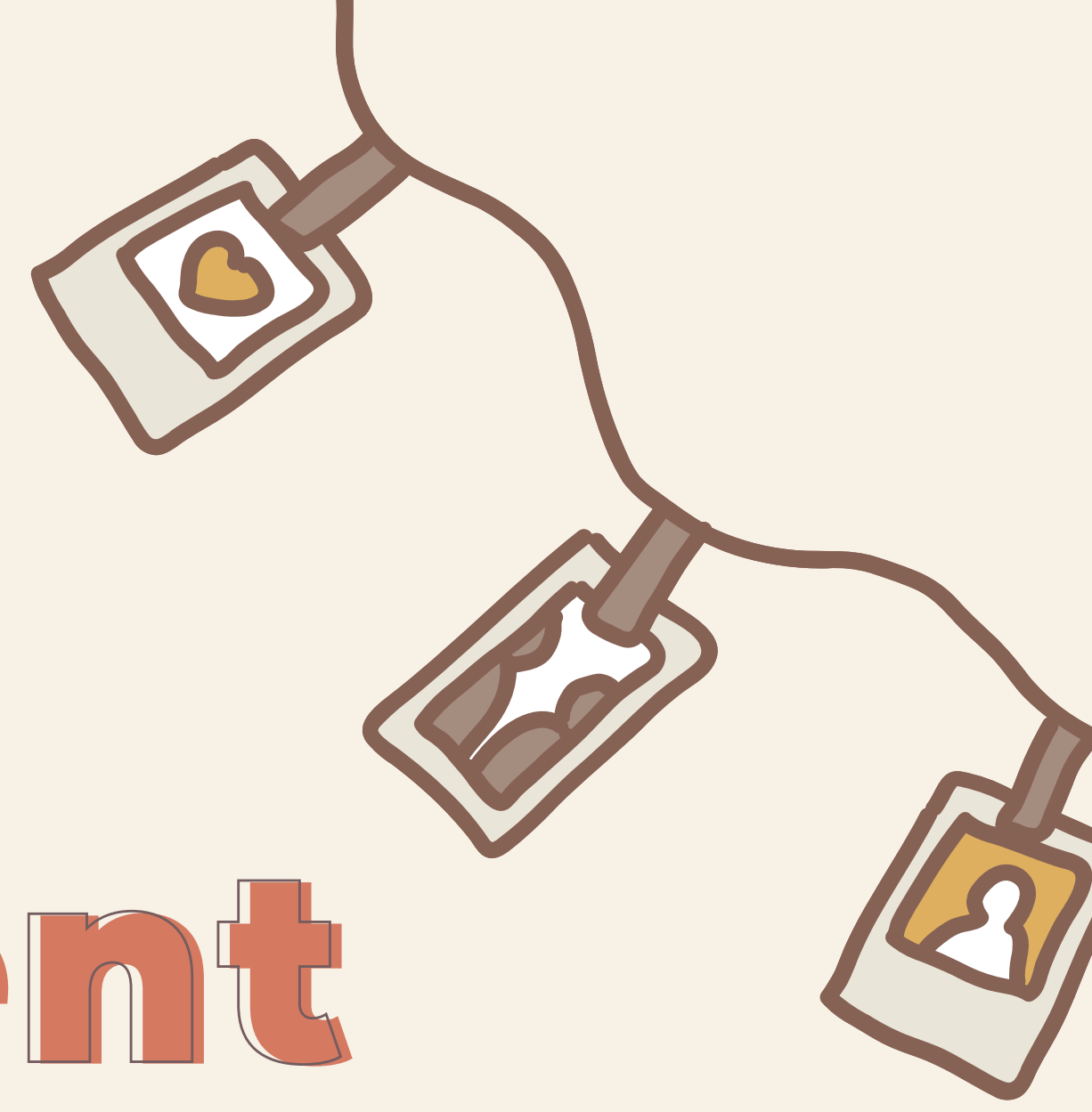
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Prognosis

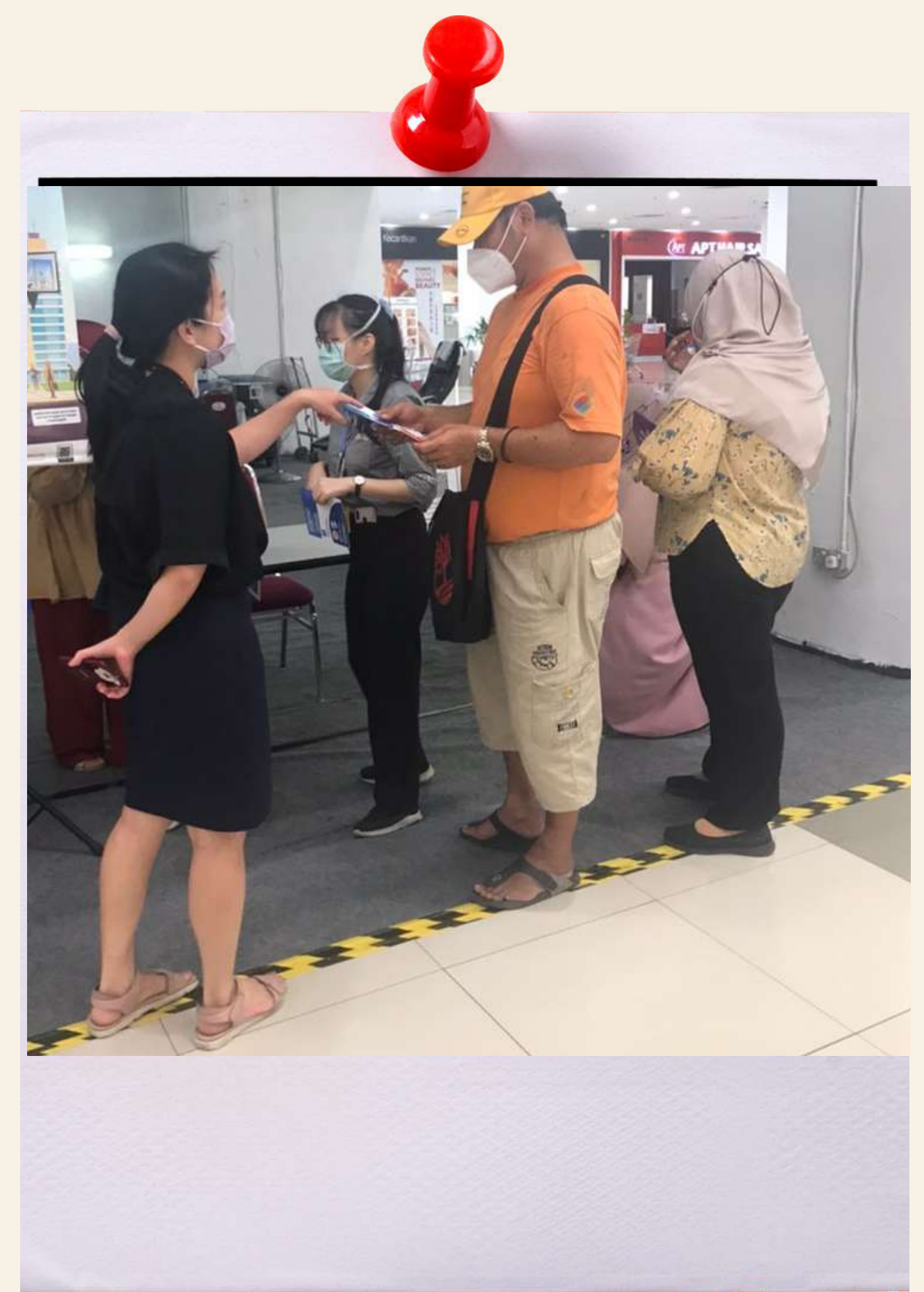
10 years after diagnosis, about 50% of patients recover and is able to live an independent and functional life. 25% of patients require continuous medical and family support whereas 15% of patients do not show any improvement in their disease. Early-onset of illness, family history of schizophrenia, structural abnormalities in brain and prominent cognitive symptoms are associated with a poorer outcome. (5)

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Happenings in Pharmacy Department



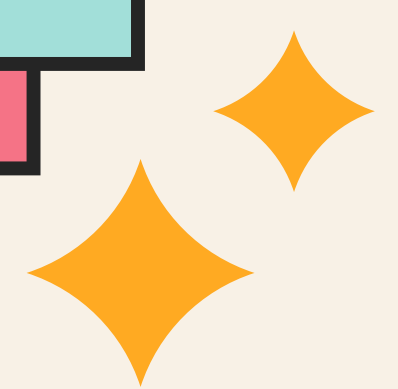
By: Nurul Balqis Binti Zainal Azim



QUMC Exhibition in AEON Mall, Seri Manjung on 26th March 2022.
focusing on Vaccination and Reporting of Adverse Event Following
Immunisation (AEFIs)



Hari Raya Celebration 2022 organized by
OPD Pharmacy on 27 May 2022.



SAFE AND APPROPRIATE LABELLING OF MEDICINES FOR END USERS

By Cik Amy Tan, Pn Lim Tse Mun & Cik Norazrina

Confusion between medicine products that have **similar names or packaging** has long been acknowledged as one of the major causes of medication error where these errors often result in patients receiving the wrong medicine or the wrong strength intended and depending on the medicines involved, the error outcomes can range from minor to catastrophic.

Therefore, a careful and accurately labelled medicines with clear instructions about its use and is easily identifiable by health professionals and consumers is important to ensure the safe use of medicine. Proper medicine label with information such as the **name of the patient and medicine, dosage form, administration time and indication** will educate consumers and help prevent any potential confusion among medications, especially when patients have been prescribed and dispensed with more than one medication. This is important as patients need to extract information from the labels in order to act upon it.

Pharmacy undoubtedly plays a very important role in medicine labelling as pharmacy is the last interaction point between healthcare professionals and patients. Therefore, the Pharmacy Department Hospital Seri Manjung has published a guideline in March 2022 titled **"GUIDELINE FOR SAFE AND APPROPRIATE LABELLING OF MEDICINES FOR END USERS"** with the purpose to encourage the practice of appropriate medicine labelling among pharmacy staff.

CRITERIA FOR GOOD DRUG LABELLING

taken from Guideline for Safe and Appropriate Labelling of Medicines for End Users, HSM 2022

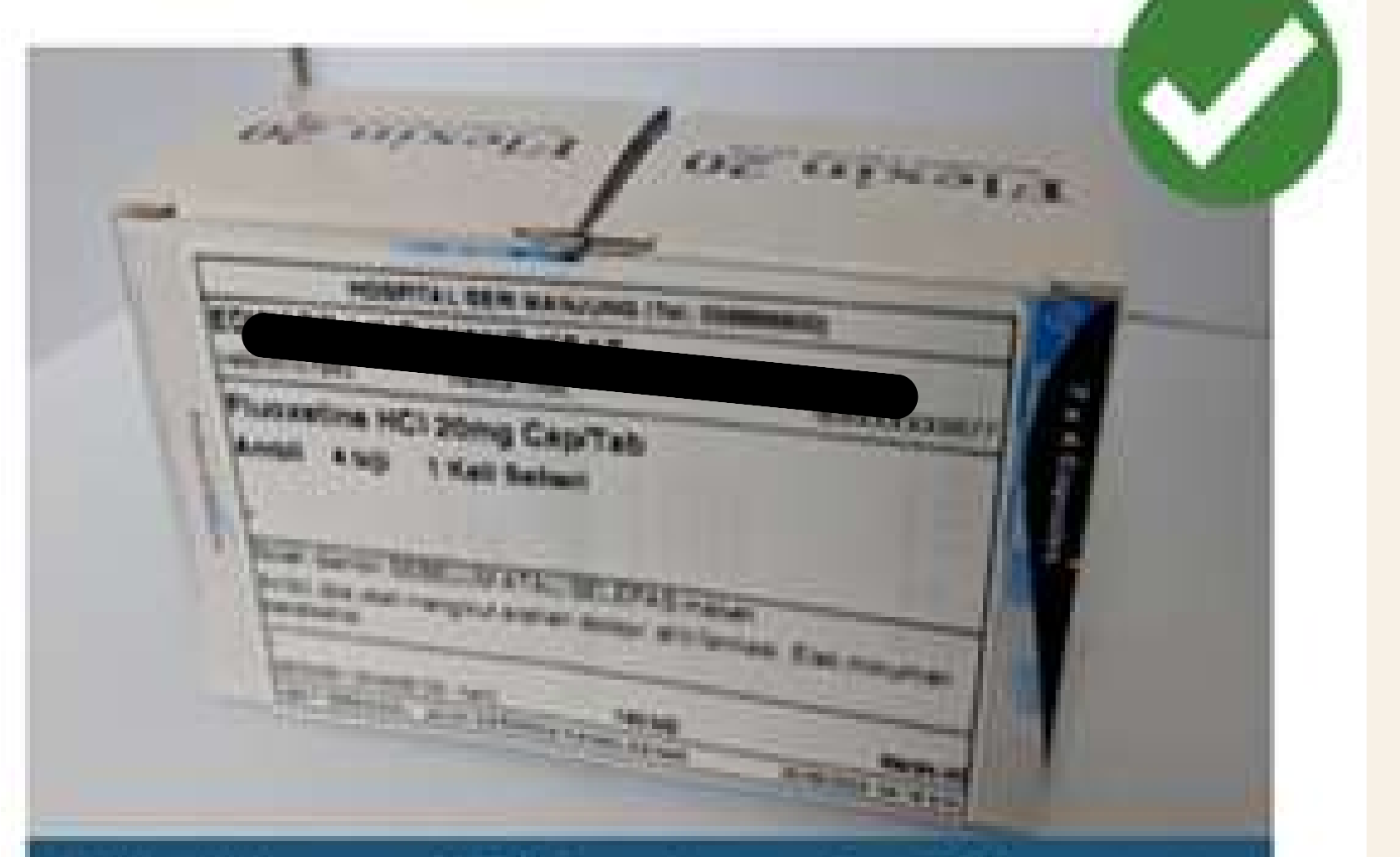
- Labels should **NOT** be folded whenever possible.
- Labels should **NOT** obstruct the readability of Drug Name/Strength/Expiry Date of primary packaging (especially drugs that comes in multiple strengths or similar packaging).
- **DO NOT** fill the same medication with loose strips of multiple/different brands.
- Multiple boxes of ONE medication for ONE patient, should be tied together prior labelling.
- For small-sized medication (bottles/eye or ear drops/injection vials or ampoules/cream) where labelling on the bottle is impractical, place the medication inside a plastic zipper bag and label the plastic zipper bag.

A) BOX / MULTIPLE BOXES

No box(es) should be dispensed unlabelled



Whenever possible, ensure label does not obstruct the readability of Drug Name and Strength on primary packaging.



Multiple boxes of ONE medication for ONE patient is tied together prior to labelling.



Label has fully covered the Drug Name and Strength on the packaging, thus obstructing proper counter-checking of the medication filled.

B) LOOSE STRIPS OF TABLETS

Labels should NOT be placed on the aluminium foil side of the blister strips, so as not to obstruct readability of drug name and strength.



Labels with special instructions should NOT be folded.



Labels with simple instructions can be folded.



DO NOT fold the labels, this will obstruct the readability of important instruction regarding the warfarin regime.

C) TAPERING REGIME/ WARFARIN REGIME/ UNCOMMON REGIMES

- Dose/Frequency/Days should be highlighted with red/blue pen whenever appropriate.
- For tapering regimes, to write the order of regime with red/blue marker pen.



Write the order of the regime with blue/red marker, and staple accordingly.
Highlight the dose/frequency with red pen.
Pack all the medications uniformly in ONE type of packaging.



DO NOT pack the medications in different types of packaging.

D) SYRUPS/BOTTLES/EYE OR EAR DROPS

Labels can be folded by 1/3 of its length as long as does NOT obstruct the visibility of Drug Name/Strength/Expiry/Date of primary packaging



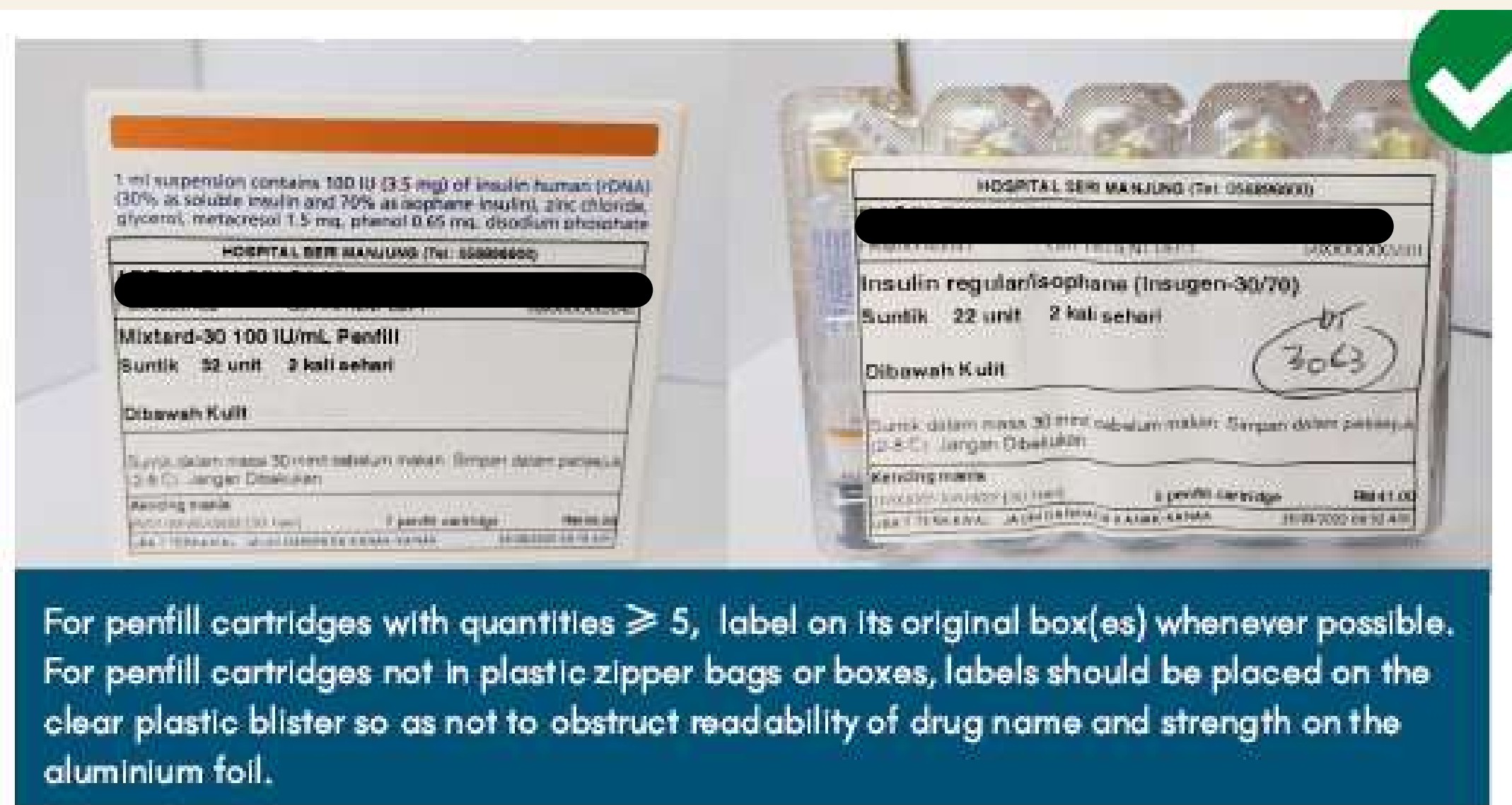
Fold 1/3 of the label.
Label on the bottle instead of the box.
Label should not obstruct the Drug Name, Strength/Concentration and Expiry Date on the bottle.



DO NOT obstruct the Drug Name, Strength/Concentration and Expiry Date on the bottle.

E) INSULIN INJECTIONS / OTHER INJECTIONS

Penfill cartridges in quantities < 5, should be filled in a plastic zipper bag prior to labelling. Penfill cartridges in quantities ≥ 5 , should be labelled in their original box(es) whenever possible.



For penfill cartridges with quantities ≥ 5 , label on its original box(es) whenever possible. For penfill cartridges not in plastic zipper bags or boxes, labels should be placed on the clear plastic blister so as not to obstruct readability of drug name and strength on the aluminium foil.

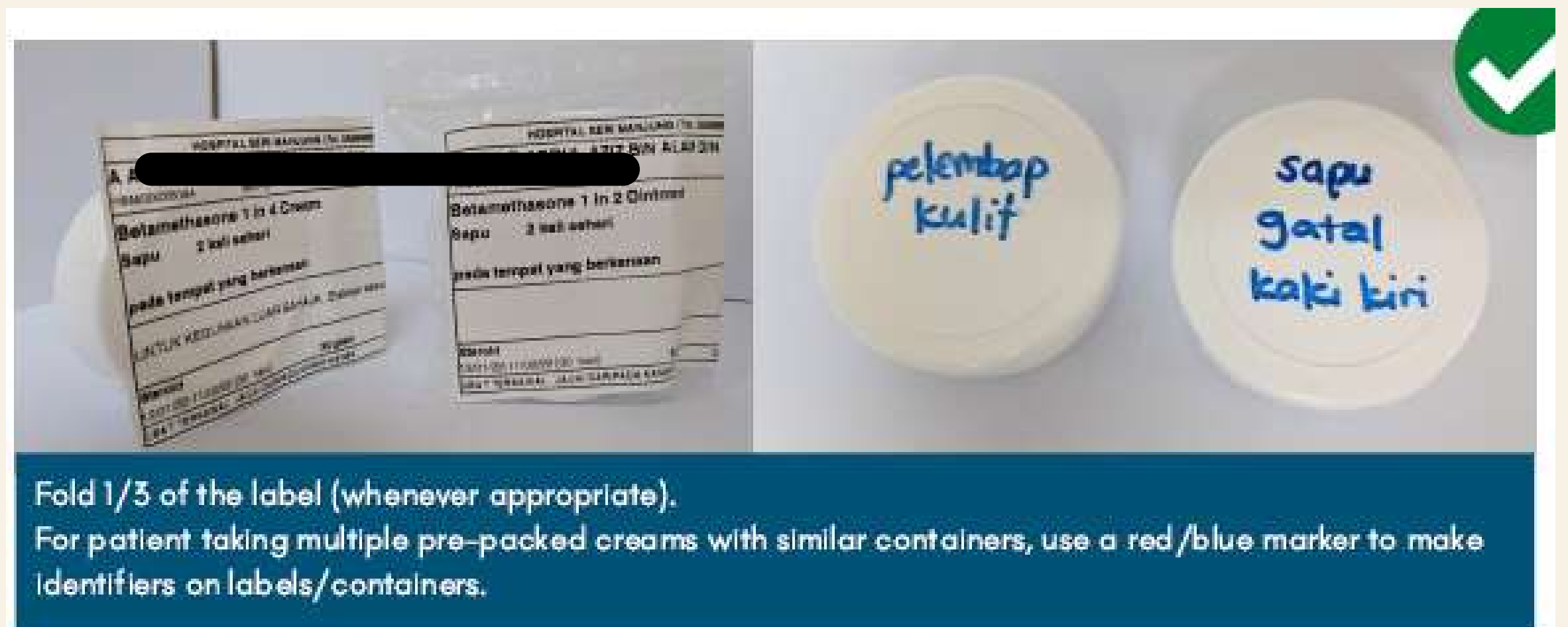


DO NOT dispense any penfill cartridge(s) unlabeled.

F) EXTERNAL PREPARATIONS (COMMERCIAL & PREPACKED)

For patient taking multiple pre-packed creams with similar containers, use a red/blue marker to make identifiers on labels/containers.

No container(s) or tube(s) should be dispensed unlabeled.



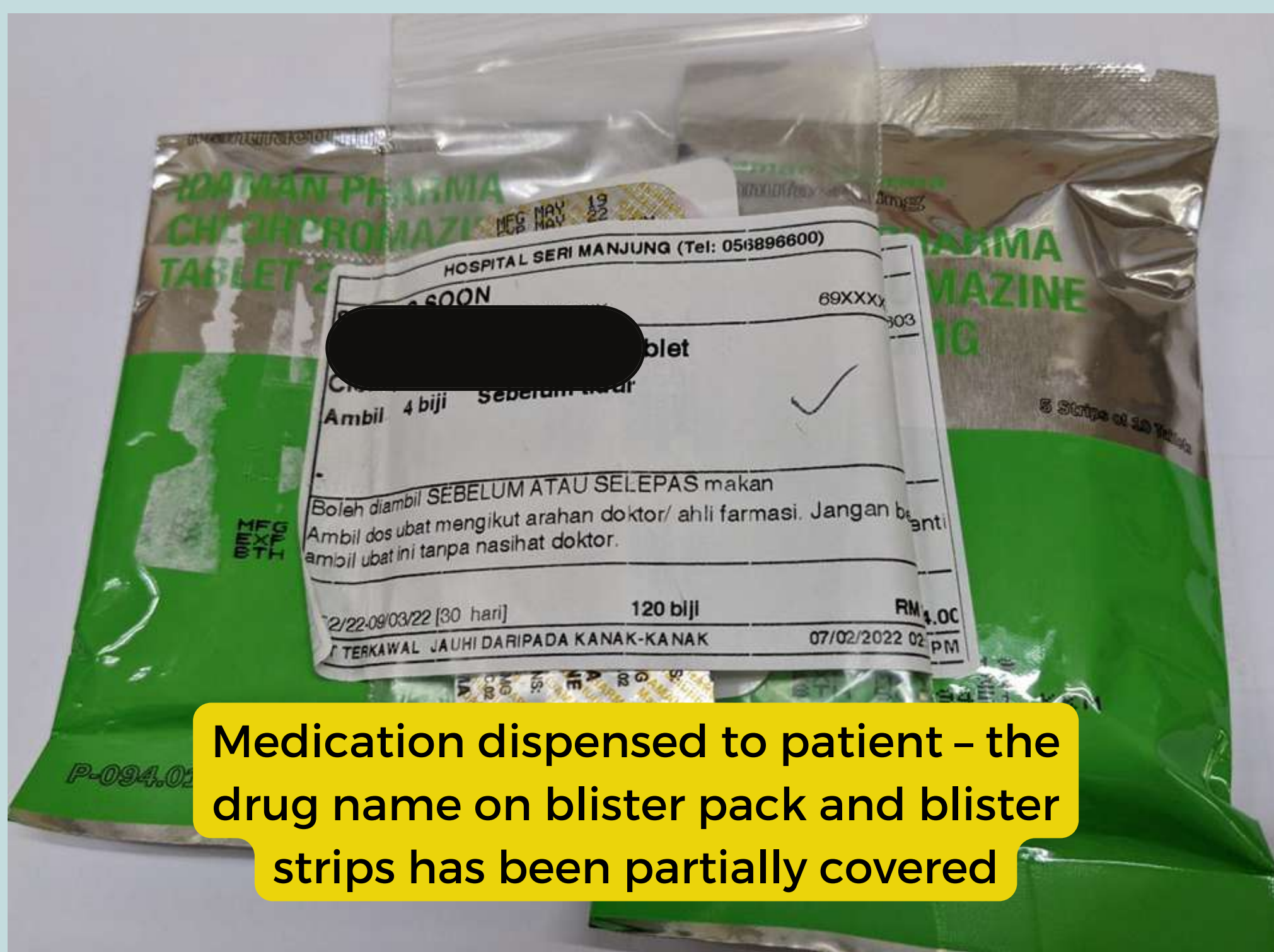
Fold 1/3 of the label (whenever appropriate). For patient taking multiple pre-packed creams with similar containers, use a red/blue marker to make identifiers on labels/containers.



Fold 1/3 of the label (whenever appropriate). Label on the side that does not obstruct the readability of Drug Name/Strength/Expiry Date of primary packaging.

EXAMPLES OF ACTUAL MEDICATION ERRORS CAUSED BY POOR LABELLING IN HOSPITAL SERI MANJUNG 2022

Patient was prescribed with T. Clomipramine 100mg ON (4 tabs of 25mg) but was wrongly filled with T. Chlorpromazine 100mg ON (4tabs of 25mg). The labelling error failed to be detected as the drug name on blister pack and blister strips has been partially covered



Medication dispensed to patient - the drug name on blister pack and blister strips has been partially covered



Content of packaging upon checking.

Patient was prescribed with T. Fluvoxamine 200mg ON (2 tabs of 100mg) but was wrongly filled with T. Fluvoxamine 100mg ON (2 tabs of 50mg). The filling error failed to be detected as drug name and drug strength on the box has been fully covered by the medicine label.



Comparison of the packaging for Fluvoxamine 50mg and 100mg



STAFF MOVEMENT

April 2022 – June 2022

New Staff

1	CIK ANISA ZAWANI BT KAMARUDDIN	PF UF41 (PRP)
2	CIK UGHASHEENI A/P MANIVANNAN	PF UF41 (PRP)
3	PUAN IRMAYUNI BT SELAMAT SUJAYMO	PEN. PT N29

Internal Transfer

1	PUAN MURNI BT HAMIL	PF UF52
2	PUAN HUI YI JIE	PF UF52
3	CIK KOAY HUI YING	PF UF52
4	PUAN SURAIYA HANI BT MOHAMAD ZABIDI	PF UF48
5	CIK NOOR AZRINA BT SANIK	PF UF48
6	PUAN YVONNE HAR	PF UF48

Transferred In

1	PUAN CHERYL CHEN KEOK LING	PF UF52
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Transferred Out

1	PUAN SOFIYYAH BT SA'ADON	PF UF54
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