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Simulation Manual

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Preface

Pharmacy training, where technological innovations are advancing practice, is preparing to integrate with simulation that is gaining popularity for the means to provide immersive learning experiences and a better understanding of content.

A clinical simulation experience as a teaching technique is an active activity where students are immersed in a simulated clinical environment or circumstance. Students should develop critical thinking and decision-making skills through a process involving assessment, analysis, planning, execution or action and evaluation.

Simulation also provides an opportunity to test medical judgment and critical thinking without jeopardizing patient safety. Throughout clinical rotations, teachers can use well-founded simulation methods to help students reach educational goals. During this realistic clinical experience, learners are expected to incorporate and synthesize core concepts and expertise and to apply relevant communication and psychomotor skills.

On this context, College of Pharmacy introduced simulation practice settings for IPPE PharmD students to understand and practice the core concepts of clinical pharmacy activities and its importance.

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SIMULATION

Simulation is a training and learning tool that can be applied to a wide range of subjects and trainees. It is a technique that replaces and amplifies real experiences with directed ones, often "immersive" in nature, which evokes or replicates significant aspects of the real world in a fully interactive way. Simulation-based learning can be the way to develop health professionals' knowledge, skills, and attitudes, whilst protecting patients from unnecessary risks.

SIMULATION LABS

The Pharmacy Simulation Laboratory is designed to give students hands-on clinical experience on various activities. The following are the simulation labs

- Intra Venous (IV) Admixture Room
- Simulation Lab
- Model Pharmacy

The patient counselling, Medication history interview, dispensing and other simulation activities will be recorded by using IP Camera and it will be stored for debriefing purpose.

KEY COMPONENTS IN SIMULATION

- Simulation perspectives include actual experience of simulation, debriefing, and assessment.
- Simulated experience will have clearly stated goals to be addressed to the student prior to the simulation experience.
- Students are required to prepare for a clinical simulation experience in the same manner as they would prepare for an actual patient care experience.
- The simulation may challenge the student to use problem solving and critical reasoning skills to assess the situation and determine the correct interventions.
- The educator assumes the role of facilitator, providing clues when necessary, but is not an active participant in the simulation.
- The educator and the student should participate in an active debriefing facilitated by the educator, the debriefing should challenge the student to think critically about his/her practice and clinical judgment.

- The debriefing session should occur immediately after the simulation is completed so the thoughts and feelings of the learner are not forgotten and do not get distorted over time).
- Video recording of the simulation can be utilized as a tool to provide objective data for review.
- The environment in which the simulated patient experience is to be performed must reflect reality as much as possible.
- Introduction to the environment is important because it allows students to become familiar with the simulator and resources available.

SIMULATION ACTIVITIES

Simulation activities conducted for II, III, and IV PharmD students as a part of their introductory pharmacy practice experience to improve their specific skills and competencies.

All the II, III, IV PharmD students used to perform each activity three times in a year and individual subject teachers decides the schedule. Mainly their therapeutic practical hours will be engaged for simulation practice activities.

II PharmD Simulation Activities

- ✓ BP monitoring
- ✓ Blood Glucose monitoring
- ✓ Patient Counselling
- ✓ ADR Monitoring
- ✓ Dose Division

III PharmD Simulation Activities

- ✓ Patient counselling
- ✓ Medication History Interview
- ✓ Treatment Chart Review
- ✓ Medical Reconciliation
- ✓ Drug Information Service

IV PharmD Simulation Activities

- ✓ Patient counselling
- ✓ Medication History Interview
- ✓ Treatment Chart Review
- ✓ Drug Dispensing
- ✓ IV Admixtures

1. BLOOD PRESSURE MONITORING

Introduction

Blood Pressure is defined as the pressure of the blood in the circulatory system, often measured for diagnosis since it is closely related to the force and rate of the heartbeat and the diameter and elasticity of the arterial walls.

The control of blood pressure begins with an accurate measurement leading to a correct diagnosis, effective treatment, routine monitoring, and medication adherence.

For more than a century, the mercury sphygmomanometer is the gold standard for measuring blood pressure. Nowadays digital blood pressure equipment's are available for the ease of use by patients especially at home.

Common sources of error in blood pressure measurements include

- Human errors (e.g., incorrect cuff size, improper body positioning, inadequate rest period, terminal digit preference, lack of repeat measurements),
- Patient factors (e.g., recent caffeine, decongestant, or nicotine use; talking during the measurement),
- Device-related factors (e.g., failure to properly use, inspect, maintain, or calibrate a device validated by the American National Standards Institute, Association for the Advancement of Medical Instrumentation, or International Organization for Standardization).

Objectives

To train the Doctor of Pharmacy students in the following areas:

- To monitor the Blood Pressure using Sphygmomanometer.
- To interpret the blood pressure findings and make necessary recommendations.
- To understand the role of pharmacist in disease management.

Procedure

- Blood pressure monitoring equipment must be checked for calibration prio r to the procedure
- Clean blood pressure machine and cuff with appropriate cleaning wipe
- The circumference of the upper arm must be measured at the widest point in order to determine which size cuff be used. See table below: -

Arm Circumference	Cuff Size
Less than 23cm	Small Adult
23cm to 33cm	Standard Adult
33cm to 50cm	Large Adult
51cm to 53cm	Adult Thigh Cuff

Table-1 Details the Arm Circumference respect to the Cuff Size

- Valid consent must be given voluntarily by an appropriately informed person prior to any procedure or intervention.
- Prior to procedure, advice patient not to eat, take alcohol, smoke or exercise for 30 minutes before their blood pressure is measured, as these factors may affect the accuracy of the blood pressure reading.
- Verbally confirm the identity of the patient by asking for their full name and date of birth. If client unable to confirm, check identity with family/caregiver. This is done to avoid mistaken identity.
- Introduce yourself. This is to promote mutual respect and put client at ease.
- Wear identity badge which includes name status and designation. This is for patients to know who they are seeing and to promote mutual respect.
- Ensure verbal consent for the presence of any other third party is obtained (Students for example, as the client has the choice to refuse).
- Explain procedure to patient including risks and benefits and gain valid consent. This will enable patient to make an informed decision to proceed with blood pressure monitoring.
- Make sure you decontaminate hand, so that the risk of transfer of transient microorganisms on the healthcare worker's hands is reduced.
- Ask patient to remove any tight arm clothing. Assist the patient if required, ensuring privacy and dignity at all times. This will allow the cuff to be applied in the correct position thus reducing the potential for error.
- Check skin condition of the upper arm. If patients arm is: - Swollen/edematous or has any breaks do not continue, seek advice. If necessary, clean arm to prevent cross infection.

- Request the patient to empty their bladder if they need to, because full bladder can affect blood pressure reading.
- The patient should be relaxed for at least 5 minutes prior to procedure. Their legs should be uncrossed and flat on the floor. This can minimize the effects of the environment to ensure an accurate reading is obtained.
- Whilst patient is seated measure the circumference of the upper arm at the widest point and record in the health care record so that the correct sized cuff will be used.
- Select appropriate cuff from measurements obtained. Using the wrong sized cuff can affect the reading obtained.
- The Blood Pressure -Documentation form is enclosed in **ANNEXURE I**

2. BLOOD GLUCOSE MONITORING

Introduction

Blood glucose monitoring is a way of testing the concentration of glucose in the blood (glycaemia). Particularly important in diabetes management, a blood glucose test is typically performed by piercing the skin (typically, on the finger) to draw blood, then applying the blood to a chemically active disposable 'test-strip'.

Different manufacturers use different technology, but most systems measure an electrical characteristic, and use this to determine the glucose level in the blood. The test is usually referred to as capillary blood glucose. Conditions where a patient's blood glucose may need careful monitoring are:

- In order to make a diagnosis of diabetes mellitus.
- In the acute management of unstable diabetic states, diabetic ketoacidosis, hyperosmolar non- ketotic coma, and hypoglycemia.
- In order to make a diagnosis of hypoglycemia,
- Where blood glucose levels are not in keeping with the patient’s clinical status.

Objectives

This activity helps to train clinical pharmacists in the following areas:

- Monitoring of blood glucose using Glucometer.
- To understand the role of Pharmacist in Diabetic Disease Management.
- The need for an interdisciplinary, shared responsibility between pharmacists and physicians to improve patient treatment outcomes.

Procedure

Any blood glucose monitor used must have undergone the calibration prior to use.

Verbally confirm the identity of the patient by asking for their full name and date of birth. If client unable to confirm, check identity with family/caregiver (To avoid mistaken identity)

Introduce yourself. (To promote mutual respect and put client at their ease)

Wear identity badge which includes name status and designation (For patients to know who they are seeing and to promote mutual respect)

Ensure verbal consent for the presence of any other third party is obtained (Students for example, as the client has the choice to refuse)

Explain procedure to patient including risks and benefits and gain valid consent. (To ensure client understands procedure and relevant risks and to allay fears or anxieties)

Check that quality control test has been carried out that day – test machine if necessary (To ensure machine is functioning correctly)

Advise patient to wash and dry their hands using soap and water, prior to procedure – assist if necessary. Do not use alcohol gel. (To prevent sample contamination)

Decontaminate hands prior to the procedure (To reduce the risk of transfer of transient micro-organisms on the healthcare worker's hands)

If indicated, apply single use disposable apron (To protect clothing or uniform from contamination and potential transfer of micro-organisms)

Apply single use disposable non sterile gloves (To protect hands from contamination with organic matter and transfer of microorganisms)

Prepare single-use disposable lancet device as per manufacturer's instructions (To ensure correct use of equipment)

Remove new test strip from vial, replace lid tightly (To prevent deterioration of remaining strips)

Within 30 seconds, insert test strip (yellow window facing up) into test strip slot The meter should turn on automatically (To initiate process of analysis)

Check that current meter code and test strip code match. If a new pack of strips is required, the meter should be recalibrated. (To ensure machine is calibrated to test strip)

Ask patient to sit or lie down (To ensure the patient's safety and minimize the risks if they feel faint when blood is taken)

Using the single use lancet, obtain a blood sample from the side of the finger (Side of finger is a less painful site to use)

Sites should be rotated if testing is frequent (Reduce the risk of infection from multiple puncturing and prevents areas from toughening)

Avoid using thumb or index finger Less painful (most frequently used digits have a more sensitive nerve supply)

The finger may bleed without assistance, but may need 'milking' gently (Droplet needs to be of sufficient size to cover test pad)

Apply a drop of blood to the strip by holding the patient's finger to the edge of the strip until the yellow window is completely filled with blood. (The blood will be drawn into the strip automatically)

Do not place blood on top of the strip (A bleep should be heard which indicates that the test is beginning)

If any part of the yellow window remains yellow after the initial drop of blood has been applied, a second drop of blood may be applied to the edge of the test strip within 15 seconds of the first drop. If more than 15 seconds have passed, the test result may be erroneous and you should discard the test strip and repeat the test

Dispose of used lancet into a sharps container (To reduce the risk of inoculation injury)

Remove test strip from meter and switch meter off

On completion of procedure remove and dispose of PPE to comply with waste management policy. (To prevent cross infection and environmental contamination)

Decontaminate hands following removal of PPE (To remove any accumulated transient and resident skin flora that may have built up under the gloves and possible contamination following removal of PPE.)

Decontaminate reusable equipment using a Trust approved cleaning wipe. Decontamination of medical equipment is essential to the effective delivery of patient care

Document all actions, observations and results (including consent and patient perceptions) in patient records.

The Blood Glucose Documentation Form is enclosed in **ANNEXURE II**

3. PATIENT COUNSELING

Introduction

Patient counseling is an empathic communication between the pharmacist and the patients which help in providing advice, support and information to the patients regarding the drugs and drug therapy and can lead to the optimum effectiveness of drug therapy (rational drug therapy)

Objective

- To make the students to learn about the Patient Counseling procedure
- To make the students to learn about setting objectives for counseling session
- To train the students on setting priorities during the patient counseling.
- To improve Communication Skill and Inter Personal Behaviors.

Procedure

Students should complete the following tasks before they make the actual counseling session,

- Patient related information's like, past medical history, past medication history, chief complaints and other medical related information should be collected from the given case.
- Patient disease related risk factors should be critically reviewed by the students.
- Scope and need of the counseling session should be justified by the students to the preceptors.
- Points to be covered during the counseling session should be mentioned with relevant reasons.
- Prioritize the counseling key points in an order based on its importance

Students should perform the below steps during the counseling session with the patient.

1. Self-Introduction
2. Purpose of counseling should be detailed to the patient.
3. Counseling or Education should be provided to the patient.
4. Should be warned about taking OTC, herbal, etc.
5. Patient understanding towards other medication should be reviewed by the pharmacist
6. Counseling points should be summarized by the pharmacist to the patient.

General Instructions

- Approach is based on encounters in small group teaching sessions using the instructor (a preceptor) as a simulated patient, while a student assumes the role of the pharmacist.
- Counseling session will take 5-10 minutes' maximum.
- Should wear white clean aprons during counseling session
- Students can bring counseling aids like pamphlets, dummy inhalers etc. Also students can use any audio and video visuals during their counseling session if necessary.
- Counseling session should be recorded and debriefing session will be conducted by the preceptor.
- Teach back session will be conducted during the debriefing session by the preceptor to evaluate the students' performance.
- The Patient Counseling Form is enclosed in **ANNEXURE III**

4. TREATMENT CHART REVIEW

Introduction

Treatment Chart Review is a process where a pharmacist reviews the patient's drug treatment during his hospital admission and involves evaluation of the therapeutic efficacy of each drug and the progress of the conditions being treated. It addresses issues such as adverse drug reactions, drug-drug interactions, and medication errors, lack of efficacy, suboptimal patient adherence, poor quality of life, economic consequences and patient experience as well as understanding of the condition. Recommendations from a pharmacist to a clinician and framing a good rapport between them are essential for rendering better clinical services to the patients.

Objectives

- To master the Clinical Pharmacy students to evaluate and interpret a medication chart.
- To make the students learn to set goals according to the patient's medical condition and to intervene at the right time, if necessary.
- To train students in continuity of care through involvement in decision making about treatments, monitoring of patients, discharge medication and provision of medication information counseling.
- To train students in building a rapport with the clinical team members and creating an interpersonal relationship among them.

Procedure

The real or hypothetical case will be assigned to the students to perform the TCR activity using the activity form.

Students are expected to learn and perform the followings for the allotted case,

- Evaluate whether all of the patient's medications are appropriately indicated, the most effective, the safest possible and affordable and if the patient is able and willing to take the medication as intended to rule out some medication problems.

- With other members of the health care team, assess the appropriateness of the current medications on the basis of health conditions, indications, and the therapeutic goals of each medication.

- Check whether the medicine order is comprehensive and unambiguous, that appropriate terminology is used, and that medicine names are not abbreviated.
- Make sure, if necessary, medications are ordered and the patient has access to it, whether administration times are appropriate, e.g. with respect to food, other medicines, and procedures.
- Perform calculations form dosage adjustments, aid in the reconstitution for parenteral preparations, and follow-up on the stability after reconstitution.
- Evaluate medication-taking behaviors and adherence to each medication. Detect actual and potential DRPs (drug related problems), record and document any identified DRPs on the Inpatient Medication Profile Form and report the identified adverse drug event (ADE).
- Mention the relevant subjective / objective findings to monitor the expected health outcome and possible side effects of drugs, if anything details that in remarks section.
- Based on the agreed goals of therapy, prepare pharmaceutical care plan (PCP) based on patient progression that addresses the medicine therapy needs and prioritized DRPs, according to the patient's disease condition, age, co-morbidity, renal and liver functions, pregnancy status, etc
- Evaluate the patient's outcome, determine the patient's progress toward the achievement of the goals of therapy, determine whether any safety or adherence issues are present, and assess whether any new DRPs have developed.
- The Treatment Chart Review Form is enclosed in **ANNEXURE IV**

5. IV ADMIXTURE

Introduction

According to Joint Commission on Accreditation of Healthcare Organizations (**JCAHO**) Intravenous (IV) admixture is the preparation of pharmaceutical product that requires the measured additive of a medication to a 50 ml or larger bag or bottle of IV fluid (e.g., IV, IM, IT, SC, etc). When a licensed pharmacy is available, only the pharmacy compounds or admixes all sterile medications, IV admixtures, or other drugs except in emergencies or when not feasible

Objectives

- To make the students learn about the components of an intravenous administration set.
- To make the students learn handling, preparation and administration procedures for IV drug products in an aseptic environment.
- To train the students to prepare labels for IV admixtures.
- To train the students to calculate the intravenous rates.

Procedure

- ✓ Obtain the physician's orders for IV admixtures and identify the patient
- ✓ Components of IV admixtures set include syringes, needles, medication vials and ampoules, 70% isopropyl alcohol, bag or bottle. They must be sterilized before use
- ✓ Perform proper garbing and gowning procedure and assemble all equipment and supplies needed in a laminar airflow workbench. Working area must be free of interruption
- ✓ Complete the appropriate label to include: Patient's name, location and medical record number, room number, name of drug, amount of drug, name of basic parenteral solution and solution volume, expiry date and time.
- ✓ Select the appropriate diluents as per the IV admixture order
- ✓ Remove the protective cap from the diluent's container.
- ✓ Swab the diaphragm or stopper of the vial with alcohol swab and allow drying.
- ✓ Draw up the recommended amount of diluents and inject the diluents into the drug vial
- ✓ Mix the drug and diluents as directed and check for incompatibilities
- ✓ Swab the stopper and port of entry on the IV bag with alcohol swab and allow drying
- ✓ Pull up the required amount of medication and inject into the bag
- ✓ Complete and affix the Medication Additive label to the mixture

- ✓ Double check against physician's orders before hanging
- ✓ A common problem when using a syringe to withdraw a solution from a vial is that air bubbles can form in the barrel.

Intravenous fluid must be given at a specific rate, neither too fast nor too slow. The specific rate may be measured as ml/hour, L/hour or drops/min. To control or adjust the flow rate only drops per minute are used.

To measure the rate, we must know:

(a) The number of drops
(b) Time in minutes.

The formula for working out flow rates is:

$$\frac{\text{volume (ml) X drop factor (gtts / ml)}}{\text{time (min)}} = \text{gtts / min (flow rate)}$$

The Patient Counseling Documentation Form is enclosed in **ANNEXURE V**

6. MEDICATION HISTORY INTERVIEW

Introduction

A medication history is a detailed, accurate and complete account of all prescribed and non-prescribed medications that a patient had taken or is currently taking prior to a newly initiated institutionalized or ambulatory care.

It provides valuable insights into patients' allergic tendencies, adherence to pharmacological and non-pharmacological treatments, social drug use and probable self-medication with complementary and alternative medicines.

Objectives

- To improve the Communication Skills and Interpersonal Behavior of the students.
- To make the students to learn about the importance of Medication History Interview.
- To make the students to learn the steps involved in conducting Medication History Interview.

Procedure

Medication histories are important in preventing prescription errors and consequent risks to patients. Apart from preventing prescription errors, accurate medication histories are also useful in detecting drug-related pathology or changes in clinical signs that may be the result of drug therapy.

A good medication history should encompass all currently and recently prescribed drugs, previous adverse drug reactions including hypersensitivity reactions, any over-the counter medications, including herbal or alternative medicines, and adherence to therapy for the better health care plan.

Through the Medication History interview the followings major information's were captured,

• A full medication history

• Identify patient's need

• Explore the patient's perspective of illness and its treatment (needs and concerns)

Information sources

• Patient

• Family or Caregiver

• Medication Vials

• Medication List

• Community Pharmacy

• Medication Profile from other facility

Procedure

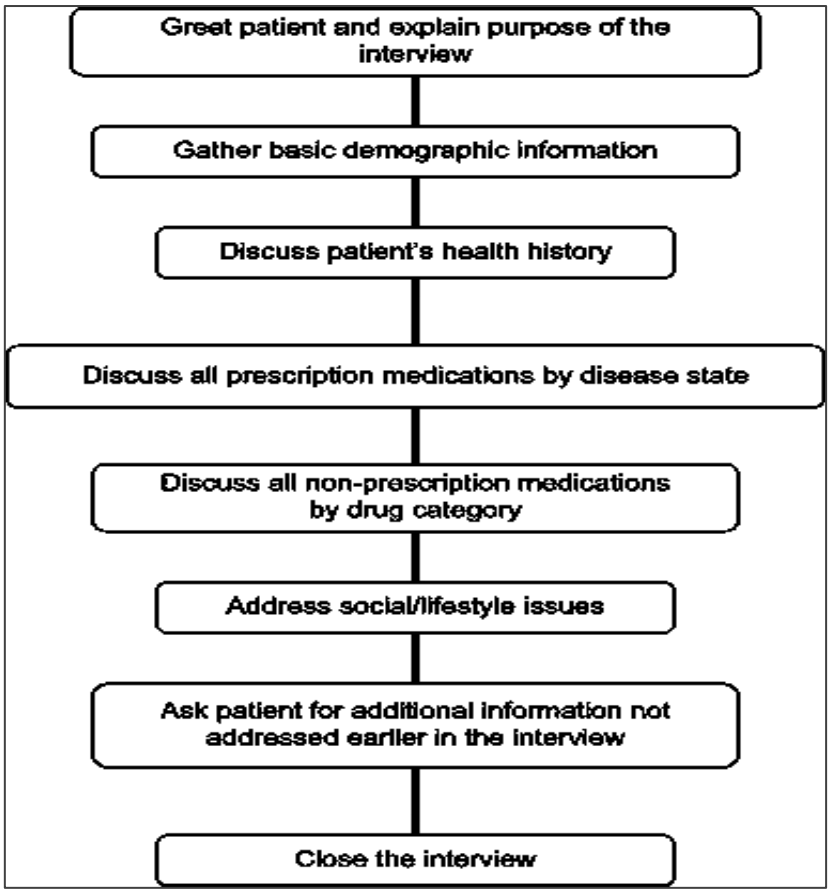


Fig-1 Details of steps involved in Medication History Interview

Medication History Interview Documentation Form is enclosed in **ANNEXURE VI**

7. MEDICATION RECONCILIATION

Introduction

Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking including drug name, dosage, frequency, and route and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.

Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient.

Objectives

- To educate the students to get the best possible medication history during admission, hospital stay and discharge.
- To educate the students to identify discrepancies in medical transit care.
- To educate the students in finding resolutions for the discrepancies

Procedure

STEP 1: Obtain a best possible medication history

Compile a comprehensive list of medicines the patient is currently taking from interview with patient, referral letters and other sources. Include: Prescription, OTC and complementary medicines. Also include name, dose, route and frequency of medication, duration of therapy and its indication.

STEP 2: Confirm the accuracy of the history

Verify the medication history by reviewing patient's medication list, inspecting patient's medicine containers, contacting other prescribers of the patient, communicating with family and reviewing past health records.

STEP 3: Reconcile history with prescribed medicines

Compare the history with the medicines ordered with respect to patient's present medical condition into consideration. Resolve discrepancies if any and document the changes.

STEP 4: Supply accurate medicine information

Provide a list of current medications and reasons for any changes during the transfer of care to receiving physician, patient or career.

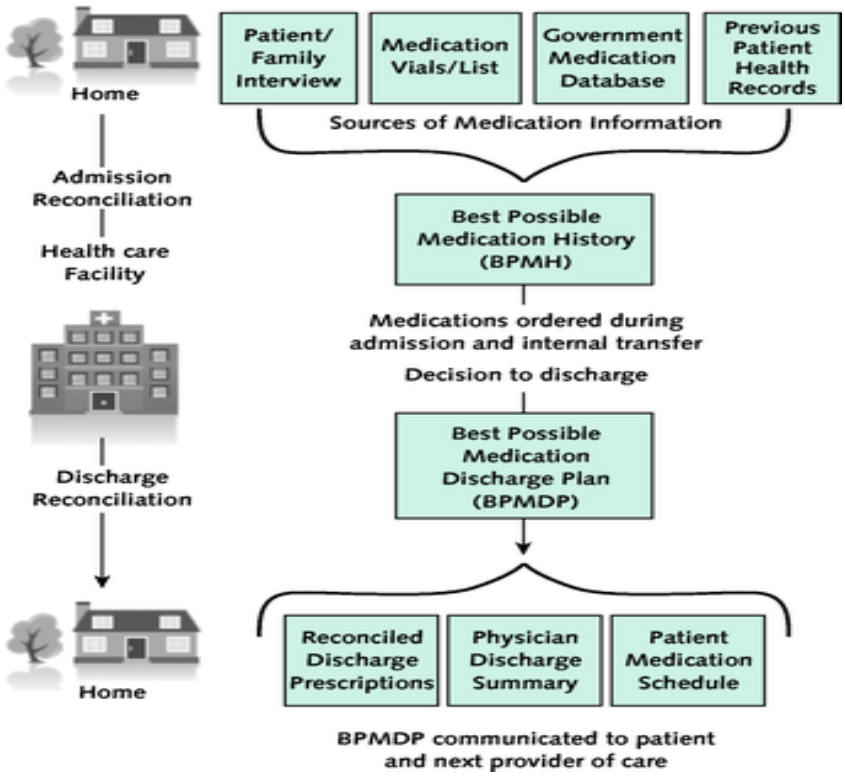


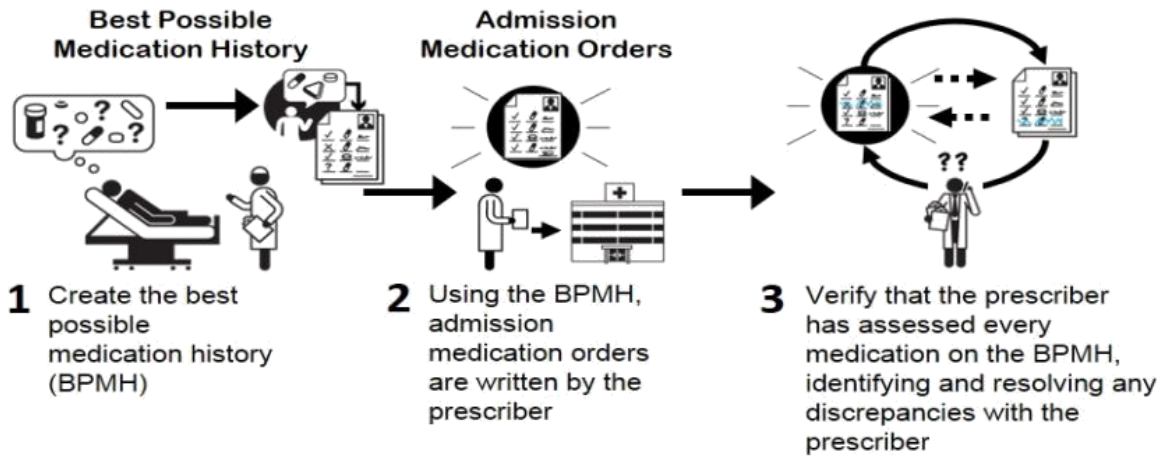
Fig -2 Details the Process of Reconciliation of Medications in Various Phase

A best possible medication history (BPMH) is a systematic process of interviewing the patient/family. A review of at least one other reliable source of information to obtain and verify all of a patient's medication use (prescribed and non-prescribed).

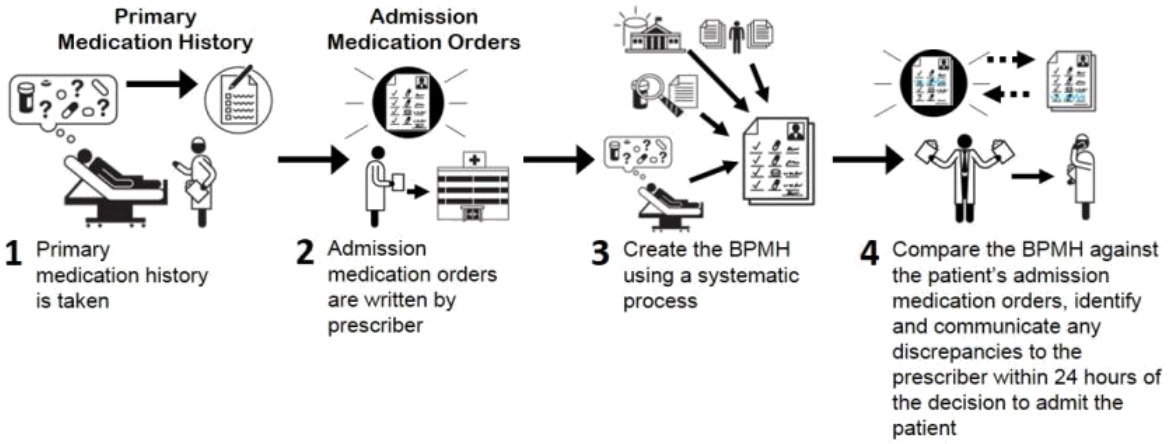
The **best possible medication discharge plan** is a comprehensive plan that account for new medications started in the hospital, new medications started on discharge, preadmission and hospital medications held during the hospital stay, and automatic hospital formulary substitutions, as well as discontinued, adjusted, and unchanged preadmission drugs. Admission medication reconciliation processes generally fit into two models: the proactive process or the retroactive process, or a combination of the two. The proactive model occurs when the BPMH is created prior to writing admission medication orders. In the retroactive model, admission orders are written before the BPMH is created.

In both models, reconciliation takes place between the BPMH and the admission orders, discrepancies are identified and resolved.

Proactive Model – Reconciliation Method



Retroactive Model – Reconciliation Method



The Medication Reconciliation form is enclosed in **ANNEXURE VII**

8. MEDICATION DISPENSING

Introduction

Dispensing refers to the process of preparing and supplying medicines to a named person together with clear instructions, advice and counseling where necessary on the use of those medicines.

It involves the correct interpretation of the order for prescribed medicines and accurate preparation and labeling of medicines for use by the patient.

The dispensing process includes all activities that occur between the times the prescription or request for medicine is presented up to the time the medicines or other prescribed items are issued to the patient.

Good Dispensing Practice ensures that the right medicines of desired quality are delivered correctly to the right patient with the right dose, strength, frequency, dosage form and quantity, together with clear instructions, both written and verbal and with appropriate packaging suitable for maintaining the quality and efficacy of the medicine.

Objectives

- To train the students in handling of prescriptions and medicine dispensing process
- To understand the ethical matters which is important while dispensing
- To understand the storage condition for the medicines

Ethical Considerations

Clinical pharmacists are ‘front line’ health care professionals and are involved in dispensing life-saving medication and giving health advice about medicines and the treatment of minor ailments to members of the public.

Clinical pharmacists also need education and official training on ethics and where to find ethics information and how to evaluate it to make an appropriate decision before making a recommendation and providing information for their patients.

The pharmacist has to legally follow all the obligations while dispensing drugs such as, drugs without prescription, Schedule X drugs etc. The legal guidance for pharmacists are available in the following links: https://ipapharma.org/portfolio/regulations-and-guidelines/

Drug Classifications and Registration

The federal government has divided drugs into three categories: legend (prescription) drugs, controlled substances, and over-the-counter (OTC) drugs.

All controlled substances are placed in one of five classes, based on the characteristics of that particular drug. The most strictly controlled drugs are placed in Schedule I, while those drugs that are the least controlled are placed in Schedule V.

Schedule I:

1) The substance has high potential for abuse.

2) The substance has no accepted medical use. Examples: heroin, lysergic acid diethylamide (LSD), and marijuana.

Schedule II:

1. The substance has a high potential for abuse.
2. The substance currently has accepted medical use in treatment in the United States or accepted medical use with severe restrictions.
3. The abuse of the substance may lead to severe psychic or physical dependence. Examples: diphenoxylate, morphine, and methadone.

Schedule III:

1. The substance has a potential for abuse less than the substances listed in Schedules I and II.
2. Abuse of the substance may lead to moderate or low physical dependence or high psychological dependence. Examples: anabolic steroids, methylphenidate, and phencyclidine

Schedule IV:

1. The substance has a low potential for abuse relative to substances in Schedule H.
2. The substance currently has accepted in medical use for treatment.
3. Abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples: barbital, chloral hydrate, and Phenobarbital.

Schedule V:

1. The substance has a low potential for abuse relative to the controlled substances listed in Schedule IV.
2. The substance currently has accepted in medical use for treatment.
3. The substance may lead to limited physical or psychological dependence relative to the controlled substances listed in Schedule IV. Examples: codeine and ethyl morphine.

Record Documentation

The Food and Drug Administration (FDA) has developed a system of labeling any substance found in Schedules I to V.

The following label information is the minimum required:

a) The name of the patient to whom the controlled substance was dispensed

b) The date that the controlled substance was dispensed

c) The name and quantity of the controlled substance

d) Instructions for taking or administering the controlled substance

e) The name of the physician dispensing the controlled substance

f) A statement explaining what the drug is intended to be used for state law may require additional information such as:

- The name and address of the pharmacy
- The serial number of the prescription
- The address of the patient
- The initials or name of the dispensing pharmacist
- The drug name, strength, and manufacturer's lot or control number
- The expiration date of the drug, if any
- The name of the manufacturer or distributor furthermore, over-the-counter (OTC) drugs must have certain information on the container label before the substance can be legally dispensed without a prescription.

Furthermore, over-the-counter (OTC) drugs must have certain information on the container label before the substance can be legally dispensed without a prescription. The label must include:

- ✓ Name of the product
- ✓ Name and address of the manufacturer
- ✓ Net contents of the package
- ✓ Name of all active ingredients
- ✓ Name of any habit-forming drug contained in the preparation
- ✓ Cautions and warnings
- ✓ Adequate directions for safe and effective use

The label must be legible and attached to the container in which the drug is administered. Furthermore, the information must be written with "adequate directions for use" which means that the average person can safely use the medication for the purpose intended.

Another aspect in the control of medications is keeping accurate dispensing records. The minimum standards include:

- Date that the controlled substance was dispensed
- Name and quantity of the controlled substance dispensed
- Method of administration of the controlled substance
- Name of the patient to whom the controlled substance was dispensed
- The diagnosis and the reason for the prescription for Schedule II

Storage Recommendation

Proper storage practices for all pharmaceuticals are an important role to play by clinical pharmacists. The stability testing of pharmaceutical products containing well-established drug substances in conventional dosage forms has to be essentially practiced by Clinical pharmacists.

The personnel must be well aware of the API, excipients, expiry date, labeling, packing materials and their storage conditions.

Pharmacist must be properly trained in storing drugs, and deal with storage areas which must be clean and designed in such a manner it permits excellent storage conditions.

The guidelines by WHO for proper storage of pharmaceutical products,

- http://www.who.int/medicines/areas/quality_safety/quality_assurance/GuideGoodStoragePracticesTRS908Annex9.pdf

The guidelines by WHO for Good Dispensing Practice

- http://apps.who.int/medicinedocs/documents/s23091en/s23091en.pdf

Use **Annexure – VIII** to document this activity.

9. DOSE DIVISION

Introduction

This SOP enables the students to adopt uniform approach during dose division, Dose Division is a service provided by the Department of Clinical Pharmacy at JSS Hospital and Government Hospital, Ooty to pediatric patients and is usually performed by the postgraduate students of Pharmacy Practice and PharmD students.

Objectives

- To make the students to learn the importance of dose division.
- To make the students to learn the procedure involved in dose division method.

Procedure

After prescription is received, note the dose that is required and number of doses to be dispensed. Ensure that the labeled strength of commercial preparation brought for dose division is sufficient to carry out the procedure. Else, inform the requester to bring the appropriate preparation.

Clean the weighing balance and area. Cut out the required number of butter paper squares.

Weigh the required quantity of tablets. Clean the mortar and pestle with some sterile water for injection. Sterilize your hands using sanitizer. Wear the mask and gloves. Powder the tablets and remove any film coating that cannot be triturated into powder form.

Calculate the amount to be dispensed for tablets as follows: Required dose of drug = x

Weight of n number of tablets = a (in gms) Weight of powdered tablets = b (gms)

Labelled amount of drug on formulation X n (number of tablets) = c Amount of drug present in powdered tablet = b X c/a = d (gms) Amount of powder to be weighed = x X b/d = ygms

Place the butter paper square on the weighing machine and tare it. Weigh out the calculated quantity of powder. Remove butter paper and pack it in a manner such that the contents will not spill out. Weigh out the required number of doses in a similar manner.

Place all the doses in an envelope and label as follows: Name of the patient:

Name of the drug:

Number of doses dispensed:

Each sachet contains …… gms of drug. No of Doses to be taken per day:

Date Dispensed:

GENERAL INSTRUCTIONS

- Receive the prescription at OPD and note the details of the dose division request. Note the date on the prescription and send back prescriptions that are more than a month old to the prescriber for a fresh prescription.
- Check whether the drug is mentioned in the list of drugs that are NOT to be crushed or split. Suggest alternate dosage form if drug name is mentioned in the list.
- Check whether the drug is in a sustained release/extended release/slow release or enteric-coated form. If so, send back the prescription to the prescriber for prescribing a conventional dosage form.
- Check whether the drug for division is available in alternate dosage form meant for pediatric use. If so, suggest the same to the prescriber.
- Inform the requester a probable time estimate that the divided doses may be dispensed.
- Calculate the required dose to be dispensed and get approval from the OPD staff in-charge for the same.
- Perform the dose division as per the procedure.
- Ensure that the envelope containing the divided doses is properly labeled before dispensing.
- Document the activity in the Dose Division Request Form as well as on the online database of Clinical Pharmacy activities

Use **Annexure – IX** to document this activity.

10. ADR MONOTORING

Introduction

The World Health Organization (WHO) defines an ADE as “any untoward medical occurrence that may present during treatment with a pharmaceutical product but which does not necessarily have a causal relationship with this treatment” (WHO 2005). The WHO defines an ADR as “a response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function.”

Objectives

- To make the students to learn ADR detection and classification.
- To make the students to learn causality and severity assessment methods.
- To make the students to learn management the reported ADR.

Procedure

The NCC has designed a ‘Suspected Adverse Drug Reaction Reporting Form’ to record adverse reactions related to drugs (page no 14). Separate forms are available to record adverse reactions associated with transfusion of blood and blood related products and Adverse Event Following Immunization (AEFI). A report that contains information describing a suspected ADRs related to the administration of one or more medicinal products to an individual patient is termed as ICSR. Following are the points to be filled in an ADR form.

A. Patient Information

1. Patient initials: Write only the initials of a patient instead of full name. For e.g.: Srinivas Sadagoban should be written as SS.

2. Age at time of event or date of birth: Write either the date of birth or age of the patient at the time of event or reaction occurred.

3. Sex: Mention the gender of the patient.

4. Weight: Mention the weight of the patient.

B. Suspected Adverse Reaction

5. Date of reaction started: Mention the date on which the reaction was first observed.

6. Date of recovery: If the reaction recovered, the date on which the patient recovered from the reaction should be report.

7. Describe reaction: Provide the description of the reaction in terms of nature, localization etc. For example, patient developed erythematous maculopapular rash over upper and lower limb.

C. Suspected Medications

8. The details of suspected medication(s) such as drug name (brand or generic name), manufacturer, batch no/lot no, expiry date, dose used, route used, frequency, dates of therapy started and stopped, and indication should be provided by the reporter.

9. *Dechallenge details: Mention the status on dechallenge as:*

- 'Yes'- if reaction abate after dechallenge

- 'No'- if reaction did not abate after dechallenge

- 'Unknown'- if effect of dechallenge is not known

- 'Not Applicable' or 'NA'- if dechallenge is not applicable as in case of vaccines, anaesthesia, where single dose is given, death, or treatment is completed prior to reaction or event

- 'Reduced dose'- If dose at which the reaction occurred is reduced

Note: Also mention the reduced dose and date.

10. Rechallenge details: Mention the status on rechallenge as:

- 'Yes'- if reaction reappeared after rechallenge

- 'No'- if reaction does not reappear after rechallenge

- 'Unknown'- if effect of rechallenge is not confirmed

- 'Not Applicable' or 'NA'- if rechallenge is not applicable as in case of anaphylaxis reaction

- 'Re-introduced dose'- Mention the dose and date of rechallenge

11. Concomitant drugs:

Write the details of all concomitant drugs including self- medication, OTC medication, herbal remedies with therapy dates.

12. Relevant tests/ laboratory data: Mention all laboratory data (if available) relevant to the reaction occurred.

13. Other relevant history: Write the relevant history persistent to patient including pre-existing medical conditions (e.g. allergies, pregnancy, smoking, alcohol use, hepatic/ renal dysfunction) and concurrent condition can be describing in this section.

14. Seriousness of the reaction: If any reaction is serious in nature, tick the appropriate reason for seriousness as:

- 'Death' - if the patient died due to adverse event

(Note: Mention the death cause & date in the seriousness of the reaction.)

- 'Life-threatening'- if patient was at substantial risk of dying at the time of the adverse event
- 'Hospitalization/prolonged'- if the adverse event caused hospitalization or

increased the hospital stay of the patient

- 'Disability'- if adverse event resulted in a substantial disruption of a person's

ability to conduct normal life functions

- 'Congenital anomaly'- if exposure of drug prior to conception or during pregnancy may have resulted in an adverse outcome in the child.

- 'Required intervention to prevent permanent impairment/damage'- if medical or surgical intervention was necessary to preclude permanent impairment of a body function, or prevent permanent damage to a body structure

- 'Other' -when the event does not fit above conditions, but the event may put the patient at risk and may require medical or surgical intervention to prevent one of the above conditions. Examples include serious blood dyscrasias (blood disorders) or seizures/convulsions that do not result in hospitalization, development of drug dependence or drug abuse

15. Outcomes: Tick the outcome of the event as:

- 'Fatal'- if the patient dies

- 'Continuing'- if the patient is continuing to experience the reaction

- 'Recovering'- if the patient is recovering from the reaction

- 'Recovered'- if the patient has completely recovered from the reaction (mention the date of recovery)

- 'Unknown'- if the outcome is not known

D. Reporter

16. Name and Professional address:

A reporter must mention his/her name and professional address on the form. The identity of the reporter will be maintained confidential

17.Causality assessment:

The reporter (if trained) must perform the causality assessment and justify the assessment

18. Date of report:

Mention the date on which he/she reported the adverse event. Collect all the information required to be filled in the suspected ADR reporting form. In case complete information is not available fill all the Essentially Required Items (ERI) for a quality ICSR. In case ERI are not available make sure that the form contains all the mandatory fields.

Note: For a valid case report mandatory fields are the minimum requirement.

Use **Annexure – X** to document this activity.

11. DRUG INFORMATION SERVICE

Introduction:

Drug information service is a dedicated and specialized service provided by pharmacists to enhance knowledge of medicines use, promote rational prescribing among prescribers, and reduce medication errors. This service is provided in response to the queries sought by allied health professionals in addressing medication-related problems pertaining to pharmacotherapy and medicine management issues of patients. One of the most important aspects of drug information is to be unbiased in its contents.

Objective:

- To learn the steps involved in drug information service.
- To learn about the various drug information resources and its applications.
- To improve the writing and communication skills.

Procedure:

1. Secure requestor demographics.

It's important to know your audience, as your response technique may differ depending on whether the question comes from a health care professional or a patient. For example, you'd use the word "renal" with a pharmacist and "kidney" with a patient. It's always best to inquire how the requestor would like the information delivered (e.g., phone or fax), as this will help ensure adequate followup.

2. Obtain background information.

This is historically the most difficult step because you must act as a detective. Determine whether it's a general or patient-specific question, and then identify resources the requestor has already consulted to help facilitate the process. For patient-specific questions, it's important to inquire about pregnancy, weight, and renal function.

3. Determine and categorize the question.

If a pharmacist requests information about whether a patient who's breastfeeding can take amoxicillin, this would be classified as a lactation question. Various categories may include pregnancy, drug interaction, pharmacy law, or pill identification.

4. Develop a strategy and conduct a search.

First, begin with tertiary literature, which is a compilation of primary literature. This may include text books like Drugs in Pregnancy and Lactation or drug information databases like Clinical Pharmacology or Lexicomp. Next, consult your secondary literature resources, which is the path to primary literature. Secondary resources include PubMed and EMBASE, which will enable you to locate primary literature or original research. It's important to use reputable resources when researching. When using websites, be sure to consult ones ending in .gov or .org.

5. Perform evaluation, analysis, and synthesis.

Objectively critique all of the information you retrieve from your comprehensive literature search. Also, consider the background information of your question. Consult with pharmacists and other health care professionals with expertise in your specific drug information question.

6. Formulate and provide a response.

Inform the requestor when one course of action is more desirable. Present competing viewpoints and considerations. Also, describe your evaluation of the research. Written responses should always be concise and fully referenced.

7. Conduct follow-up and documentation.

Following up is important for ensuring the information was received. Always document your drug information questions so you can refer back to them. You'll likely see the same question in the future, and this well help serve as a reference point.

Use **Annexure – XI** to document this activity.

DEFINITIONS

- **Adverse drug reaction:** A noxious and unintended effect of medicine that occurs in doses normally used in humans or animals for the diagnosis, prophylaxis or treatment of disease.
- **Dispenser:** Any person who is licensed or authorized by the appropriate body to dispense medicines and/or medical supplies.
- **Dispensing:** The act of preparing medicines and/or medical supplies and distributing to users with adequate information, counseling and appropriate follow up.
- **Label:** Any material which is printed or affixed to a packing material which provides the necessary information about medicine, and includes an insert.

- **Medical Instrument:** Any instrument or supply that may be used on the inner or outer part of the body for diagnosis or treatment of a disease in human, and includes various diagnostic, laboratory, surgery, dental, medical instruments, suturing materials, syringes and needles.
- **Medicine:** Any substance or mixture of substances used in the diagnosis, treatment, mitigation or prevention of a disease in human and includes narcotic drugs, psychotropic substances and precursor chemicals, traditional medicines, complementary or alternative medicine, poisons, blood and blood products, vaccine, radioactive pharmaceuticals, cosmetics and sanitary items and medical instruments.
- **Over-the-counter medicines:** Medicines that can be dispensed without prescription.
- **Packing material:** means any article that may be used for filling, inserting or wrapping or packing medicine and includes immediate container and other materials for wrapping the product.
- **Prescriber:** Any medical practitioner who is licensed or authorized by the appropriate body to write a prescription.
- **Prescription medicines:** medicines dispensed only with prescription.
- **Prescription:** Any order for medicine written and signed by a duly licensed or authorized practitioner issued to a patient in order to collect medicine from dispensing outlet.
- **License:** The grant of authority by the State Board of Pharmacy to a person authorizing him or her to engage in the practice of pharmacy in that state.
- **Medical Practitioner:** Any physician, dentist, veterinarian, or other person authorized by law to treat, use, or prescribe medicine and drugs for sick and injured humans or animals in a particular state.

ABBREVIATIONS

FBS - Fasting Blood Sugar

RBS - Random Blood Sugar

PPE- Personal Protective Equipment

PPBS - Post Prandial Blood Sugar

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

DTP's – Drug Therapy Problems

ADE – Adverse Drug Event

PCP – Pharmaceutical Care Plan

HbA_1C – Glycated Hemoglobin

IV- Intravenous

IM – Intramuscular

IT – Intrathecal

SC – Subcutaneous

BPMH – Best Possible Medication History

BPMDP – Best Possible Medication Discharge Pl

ANNEXURE - 1

BLOOD PRESSURE DOUMENTATION FORM

(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

PATIENT NAME:	AGE:	WEIGHT:	GENDER:
K/C/O HYPERTENSION: ☐ YES ☐ NO	CURRENT MEDICATIONS		
K/C/O HYPOTENSION: ☐ YES ☐ NO			
ANY OTHER COMORBIDITIES			
ANY ALLERGIES (FOOD/DRUG)			

DATE (DD/MM/YYY)	TIME	BLOOD PRESSURE (mmHg)		REMARKS
		SYSTOLIC	DIASTOLIC	

STUDENT NAME:	R NO:	COURSE:	YEAR:

PROCEDURE FOLLOWED	MARKS (Max 2 Marks for Each Task)
Patient preparation was done appropriately	
Patient/equipment positioned correctly	
Selection of correct cuff size & checked the equipment	
Estimated systolic pressure correctly	
Documented and reported with relevant remarks	

PRECEPTOR DEBRIEFING COMMENTS:

PRECEPTOR SIGNATURE: **SCORE: …../10**

ANNEXURE - 2

BLOOD GLUCOSE DOUMENTATION FORM

(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

PATIENT NAME:	**AGE:**	**WEIGHT:**	**GENDER:**
K/C/O HYPERGLYCEMIA: ☐ YES ☐ NO	**CURRENT MEDICATIONS**		
K/C/O HYPOGLYCEMIA: ☐ YES ☐ NO			
ANY OTHER COMORBIDITIES			
ALLERGIES (DRUG/FOOD)			

DATE (DD/MM/YYY)	**TIME**	**RBS (mg/dL)**	**PPBS (mg/dL)**	**FBS (mg/dL)**	**REMARKS**

STUDENT NAME: **R.NO:** **COURSE:** **YEAR:**

PROCEDURE FOLLOWED	**MARKS (Max 2 Marks for Each Task)**
Collected all necessary equipment for the procedure	
Introduced him or herself and explained the procedure to the patient	
Hand sanitization was done for patient and also for him/her	
Calibrated the glucose monitor and used the lancet appropriately	
Safety disposal procedures was done appropriately	

PRECEPTOR DEBRIEFING COMMENTS:

PRECEPTOR NAME & SIGNATURE **SCORE: …../10**

ANNEXURE - 3
PATIENT COUNSELLING DOCUMENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Date & Time		**Age**	
Name of the Patient		**Sex**	
IP/OP Number		**Preferred Language (Patient)**	
Ward		**Reference Number**	
Allergies		**Patients Counselled No's**	
Diagnosis		**Average Score (Up to Date)**	
Current Medications (Mention Drug Name, Dose, Frequency and etc.)			
Priority Settings (List out major (Max=3) counselling information's based on the level of importance towards patient health care)			
Points to be Covered and Reasons / Counseling Summary			
Patient's Query	☐ Yes	☐ No	
***If Yes,* (Detail the patients query and your answers)**			
Time taken for counselling	☐ < 10 min ☐ > 10 min ☐ < 5 min ☐ > 5 min		

Counselling provided to	☐ Patient	☐ Patient's Representative
If patient's representative, given reason	☐ Patient unconscious ☐ Language problem ☐ Pediatric patient	☐ Hearing problem ☐ Others
Counselling aids used	☐ Pictograms ☐ Dummy inhalers ☐ Spacer	☐ None ☐ Others (Specify) ……..
Counselling material provided	☐ Information Leaflets ☐ Pamphlets ☐ Videos	☐ None ☐ Others (Specify) ……..
Counselling steps followed (Preceptor Evaluation)	☐ **1.** Case sheet reviewed ☐ **2.** Initial drug related information obtained ☐ **3**. Self-introduction done ☐ **4.** Purpose of counselling told ☐ **5.** Patient was warned about taking OTC, herbal, etc.	☐ **6.** Actual counselling done ☐ **7**. Patient understanding towards other medication ☐ **8**. Counselling points summarized
Points covered during counselling session	☐ Name and purpose of ☐ Disease information ☐ Dosage regimen ☐ Advice on missed dose ☐ Potential side effects ☐ Significant interactions	☐ Precautions to be taken ☐ Storage recommendations ☐ Benefits of completing the medication course ☐ Refill information ☐ Life style modification
Barriers Involved	☐ None ☐ System Based ☐ Provider Based ☐ Patient Involved ☐ Other	
If Other barrier (Explain)		

Preceptor Evaluation					
Student Name:	**Year:**		**Course:**		
Appropriateness of medical history	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Counseling Steps Followed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Communication Skills	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Counseling Aids/Materials Used	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Patient Understanding (Teach Back)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Preceptor Suggestions/ Remarks **Total Score =** …**/5**					
Preceptor Sign:			**Date of Audit:**		

ANNEXURE - 4
TREATMENT CHART REVIEW FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

PATIENT NAME:	IP NO:	AGE:	GENDER:	WARD:
DIAGNOSIS	ADMISSION DATE:		DISCHARGE DATE:	
REASON FOR ADMISSION		PAST MEDICAL/MEDICATION HISTORY		

DATE	DRUG (DOSE, FREQUENCY, DOSAGE FORM)	DRUG GIVEN (Y/N)	TIME OF ADMIN.	POSSIBLE SIDE EFFECTS	EXPECTED HEALTH OUTCOMES	REMARKS

STUDENT NAME	ROLL NO	COURSE	CLASS
PRECEPTOR DEBREIFING COMMENTS			
PRECEPTOR NAME & SIGNATURE			SCORE……/10

ANNEXURE - 5
IV ADMIXTURE DOUMENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Patient Name:	Sex:	IP No:	Ward:
Doctor In charge:		Order Received Date:	
IV Admixture Order Details:			
Student Name:	**Roll No:**	**Course:**	**Year:**

Related Tasks	**Preceptor debriefing comments**	**(Maximum 2 Marks for Each Section)**
Students properly receives and understands physician IV admixture order		
Proper garbing and gowning procedure was followed by the student		
Checked for Incompatibilities		
Selection of diluents was appropriate		
Appropriate Labeling was done by the student		
Preceptor Name & Sign	**Date:**	**Total = /10**

ANNEXURE - 6
MEDICATION HISTORY INTERVIEW DOCUMENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

<table>
<tr><td colspan="2">Patient Name:</td><td>Gender:</td><td>Age:</td></tr>
<tr><td colspan="2">Admission Date:</td><td>Interview Date:</td><td>Ward:</td></tr>
<tr><td rowspan="2">Prescribed Medications

(Mention Dose, Frequency and ROA)</td><td>Current</td><td colspan="2">Past</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td rowspan="2">Non Prescribed Medications

(Mention Dose, Frequency and ROA)</td><td>Current</td><td colspan="2">Past</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td colspan="4">Social Drugs (Tick the appropriate one and mention how much/how many per week)
◯ Alcohol ◯ Smoke ◯ Illicit Drugs

(Detail ……..)</td></tr>
<tr><td rowspan="2">Response to Drug Therapy
e.g. Which medication benefited you?</td><td>Current</td><td colspan="2">Past</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td colspan="4">Side Effects – (Which drugs causes SE? What are those?)

Compliance – (Remember to Take Medication?)</td></tr>
</table>

Reason for Non Compliance - (If any)

OTC Medications – (Mention the OTC medicine name and the problem statement by the patient)

Student Name:	**R No:**	**Course:**	**Year:**
Checklist	**Remarks**		**Score Obtained (Max 2 Marks for Each Section)**
Communication Skills			
Procedure Followed			
Professionalism			
Time Management (Max:5 minutes)			
Documentation Skills			
In Words -			**Total Score: /10**
Preceptor Name :	**Signature:**		**Date:**

ANNEXURE - 7

MEDICAL RECONCILIATION DOUMENTATION FORM

(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Patient Name:	**IP No:**	**Sex:**	**Ward:**
DOA:	**Recent Diagnosis:**		**DOD:**
Best Possible Medical History (BPMH)			
Past Medications (Ongoing)			

Newer Medication	**Dose**	**Route**	**Frequency**	**Indication**	**Start date**	**End date**

Explain discrepancies if any,	
Transition care provided during,	□ **Admission** □ **Transfer** □ **Discharge**
Resolution for the identified discrepancies,	
Student Name: **R No:** **Course:** **Year:**	
Preceptor Debriefing Comments:	
Score …. / 10	**Preceptor Sign:**

ANNEXURE - 8
MEDICATION DISPENSING DOUMENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Patient Name:	**Age:**	**Weight:**	**Gender:**	**Ph:**
Doctors Name:	**Reg No:**	**Address:**		**Ph:**
Diagnosis:	**Date of Prescriptions Rx**			
	Current Rx:		**Previous Rx:**	

Generic Name of Medication	**Dose**	**Freq**	**Price (Rs)**	**Reported Side Effects (If any)**	**Suggestions Provided (If needed)**

Student Name:	**R No:**	**Course:**	**Year:**
Preceptor Checklist	**Yes= 2 Marks No= 0**	**Comments (Debriefing)**	
1. Screening and validation of Rx			
2. Understand and Interpret the Rx			
3. Preparation and Labeling was done appropriately (If needed)			
4. Counter checking & documentation was appropriately done.			
5. Issue medications to patient with clear instruction			
	Total=		
Preceptor Name	**Signature:**	**Date:**	

ANNEXURE - 9
DOSE DIVISION DOCUMENENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Patient Name:	**ID.No**	**Age:**	**Weight:**	**Gender:**	**Ph:**
Doctors Name:	**Reg No:**		**Ward:**	**Diagnosis:**	**Ph:**
Approved by OPD staff in-charge			**☐ Yes ☐ No**		
Drug Name	**Dose**		**No of Doses**	**Sachet Quantity (gms)**	**No of Doses/Day**
Dose Calculation: (Write in detail)					
Order Received Date & Time				**Dispensed Date & Time:**	

Dose Division Activity Evaluation	
Student Name: **R No:** **Course:** **Year:**	
Procedure Followed	**Preceptor Debriefing Comments (Max 2 marks for each step)**
Received the prescription at OPD and noted the details appropriately	
Checked whether the drug is suitable for dose division, e.g. Breakable and Suitable formulation	
Performed the dose division procedures appropriately	
Labelling was done appropriately	
Dose calculation was done appropriately	
Preceptor Name & Signature	**Score…./10**

ANNEXURE - 10
ADR EVALUATION/ DOCUMENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Student Name:	**R No:**	**Course:**	**Year:**
Tasks	**Preceptor Debriefing Comments**		**Marks (Max=2)**
Patient Information's were captured appropriately			
Suspected adverse reaction was described appropriately			
Identified the suspected drug with proper dechallenge and rechallenge techniques			
Severity and causality was assessed by the student			
Documented and communicated appropriately			
Preceptor Name & Signature		**Total Score …./10**	

Note: ADR Reporting Form is available in Simulation Manual - 2019

Link for ADR Reporting Form - http://www.ijp-online.com/documents/AdverseReaction.pdf

ANNEXURE - 11

DRUG INFORMATION EVALUATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Student Name:	**Enq No:**	**Roll No:**	**Course:**	**Year:**

Quality Assessment Checklist for Drug Information Service		
Tasks	**Comments (Debriefing)**	**Marks Max=2**
Background information's (Patient /Enquirer) was collected Appropriately		
Appropriate resources are referred		
Appropriate answer was given and delivered		
Information provided within specified time and feedback was obtained.		
Was drug information provided documented completely?		
	Total Score =	
Preceptor Name & Signature:	**Date:**	

ANNEXURE – 11.A
DRUG INFORMATION DOCUMENTATION FORM
(Simulated Settings)

College of Pharmacy

Department of Pharmacy Practice, Mysuru

Enquiry No:		Date:	
Name of the Requester:			
Requester identity:	☐ Patient ☐ Pharmacist ☐ Physician ☐ Nurse ☐ Others (specify)_____		
Response needed in	☐ Within 2 hours ☐ 2-6 hours ☐ End of day ☐ When time permits		
Phone Number			
E-mail ID			
Details of Enquiry:			

Question category: (Tick whichever applies)

[ ] Admin & Dosage	[ ] Availability & Supply	[ ] Therapeutics
[ ] Pregnancy	[ ] Lactation	[ ] Side Effects/ADR
[ ] Interactions	[ ] Compatibility / Stability	[ ] Pharmacokinetics
[ ] Pharmacology	[ ] Identification	[ ] Poisoning
[ ] Others (specify)		

Mode of Request: ☐ Direct access ☐ E-mail ☐ During Ward Rounds ☐ Telephone

Time taken to address the query:
☐ Immediate ☐ Same day ☐ Next day ☐ Within a Week ☐ No time limit

References: (Tick whichever applies)

[ ] AHFS	[ ] G & G	[ ] Martindale	[ ] Facts & Comparisons
[ ] USP DI	[ ] Harrisons	[ ] Merck Manual	[ ] Pharmacotherapy
[ ] Reference Books	[ ] IDIS	[ ] Poisindex	[ ] Micromedex
[ ] Medline	[ ] IPA	[ ] Others	[ ] Web

(specify) _____

Purpose of enquiry: ☐ Update Knowledge ☐ Better Patient Care ☐ Other

Patient Background Information: Name (optional)		IP No:
Age: Sex :	Weight : Height :	Ward:
Current Medical Problem / Diagnosis		
Allergies	Relevant Lab values	
Past Medical History		

Past Medication History	
Current Drug Therapy	
If Pregnant ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester If Brest feeding, Age of the infant:	
Other details:	
Response given on Date: Time:	
Responded by	
Answer communicated by: ☐ Visit ☐ Phone ☐ Post ☐ Fax ☐ E-mail	
Response: *(Attach additional sheets if necessary)*	

JSS College of Pharmacy
Sri Shivarathreeshwara Nagar
Mysuru - 570 015
Karnataka, INDIA

Phone: +91-821-2548 353
Fax: +91-821-2548 359
Email: jsscpmy@jssuni.edu.in

JSS College of Pharmacy
Rocklands
Ooty – 643 001
Tamil Nadu, INDIA

Phone: +91-423-2443393 / 2443647
Fax: +91-423-2442937
Email: jsscpooty@jssuni.edu.in