MASENO UNIVERSITY

DOCUMENT TITLE:	PROCEDURE FOR PROVISION OF HEALTH SERVICES TO STUDENTS , STAFF AND THEIR DEPENDANTS, AND THE COMMUNITY		
DOC. NO:	MSU/AFD/HS/OP/01	**ISSUE NO:**	3
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0.1

DOCUMENT CHANGES

#	Date	Details of Change		Authorization
	(dd-mm-yy)	Page	Clause/sub clause	Title
1	06/03/2023	1	Change of signature of MR to reflect the current Officer in charge.	DVC AFD
2	06/03/2023	3	3.3. Addition of Control of Documented Information procedure after the document number.	DVC AFD
3	06/03/2023	6,7	6.2.4.8, 6.2.5.4, 6.2.7.1,6.2.9.1, 6.2.9.3…amended identification of registers..".	DVC AFD
4	06/03/2023	8	6.3.2.2 omission of the word"..attendant".	DVC AFD
5	06/03/2023	15	6.7.1 Incorporated i.e. "monitoring of stock to prevent stock-outs".	DVC AFD
6				
7				

0.2 DOCUMENT DISTRIBUTION

Documents shall be available on the University website for authorized users

1.0 PURPOSE

The purpose of this procedure is to ensure the efficient and effective provision of health services to students, staff and their dependants, and to the community at the university health facility.

2.0 SCOPE

This document covers procedures for the handling of out-patients and in-patients at the university health facility.

3.0 REFERENCES

3.1 ISO 9001:2015 Quality Management System
3.2 Maseno University Quality Manual
3.3 MSU/VC/MR/OP/01-Control of Documented Information
3.4 Maseno University Strategic Plan
3.5 Procedure Manual for Nurses
3.6 MOH Statutory Requirements
3.7 Medical Practitioners and Dentists Act
3.8 Clinical Officers Act
3.9 Pharmacy and Poisons Act
3.10 Laboratory Technicians and Technologists Act
3.11 Infection Prevention and Control Policy
3.12 International Classification of Diseases (ICD) coding tools by the WHO.
3.13 Maseno University Terms of Services
3.14 Occupational Health Policy
3.15 Nurses Act Cap 257
3.16 WHO Guidelines

4.0 DEFINITION OF TERMS

4.1	ADM	Administration
4.2	ANC	Antenatal Clinic
4.3	ART	Antiretroviral treatment
4.4	B1	Birth Notification Book
4.5	CCC	Comprehensive Care Centre for HIV care
4.6	CHW	Community Health Worker
4.7	CWC	Child Welfare Clinic
4.8	D1	Death Notification Book
4.9	DTC	Direct Counseling and Testing
4.10	HIV	Human Immunodeficiency Virus
4.11	HRIO	Health Records and Information Officer
4.12	HS	Health Services
4.13	HTC	Home Testing and Counseling
4.14	ICD	International Classification of Diseases
4.15	ID	Identification card
4.16	IP	In-Patient
4.17	ISO	International Organizations for Standardization
4.18	KEMSA	Kenya Medical Supplies Agency
4.19	KOMBEWA	District Hospital and Centre of Kisumu West District
4.20	LAB	Laboratory
4.21	MCH	Mother and Child Health

4.22	MLT	Medical Laboratory Technologist
4.23	MOH	Ministry of Health
4.24	MR	Medical Records
4.25	MRC	Medical Records Clerk
4.26	MRT	Medical Records Technician
4.27	NUR	Nursing
4.28	OI	Opportunistic Infections
4.29	Obs	Observations
4.30	OP	Out-Patient
4.31	OPD	Out Patients Department
4.32	P/F	Personal File
4.33	PHARM	Pharmacy
4.34	PRN	Purchase Requisition Note
4.35	RC	Registry Clerk
4.36	SOP	Standard Operating Procedure
4.37	SRN	Stores Requisition Note
4.38	TB	Tuberculosis
4.39	VCT	Voluntary Counseling and Testing
4.40	Vital Signs	Blood pressure, Pulse rate, Respiration rate
4.41	WHO	World Health Organization

5.0 RESPONSIBILITIES

The Chairman, Health Services shall be responsible for the effective implementation of this procedure

6.0METHOD

6.1 PROCESS OF MAINTAINING CONFIDENTIALITY

6.1.1 All medical files shall be kept at the records section in lockable cabinets. At no time shall the records section be left unmanned with the door open. Access to this section remains restricted.

6.1.2 Files shall be retrieved upon positive identification of a patient using PF/no, admission no, student ID cards and pictures.

6.1.3 The files shall be delivered to the clinical rooms or the wards. Other staff members / dependants / students are not allowed to handle medical files.

6.1.4 The files shall be collected from the clinic rooms / wards back to the records for processing and filing in lockable cabinets.

6.1.5 There shall be a check against each file that has been returned to the cabinet in the daily register HS/MR/001 and 002 at the end of each day

6.1.6 Inactive files shall be filed in a separate section in lockable cabinets till authorization to destroy them is secured

6.1.7 All health care staff shall observe medical ethics at all times.

6.2 MEDICAL RECORDS SERVICES

6.2.1 **Process of Opening a Staff File**

6.2.1.1 A staff file shall be opened on receiving an appointment letter from the university administration.

6.2.1.2 Name, department and PF number shall be written on the cover.

6.2.1.3 A medical scheme beneficiaries list with details of family members and photographs of dependants shall be filed

6.2.1.4 A treatment card HS/MR/006 with details of name and PF/ Number shall be added in the file

6.2.1.5 Then the file shall be stored according to the filing process awaiting first visit

6.2.2 **Process of Opening/ Activating a Student File**

6.2.2.1 Students admission papers shall be received from academic division containing personal details, medical examination form and a photograph

6.2.2.2 These papers shall be stored in large files according to faculty, registration number and year of admission

6.2.2.3 When the student comes for the first time the forms shall be retrieved and the file shall be activated.

6.2.2.4 Name and student number shall be written on the cover and on a treatment card HS/MR/007.

6.2.3 **Process of Opening a File at other Sections**

6.2.3.1 All new antenatal clients shall be registered in the antenatal clinic in the permanent register MOH 405 and be provided with a client identity number written on the clients' information booklet MOH 216.

6.2.3.2 In the child welfare clinic, the nurse shall enroll all new babies from other facilities and provide new serial numbers and retain old CWC numbers. Documentation shall be done in permanent register MOH 510.

6.2.3.3 On first visit in the family planning clinic the nurse shall open a file for the client with Family Planning First Visit Card by MOH and give the patient a follow up card HS/NUR/318. This file shall be retrieved during follow up visits for documentation, and shall be carried by the client if there is transfer to other facilities.

6.2.3.4 Clients who come for HIV care shall be registered and shall receive a specific number in the Comprehensive Care Clinic (CCC) irrespective if they are staff, students or community clients.

6.2.4 **Reception, Identification of patients and Retrieval of files**

6.2.4.1 The Medical Records Clerk shall greet and receive any person who approaches the reception window seeking for some assistance.

6.2.4.2 In the case of an emergency patient, registration shall be carried out later after the nurse has directed the patient to the emergency room.

6.2.4.3 The staff shall obtain either the staff employment card or student's identification card or outpatient attendance card for retrieval of file.

6.2.4.4 The records staff shall compare the identification with the details in the file and checks the medical scheme beneficiaries list and photographs of dependants for proof that the person is covered under the University Medical scheme

6.2.4.5 On first visit the patient shall receive an outpatient attendance card (HS/MR/009)

6.2.4.6 The treatment card in the file shall be stamped with rubber stamp with the date

6.2.4.7 An observation chit (HR/NUR/310) shall be given with stamp and time indication and the patient shall be directed to the observation table

6.2.4.8 The patient details shall be documented in the outpatient register MOH 204B for students & staff and MOH 204A for under 5 years containing date, name, age, sex and PF or student's registration number.

6.2.4.9 The file shall be taken to the doctor/clinician room on first come first served basis and the patient shall be directed where to wait.

6.2.5 **Process of Collection, Sorting and Editing of files and Documentation of Diagnoses**

6.2.5.1 The MRC / MRT shall collect back all the files once the patients have been attended to by the clinician/doctor.

6.2.5.2 The records staff shall sort out the files according to their labels.

6.2.5.3 The records staff shall go through the notes in the file and arrange them chronologically

6.2.5.4 The records staff shall extract the diagnosis from the patient's file and indicate it in the outpatient register books MOH 204A&B according to the international classification of diseases (ICD).

6.2.6 **Filing**

6.2.6.1 The MRC / MRT shall file staff files in straight numerical order using the PF number

6.2.6.2 All dependants' documents shall be filed chronologically in the staff's main file

6.2.6.3 The records staff shall file the student's files in straight numerical order according to the student's admission/registration number, faculty and year of admission to the University.

6.2.6.4 The records staff shall file all files in metallic lockable lateral filing cabinets.

6.2.7 **Data Management**

6.2.7.1 The Health Records and Information Officer (HRIO) shall supervise the collection of daily out-patient attendances records MOH 204A&B and morbidity data MOH 705 A+B from source documents.

6.2.7.2 The officer shall compile the data on specifically designed data collection tools (forms) for statistics on monthly out patient attendances HS/MR/015, monthly out patient morbidity MOH 705 A+B, monthly work load MOH 717 and annual reports HS/MR/010+011.

6.2.7.3 The HRIO shall dispatch monthly work load data MOH 717 to the MOH's office on or before the 5th day of a new month and aid the students with relevant data for their research projects from time to time.

6.2.8 **Civil Registration and Dispatch**

6.2.8.1 The HRIO shall coordinate with the Doctors/Nurses on the notification of birth and death that occurs within the facility by use of B_1 or D_1 books

6.2.8.2 The HRIO shall dispatch the duly completed B_1 / D_1 forms to the office of the District Civil Registrar by use of form CRP7 whenever an event occurs at the facility.

6.2.9 **Process of Ward Admission**

6.2.9.1 The MRC/MRT shall enter the patient's personal details, IP/ No, provisional diagnosis and the particular ward in the admission register book MOH 301.

6.2.9.2 The records staff shall liaise with nursing staff for opening an in-patient file with the IP/No for use in the ward

6.2.9.3 On discharge the MRC/MRT shall collect the notes from the ward and indicate date and fate of discharge in the admission register MOH 301.

6.2.10 **Booking of Appointments.**

The MRC/MRT shall get the doctor's instruction concerning the patient's next visit to the facility and book in the appointment register book HS/MR/014 indicating the patient's particulars, date, day, time, address, telephone number and the clinic / doctor or consultant.

6.2.11 **Disposal of Records**

6.2.11.1 The Health Records and Information Officer / Medical Records Technician shall prepare disposal schedule of records due for elimination or disposal.

6.2.11.2 The officer shall close qualified students out-patient files and transfer them to a lockable secondary filing area pending disposal after a period of six years.

6.2.11.3 He/she shall close staff out-patient medical files on resignation, termination of service, retirement or death and store them in secondary filing area for a period of six years pending disposal.

6.2.11.4 He/she shall transfer in-patients' closed files to the secondary filing area for a period of 10 years pending disposal.

6.2.11.5 The officer shall determine the most suitable method of records destruction after the retention period, with authority of the legal officer.

6.2.12 **Archiving of Records**

The HRIO / MRT in liaison with Internal Audit shall determine historical importance or values of records for permanent retention i.e. for reference and research purposes in the set institutional archives.

6.3 NURSING SERVICES

6.3.1 **Triage / Observation**

6.3.1.1 At the waiting area of the hospital a nurse or a clinical attendant under the supervision of a nurse shall receive and welcome all patients.

6.3.1.2 The nurse shall assist in identification of patients who may require emergency services or need a wheelchair or stretcher, or are in need of instant first aid.

6.3.1.3 The nurse shall take patients who need emergency care to the procedure room

6.3.1.4 All other patients shall be served on first come first served basis, in order to enhance the smooth flow of patients.

6.3.1.5 The nurse or the attendant allocated in this section shall make the patient comfortable, take the vitals, weight and height if indicated.

6.3.1.6 The names with number will be documented in the observation books for staff HS/NUR/313 and students HS/NUR /314, the observations shall be entered in the observation chits HS/NUR/310 for the clinician to review.

6.3.2 **Treatment / Procedure room management**

6.3.2.1 The patients shall be attended to one at a time to ensure privacy and confidentiality, the sequence is determined by the nurse depending on severity.

6.3.2.2 The nurse shall welcome the patient, and manage as per treatment card or prescription.

6.3.2.3 All procedures including injections will be explained to the patient

6.3.2.4 In case of emergency the vital signs shall be taken, the clinician shall be called to examine the patient and prescribe management and the records officer shall be called to retrieve or open the file.

6.3.2.5 Patients shall get a card with return dates if indicated, or in case of admission patient will be escorted to the ward by the nurse or attendant.

6.3.2.6 All procedures shall be recorded in procedure book HS/NUR/305 with date, time, procedure and signature.

6.3.3 **Admission Process**

6.3.3.1 The nursing staff shall receive the patient from the clinical rooms or treatment room for admission, allocate the patient a bed and make him/her comfortable

6.3.3.2 The nurse shall then commence start doses of treatment as prescribed and document this with time.

6.3.3.3 The nurse shall arrange to have all requested investigations done.

6.3.3.4 The nurse shall have a file opened for the admitted patient and file all admission documents (clinical notes HS/NUR/308, treatment sheet HS/NUR/306, observation chart HS/NUR/311, cardex HS/NUR/307, and any other chart).
6.3.3.5 Upon receipt of any test results, the nurse shall inform the doctor/clinician.
6.3.3.6 The nurse shall issue according to patient admission check list HS/NUR/312 a hospital gown, slippers, soap, towel and tissue paper.
6.3.3.7 The nurse shall document all above steps in the nursing cardex HS/NUR/307 and appropriate registers as inpatient admission book HS/NUR/301.

6.3.4 **Maintaining Cleanliness and In-patient Nursing Care**
6.3.4.1 The nurse shall make sure instruments are cleaned and sterilized.
6.3.4.2 The nurse shall make sure beds are cleaned, linen is changed daily and hospital and surrounding is kept clean.
6.3.4.3 The nurse shall ensure that very sick patients are assisted with daily bath
6.3.4.4 The nurse with assistance of nutritionist shall make sure the nutritional needs for each patient are addressed
6.3.4.5 The nursing staff shall administer medications and any other treatment as prescribed
6.3.4.6 On discharge the nurse shall issue the patient/relative with a copy of the discharge summary HS/NUR/309 and document in the discharge register HS/NUR/301
6.3.4.7 The nurse shall make sure that the patient has all the prescribed medication, knows the return date and then shall assist him/her out of the ward.

6.3.5 **Referral Process**
6.3.5.1 The referral form HS/ADM/419 shall be duly completed in triplicate by the clinician/doctor.
6.3.5.2 The nursing officer shall liaise with the transport office for the provision of an ambulance and shall contact the receiving hospital.
6.3.5.3 The referred cases shall be accompanied by the nurse or clinical attendant depending on patient's individual condition.
6.3.5.4 The escort shall have a referral letter with all the details about the patient.

6.3.6 **Process of other provided Health Services**
6.3.6.1 The hospital shall provide antenatal care services for staff, students and community
6.3.6.2 Clients are received by the nurse who shall welcome them and make them comfortable
6.3.6.3 The nurse shall take history, do physical exam, and organize for blood testing
6.3.6.4 The nurse shall give health education, supplemental medications and immunizations
6.3.6.5 In case of any abnormality in physical exam or lab results action shall be taken according to MOH guidelines
6.3.6.6 The hospital shall provide maternity care services for staff and students.
6.3.6.7 The nurse shall receive the patient in the maternity unit, take detailed and relevant medical history and perform physical examination if condition allows.

6.3.6.8 The nurse shall confirm the HIV status of all clients in maternity and act accordingly
6.3.6.9 The nurse shall conduct the delivery according to midwifery procedure guidelines.
6.3.6.10 In case of any difficulty, the nurse shall inform the doctor for appropriate action.
6.3.6.11 The nurse shall record the delivery in the maternity register MOH 333, and liaise with the records section to have the registration of birth form B1 completed
6.3.6.12 The hospital shall provide child welfare clinics for staff, students and community
6.3.6.13 The nurse in this section shall welcome the mother/mother's representative.
6.3.6.14 The nurse shall weigh all children, give health education. and administer immunizations
6.3.6.15 She will record in the child health book MOH 216 and give return date
6.3.6.16 Any child with a medical problem shall be referred to the clinician for review.
6.3.6.17 HIV follow up care shall be given for mothers and their exposed babies
6.3.6.18 Documentation shall be done in permanent register MOH 510, daily attendance register MOH 511, Immunization and vit A tally sheets MOH 702 and Child Health Nutrition Information System tally sheets MOH 704
6.3.6.19 The hospital shall provide family planning clinics for staff, students and community
6.3.6.20 The nurse shall interview the client, shall encourage the client to know her status, shall take weight and blood pressure, shall conduct health education and family planning counseling and assists the client to select a method.
6.3.6.21 The nurse shall document in patient's card HS/NUR/318, family planning file and register MOH 512.

6.4 CLINICIAN / DOCTOR SERVICES

6.4.1 Process of Clinician / Doctor Visit

6.4.1.1 The clinician shall welcome the client/patient, encourage the patient to sit and shall introduce him/herself.
6.4.1.2 The clinician shall take history and perform a local or general examination
6.4.1.3 The clinician shall make a provisional diagnosis, and if needed shall write required tests and direct the patient to the areas of the investigations.
6.4.1.4 For investigations outside the facility the clinician shall fill forms for Ultrasound (HS/ADM/417), X-Ray (HS/ADM/417), and laboratory (HS/ADM/418) to the relevant areas.
6.4.1.5 The clinician shall receive the investigations reports, shall document in the file and shall communicate the findings to the patient.
6.4.1.6 The clinician shall write the final diagnosis in the file and initiate the management plan
6.4.1.7 For drugs the clinician shall use the Maseno University prescription forms HS/PHARM/205

6.4.2 **Process of Internal Referrals and Admissions**

6.4.2.1 Clinicians shall treat the clients seen on day to day basis and refer difficult cases to the Medical Officer (MO) or Senior Medical Officers (SMO)

6.4.2.2 The MO(‘s) and SMO(‘s) shall review the difficult cases and either admit in ward, send for further investigations and / or review treatment(s) as appropriate.

6.4.2.3 The clinicians might occasionally encounter cases requiring admission, they shall admit and initiate treatment and cases shall be reviewed by the doctors.

6.4.2.4 For admission in the facility the clinician shall inform the nurse, shall write full history and findings on the clinical notes forms HS/NUR/308, write diagnosis and management plan, and shall write drugs and special observations on inpatient treatment sheet HS/NUR/306.

6.4.2.5 The clinician / doctor shall follow up with inpatient care, and discharge from the ward with discharge summary HS/NUR/309, a discharge prescription HS/PHARM/205, and a review date as necessary.

6.4.2.6 For complicated cases, lifesaving situations, or requiring surgery the patient shall be transferred to other hospitals for appropriate interventions.

6.4.3 **Process of External Referrals and Admissions**

6.4.3.1 The University doctors or clinicians after consultation shall refer cases to other consultants or hospitals as appropriate for further interventions with summary of management thus far and reasons for referral.

6.4.3.2 Referral form HS/ADM/0419 shall be written in triplicate: to the consultants, records (health) and a copy retained in the file.

6.4.3.3 Admission form to other hospitals HS/ADM/429 shall be in triplicate: original to the hospital concerned, copy in records (health) and a copy in file.

6.4.3.4 The COD shall visit the hospitalized cases to ensure that proper care is provided.

6.4.3.5 On discharge from the hospitals, a copy of the University admission form shall be attached to the invoice and delivered to the Health COD’s office for approval and signature.

6.4.3.6 Delivery of the invoice to CODs office shall be through a relative, COD health or staff member.

6.4.3.7 The office assistant shall then deliver the authorized invoice to the Finance Officer (accounts hall) for processing of a cheque

6.4.3.8 The processed cheque shall then be delivered to the appropriate hospital by: Finance assistant, staff member, COD health, a relative or the hospital representative.

6.4.4 **HIV Care**

6.4.4.1 Clients who have tested positive for HIV or who might be exposed to the virus shall be received in the comprehensive care clinic (CCC) from ANC, MCH, VCT Centre, HTC, OPD and from the community.

6.4.4.2 The CCC team shall give the client a specific number in the HIV register HS/ADM/432 or PEP file HS/ADM/440 to use for file, lab and pharmacy services instead of PF or student number for purposes of confidentiality.

6.4.4.3 Clients in need of Post Exposure Care shall be counseled, shall be sent to the laboratory for baseline blood tests, shall be given medication, and shall be given a follow up appointment.

6.4.4.4 The nurse-counselor shall counsel all sero-positive clients on first visit, with specific follow up on subsequent visits.

6.4.4.5 The CCC clinician shall take relevant history and do physical examination. He/she shall explain laboratory results to the clients, determine and prescribe medication needed

6.4.4.6 The clinician shall request for blood testing on first visit, and thereafter according to guidelines

6.4.4.7 The CCC team shall document findings using the CCC file card (MOH 257), the patient card (MOH 258), the CCC daily activity register and the daily register DAR--ART from MOH

6.4.4.8 The CCC team shall compile the patient visits overview, ART and OI use in register MOH361A and B to facilitate monthly reporting

6.4.4.9 The Laboratory Technician shall collect blood as requested with documentation in file HS/LAB/111, shall combine blood samples for transport to Kombewa and shall document the results before dispatch back to the CCC.

6.4.4.10 The Pharmacist shall compile the received stock from KEMSA and maintain the drug balances.

6.4.4.11 The Pharmacist shall compile a monthly report of ART and OI medication use in D—CDRR of MOH, which after signing by the chairman is send to Kombewa and KEMSA.

6.4.4.12 The Medical Records Technician shall send report with compilation of ART use in form MOH 711A for sending to Kombewa and Kemsa

6.5 LABORATORY SERVICES

6.5.1 C**ollection, Handling of Specimens and Storage of Reagents**.

6.5.1.1 The lab technologist shall welcome the patient, confirm personal particulars and record these with the investigations in the lab reception register HS/LAB/100.

6.5.1.2 The specimens shall be obtained, labeled, processed and analyzed according to standard operating procedure.

6.5.1.3 Results shall be recorded in respective registers HS/LAB/101-111 and dispatched.

6.5.1.4 Supplies shall be stored according to requirements.

6.5.2 **Laboratory Safety Procedures**

6.5.2.1 Precaution to prevent staff infections shall be adhered to.

6.5.2.2 Reusable glassware shall be disinfected and cleaned.

6.5.2.3 Used syringes, needles and sharps shall be discarded in safety boxes and disposed by incineration.

6.5.2.4 All contaminated materials shall be collected daily by support staff and transported for incineration.

6.5.3 **Maintenance of Equipment**

6.5.3.1 Laboratory equipments (machines) shall be cleaned daily for their continuous sustainability and covered after use.

6.5.3.2 Machines shall be serviced depending on the company's agreement within the warranty period.

6.5.3.3 The technologist using the machine/equipment shall be properly trained in setup, use and cleaning of the item.

6.5.3.4 Calibration shall be done yearly.

6.6 PHARMACY SERVICES

6.6.1 **Receiving and Storage of Drugs and Medical Supplies in Pharmacy Store**

6.6.1.1 The pharmacist or pharm-tech shall receive medicines accompanied by a delivery document (e.g delivery note, packaging lot, issue and receipt voucher), shall countercheck the number of packages and endorse the delivery document.

6.6.1.2 The pharm-tech with the store keeper shall inspect and check the shipment against discrepancies in type and number of medicines and expiry date

6.6.1.3 The pharm-tech shall record any discrepancies on the packaging slip or other delivery document and with the store keeper append signature and date.

6.6.1.4 The pharm-tech shall set aside unusable medicines and notify the source immediately for exchange or credit.

6.6.1.5 The pharm-tech shall endorse facility copy of delivery documents with signature, date and stamp, and file them chronologically by date for easy retrieval in the medicines bulk store.

6.6.2 **Ordering of Drugs from Pharmacy Store to Pharmacy**

6.6.2.1 The pharmacist or pharm-tech shall check the stock in the dispensing area and note down required items on a stores requisition note (SRN) HS/ADM/407

6.6.2.2 The SRN shall be authorized by chairman health services, and the storekeeper shall retrieve the required medicines.

6.6.2.3 The pharmacist or pharm tech shall check the quantities received, shall endorse the SRN with name, designation and signature and record in the register HS/PHARM/208.

6.6.3 **Dispensing of Drugs**

6.6.3.1 The pharm-tech shall receive the prescription and verify its validity

6.6.3.2 The pharmacy staff shall check the prescription, shall communicate with the prescriber if prescription is unclear or incorrect or drug is not available

6.6.3.3 The pharmacy staff shall retrieve the medication, check expiry date, shall dispense and label with dosage regimen and warnings/cautions.

6.6.3.4 The pharmacy staff shall communicate to the client the correct way to use the drugs.

6.6.3.5 The pharmacy staff shall enter details of encounter on prescription registers for injectables HS/PHARM/202, antibiotics HS/PHARM/203, narcotics HS/PHARM/204 and cardiovascular drug register HS/PHARM/200 and shall complete inventory records.

6.6.3.6 In case of non-availability of any drug the patient shall be requested to buy the same and shall be refunded by use of claim forms.

6.6.4 Disposal of Unusable Drugs and Medical Supplies

6.6.4.1 During the month of November every year the pharmacist shall identify the unusable items and separate them from the usable stock.

6.6.4.2 The pharmacist shall prepare a list of the unusable items detailing their quantities, expiry dates, reason for disposal and cost of the items.

6.6.4.3 The pharmacist shall notify the public Health Officer (PHO) of the unusable items in writing and copy the same to the Maseno University Internal audit and DVC, AFD.

6.6.4.4. Upon seizure of the unusable items by the PHO, the pharmacist and the PHO shall fill and sign the seizure form "B" under food, drugs and chemical substances Act (Cap 254)

6.6.4.5 The unusable items shall be sealed and kept in safe custody within the health facility awaiting disposal.

6.6.4.6. At the descrition of the PHO, the voluntary surrender form-under Cap 254 shall be filled and signed by the pharmacist and the detailed items handed over to the PHO for appropriate disposal.

6.6.4.7 The pharmacist shall keep the copies of the seizure form and the voluntary surrender form, used in the disposal process in the disposed goods file MSU/HS/PHARM/206.

6.6.4.8 The unusable drugs and medical supplies from Kenya Medical Supplies Agency (KEMSA) shall be sent to the Sub-County pharmacist after notifying him/her.

6.6.5 Process of Monitoring Drug Stock levels

6.6.5.1 The pharm-tech shall ensure that drugs shall only be issued on university hospital prescriptions HS/PHARM/205

6.6.5.2 The pharm-tech shall ensure that the prescription forms are clipped together per day, stored by month and retained for five years.

6.6.5.3 After five years' authority shall be sought for disposal of the prescription forms and the books of origin.

6.6.5.4 The pharm-tech shall conduct monthly stock taking of unopened containers within the pharmacy and shall document in the monthly stock taking form HS/PHARM/207B which is kept in the stock taking file HS/PHARM/207A.

6.6.5.5 The pharm-tech shall keep and promptly update the antibiotics, cardiovascular, injection and narcotics register.

6.7 PROCESS OF ORDERING SUPPLIES

6.7.1 The officers in charge of laboratory, pharmacy, nursing, kitchen and chairman's office shall monitor the stock of supplies to prevent stock-outs.

6.7.2 The officers in charge shall fill a purchase requisition note (PRN) HS/ADM/409 with required items and take this to chairman health services for approval.

6.7.3 The PRN shall be forwarded to the procurement officer.

6.7.4 The officers in charge shall receive supplies, verify them and store appropriately.

6.7.5 To receive supplies from the stores or main kitchen store, a stores requisition note (SRN) HS/ADM/407 shall be filled by the officers in charge or any designated personnel and countersigned by the chairman or designated person.

6.8 FEEDBACK PROCEDURE

6.8.1 Questionnaires are placed next to the pharmacy windows to be filled optionally

6.8.2 Forms with feedback or other comments shall be put a locked box

6.8.3 The box shall be opened every Friday by the chairman or his representative, evidenced by the student in charge of welfare, or the staff welfare officer

6.8.4 The forms shall be counted, sealed in a plastic bag and delivered to the chairman's office

6.8.5 The chairman or his designee shall analyze the data

6.8.6 Emergency issues shall be handled immediately

6.8.7 All results shall be presented to the hospital management meeting, the root cause determined and plans for improvement made

6.8.8 The number of feedbacks, cause and measures taken shall be entered in the feedback register HS/ADM/401.

6.8.9 Feedback report shall be send to the public relation office