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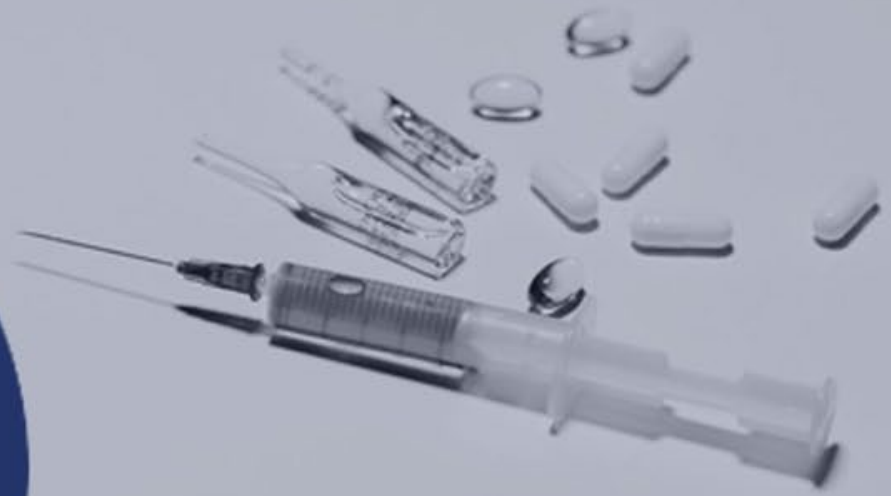

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Intern/Tutor Feedback Workshop Session 2026

Wednesday, 24 June 2026 18h00 – 21h00

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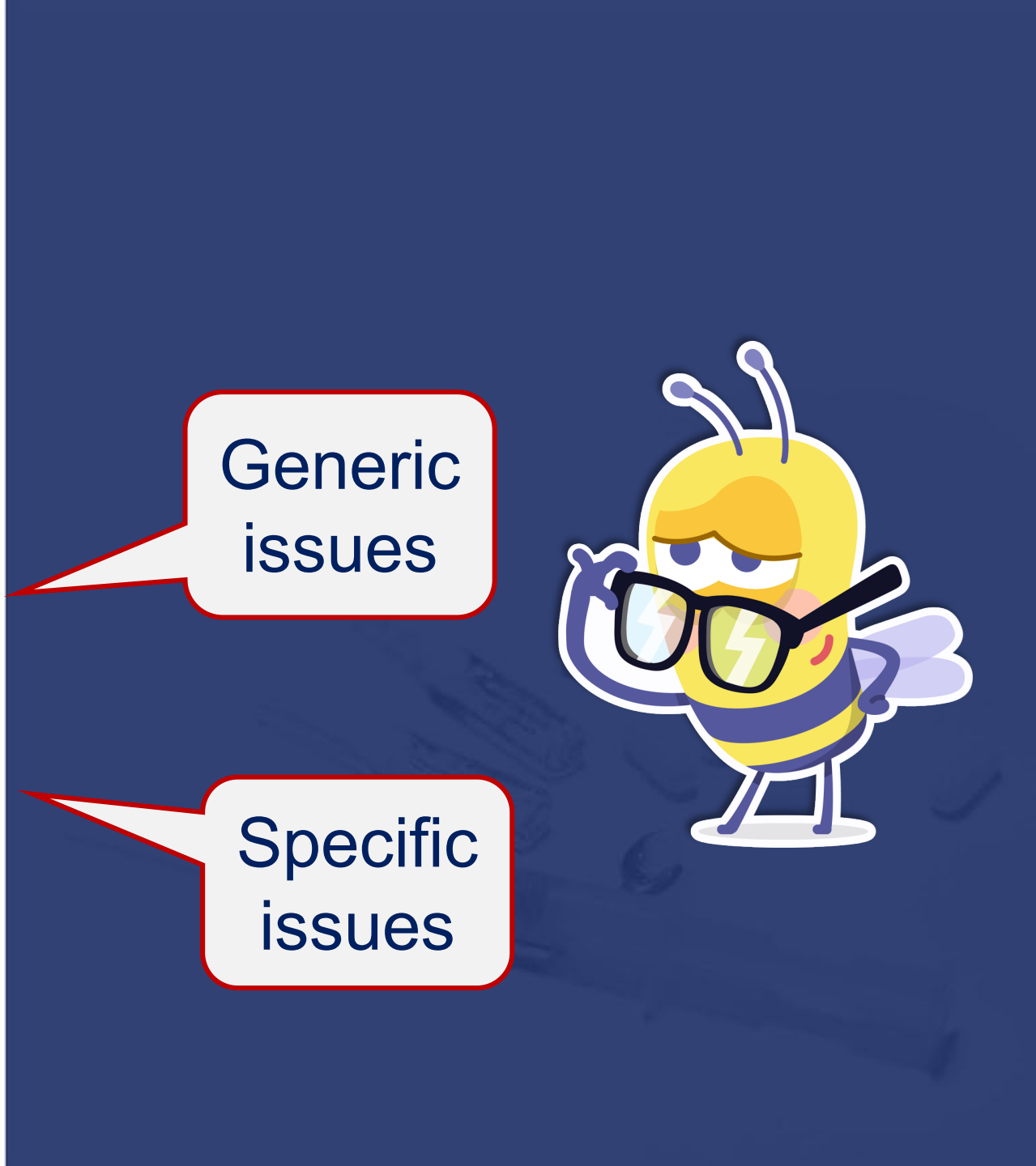
Overview

- Why do we have this session?
- Structure of the presentation
- Case studies
- The way forward
- Q & A



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Why do we have this session?

- **February/March Intern/Tutor Training Session is content heavy:**
  - Difficult to see relevance before actual involvement with Portfolio of Evidence entries.

- **All interns are now:**
  - Familiar with system, format and requirements of Competency Standards (C.S.); and
  - Have received feedback from assessors.

- **Assessors, moderators and interns are now:**
  - Able to share experiences.

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Structure of the presentation

- Linked to the 2026 Intern and Tutor Feedback Workshop presentation slides uploaded on the SAPC website.
- Portfolio of Evidence entries are provided as case studies for discussion.
- Portfolio of Evidence entries are examples of submissions from interns as well as students.
- Additional confidentiality measures applied.
- Interns and tutors are encouraged to participate.

Case Studies

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Assessment criteria

STEP 1: REFLECTION	MARK RANGE	CRITERIA
Learning title	0	Direct copy of / similar to the competency standard / behavioural statements OR title not appropriate / not related to competency standard.
	1	Original, descriptive and related to the competency standard.
Learning need	0	Irrelevant learning need OR learning need not linked to the competency standard and associated behavioural statements OR not learning need of intern (e.g., learning need of patient or nurse, etc)
	1	General description stating the role of the pharmacist in relation to the competency standard.
	2	Clear learning need according to competency standard and associated behavioural statements AND one (1) of the following: trigger scenario provided (i.e. what happened that triggered the learning need), OR indication of what the intern hopes to achieve after completion of the competency standard.
	3	Clear learning need according to competency standard and associated behavioural statements AND both: trigger scenario provided- (i.e. what happened that triggered the learning need), AND indication of what the intern hopes to achieve after completion of the competency standard.
Total	4	

STEP 2: PLANNING	MARK RANGE	CRITERIA
Description	0	Planning not related to behavioural statements and learning need OR no resources provided OR information relating to reflection, implementation and evaluation is provided.
	1	Combination of any two (2) of the following: Planning is provided in future tense OR reasoning behind the use of the resources, OR specific details of resources used is provided OR linking to 75% and above of the behavioural statements.
	2	Combination of any three (3) of the following: Planning is provided in future tense OR the reasoning behind the use of the resources OR specific details of resources used are provided, OR linking to 75% and above of the behavioural statements.
	3	All four (4): Detailed plan provided in future tense AND the reasoning behind the use of the resources AND specific details of resources used are provided AND linking to 75% and above of the behavioural statements.
Total	3	

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Assessment criteria

STEP 3: IMPLEMENTATION	MARK RANGE	CRITERIA
Achievement date	0	Invalid achievement date (i.e., not within internship period, or before the start date)
	1	Valid achievement date (i.e., during the internship period after completion of the activity)
Description	0	Invalid description
	1	Any one (1) of the following: Description of evidence provided and not linked to the outcomes/behaviours OR description of "how" only OR description of "where" only OR description of "what" only OR description of "when" only
	2	Combination of any two (2) of the following: Description of what, where, when, how OR reference made to the evidence OR linked to at least 75% of behavioural statements
	3	All three (3): Description of what, where, when, how, AND reference made to the evidence AND linked to at least 75% behavioural statements
Evidence	0	No evidence, OR not valid, OR not authentic, OR inappropriate/irrelevant OR factually incorrect OR confidentiality breeched
	1	Valid, authentic, current, sufficient (to show at least 75% of the behavioural statements were performed), but not annotated
	2	Valid, authentic, current, sufficient (to show at least 75% of the behavioural statements were performed), AND combination of any two (2) of the following: Annotated OR shows which behavioural statement it is satisfying OR how it is satisfying the behavioural statement.
	3	Valid, authentic, current, sufficient (to show at least 75% of the behavioural statements were performed), AND all three (3): annotated AND shows which behavioural statement it is satisfying AND how it is satisfying the behavioural statement.
Total	7	

STEP 4: EVALUATION	MARK RANGE	CRITERIA
Description	0	Any one (1) of the following: what was learned in terms of competency standard OR influence of learning on practice OR example of application OR possible future learning need. (Examples need to be specific).
	1	Combination of any two (2) of the following: Only states what was learnt in terms of competency standard OR gives what the influence on practice was OR gives an example of application OR identifies a possible future learning need. (Examples need to be specific).
	2	Combination of any three (3) of the following: what was learned in terms of CS OR influence of learning on practice OR gives an example of application OR possible future learning need in relation to the skills that were learnt. (Examples need to be specific).
	3	All four (4): What was learnt in terms of CS AND how the learning influenced his/her way of practice AND application by means of practical / actual examples AND identifying a future learning need in relation to the skills that were learnt. (Examples need to be specific).
Total	3	

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CASE STUDY 1

DOMAIN 5

Professional and personal Practice

Domain Competency 5.3

Ethical and legal practice

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Reflection Title:

Learning how to implement ethical and legal practices in the pharmacy.

Step 1: Reflection

What triggered my learning need:

- While working in the dispensary at XXXX Pharmacy, I encountered a Schedule 4 prescription and realised that I needed to better understand the legislation surrounding ethical and legal practice in order to handle such prescriptions appropriately.

Learning need:

- I want to become comfortable and competent in dispensing and handling prescription medicines in an ethical and professional manner.

What I hope to achieve?

- I need to familiarise myself with the responsibilities and expectations associated with working in the dispensary.

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Assessor/Moderator comments

Step 1: Reflection

Learning title

- The learning title is vague and not clearly aligned with the learning trigger.
- The learning title must be relevant to what you need to achieve in ethical and legal practice. It must be more specific to what you will be doing. Learning title should not be a direct copy/similar to the C.S. or B.S.

Learning need

- C.S. 5.3 goes beyond dispensing, as indicated by the behavioural statements; it is not just about dispensing. The learning need should be described sufficiently and align with the skills associated with the B.S., i.e., how to apply relevant regulations.
- You need to provide a very specific learning need – i.e. what aspect of dispensing a scheduled medicine specifically are you unfamiliar with? What skills or knowledge do you hope to achieve after addressing the learning need identified? Future learning need is quite vague and is not really related to the learning need/C.S.

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Step 2: Planning

Firstly, I plan to refer to the Scope of Practice for a pharmacy student in the Good Pharmacy Practice (GPP) guidelines - Chapter 3, Section 3.9 - to confirm that dispensing Schedule 4 medicines falls within my scope of practice. I will also study Section 22A(5) of the Medicines and Related Substances Act, 101 of 1965, along with the amended General Regulations of August 2017, to understand the legal requirements for dispensing S4 medicines. In addition, I will review Chapters 13 and 34 of the Pharmacy Act (No. 53 of 1974) to familiarise myself with the legislation regarding registration. To ensure I meet professional indemnity requirements, I will consult Chapter 3, Section 3.5 of the GPP. Finally, I will study Sections 1.2 and 1.4 of the Code of Conduct for Pharmacists to ensure that I uphold the ethical principles expected of me when handling S4 prescriptions. My goal is to dispense Schedule 4 medication successfully.

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Assessor/Moderator comments

Step 2: Planning

Requirement not met.

What is the reasoning behind the use of the resources you mentioned, and how does it align with the B.S. to achieve at least 75%?

Outdated legislation was used for the scope of practice; thus, planning for B.S. b & c is not accepted. How do you plan to practice within your scope of practice?

Which part of Section 22A do you intend to apply?

Which regulation within the Medicines Act deals with the authenticity and validity of a script? What other regulations do you plan to use for the rest of the dispensing cycle?

There is also no planning for B.S. (c).

Cross-reference the behavioural statements from your planning text.

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Step 3: Implementation

I confirmed that dispensing S4 prescriptions under the direct supervision of a pharmacist falls within my scope of practice after consulting the GPP guidelines, Chapter 3, Section 3.9 (E: A–a, b). In line with the Pharmacy Act No. 53 of 1974, Chapter 2, Section 13: Registration, and GPP, Chapter 3, Section 3.5: Personal Indemnity (E: B–a & C–d), I verified that I am registered and hold valid personal indemnity insurance, allowing me to legally dispense S4 prescriptions. After reviewing the Medicines and Related Substances Act No. 101 of 1965, Section 22A(5) (E: D–a, b), I gained a clear understanding of the legal requirements for dispensing S4 substances. I applied this knowledge to develop a prescription validity checklist (E: G–a, b, c) and used it to assess a prescription received on 8/7/2025, which I deemed valid. Finally, I consulted the Code of Conduct for Pharmacists to ensure I conducted myself ethically during the dispensing process (E: H–e).

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Step 3: Implementation Evidence

Evidence A: Good Pharmacy Practice in South Africa, Chapter 3, Section 3.9 – The Scope of Practice of a Pharmacy Student in dispensing S4 medicine.

Links to behavioural statement (a): Applying the Pharmacy Act (No. 53 of 1974), the Medicines and Related Substances Act (No. 101 of 1965) and any other applicable legislation in daily practice.

Links to behavioural statement (b): Practising within the scope of practice of a pharmacist, recognising own limitations of personal competency and expertise.

Good Pharmacy Practice Manual and Associated SAPC rules

3.9 SCOPE OF PRACTICE OF PHARMACY PERSONNEL

[Scope of Practice of Pharmacy Personnel amended by BN 12 of 10 March 2006, by BN 83 of 29 August 2008 and by BN 194 of 20 December 2010 (as withdrawn by BN 104 of 27 May 2011) and renumbered for ease of use.]

3.9.1.2 Pharmacist's assistant (post-basic)

Refer to 3.9.1.3 at bottom of page - Scope of a Pharmacy Student.

A pharmacist's assistant registered in the category pharmacist's assistant (post-basic) may perform the following services or acts under the direct personal supervision of a pharmacist in a pharmacy:

I need to perform all services under the direct supervision of a pharmacist, according to the GPP

(a) the sale of Schedule 1 and Schedule 2 medicines or scheduled substances;
(b) assist with the compounding, manipulation or preparation of a non-sterile or sterile medicine or scheduled substance according to a formula and Standard Operating Procedures approved by the responsible pharmacist;
(c) assist with the manufacturing of a non-sterile or sterile medicine or scheduled substance according to a formula and Standard Operating Procedures approved by the responsible pharmacist;
(d) the re-packaging of medicine;
(e) the distribution and control of stock of Schedule 1 to Schedule 6 medicines or scheduled substances;
(f) the ordering of medicine and scheduled substances up to and including Schedule 6 according to an instruction of a person authorised in terms of the Medicines Act to purchase or obtain such medicine or scheduled substance;
(g) the reading and preparation of a prescription, the selection, manipulation or compounding of the medicine, the labelling and supply of the medicine in an appropriate container following the interpretation and evaluation of the prescription by a pharmacist;
(h) the provision of instructions regarding the correct use of medicine supplied; and
(i) the provision of information to individuals in order to promote health.

Links to behavioural statement (a) & (b) – These services fall within my scope of practice, performed under direct supervision of a pharmacist.

3.9.1.3 Pharmacy student

The scope of practice of a student—

(a) A pharmacy student may provide or perform all of the services or acts pertaining to the scope of practice of a pharmacist's assistant registered in the category pharmacist's assistant (basic) under the direct personal supervision of a pharmacist in a pharmacy.
(b) A pharmacy student who has successfully completed his or her second year of study may provide or perform all the services or acts pertaining to the scope of practice of a pharmacist's assistant registered in the category pharmacist's assistant (post-basic) under the direct personal supervision of a pharmacist in a pharmacy.
(c) A pharmacy student may, for purposes of education and training, and under the auspices or a provider approved to offer education and training for a qualification in pharmacy and with whom such student is enrolled, provide or perform all the services or acts pertaining to the scope of practice of a pharmacist under the direct personal supervision of a pharmacist.

My scope of practice is that combined of a post-basic pharmacist assistant and a pharmacist, under direct supervision of a pharmacist – Links to behavioural statement (b).

[redacted] Signatures

Evidence B: Registration as a Pharmacy Student in terms of the Pharmacy Act (No. 53 of 1974)

Links to behavioural statement (a): Applying the Pharmacy Act (No. 53 of 1974), the Medicines and Related Substances Act (No. 101 of 1965) and any other applicable legislation in daily practice.

PHARMACY ACT NO. 53 OF 1974

[ASSENTED TO 9 OCTOBER, 1974]
[DATE OF COMMENCEMENT: 21 FEBRUARY, 1975]

CHAPTER II
REGISTRATION OF PHARMACISTS AND BODIES CORPORATE CARRYING ON BUSINESS AS A PHARMACIST AND MAINTENANCE OF REGISTERS

13. Registration.—

(1) No person shall be entitled to provide the services which form part of the services specially pertaining to the scope of practice of a pharmacist or assist therewith, unless he or she is duly registered in one of the categories prescribed in terms of this Act.
(2) No person shall practise as a specialist pharmacist or shall conduct himself or herself as such a specialist, or shall in any other manner profess to be a person in respect of whom any such speciality has been registered, unless the speciality in question has been registered in terms of this Act in respect of such person.
(3) Every person who has been suspended from practising in terms of this Act or whose name has been removed from a register, shall be disqualified from providing any of the services or performing any act specially pertaining to the scope of practice of pharmacy as determined in the practice rules made by the council, and his or her registration certificate shall be deemed to be withdrawn until the period of suspension has expired or until his or her name has been restored to the register by the council.
(4) Any person who has been suspended from practising in terms of this Act or whose name has been removed from a register in terms of subsection 45 (1) (c) and whose name has not been restored to such register shall not be entitled to remain, or be registered as the owner of a pharmacy, or hold any beneficial interest in a pharmacy.

[S. 13 substituted by s. 12 of Act No. 88 of 1997.]

The Pharmacy Act (No. 53 of 1974) states that I must be registered as a pharmacy student to be able to perform services pertaining to the scope of practice of a pharmacist such as dispensing S4 medicine.

On the SAPC website, I am registered as a B Pharm student and I am practicing as a B Pharm student in terms of the Pharmacy Act (No. 53 of 1974)

[redacted] Signatures

Evidence B: Continues.

COMMUNICATIONS & STAKEHOLDER RELATIONS

[redacted]
North West
2725

Your Reference	Our Reference	Date
	[redacted]	04 Jun 2025

Dear Mrs Joubert

CONFIRMATION OF REGISTRATION WITH THE COUNCIL

Document retrieved from SAPC Website confirming I am registered with the council.

This serves to confirm that you are registered as an/a B Pharm Student with the South African Pharmacy Council. You are registered with council in accordance with the provisions of section thirteen of the Pharmacy Act, 1974. You are authorised to practise within the area of jurisdiction of the South African Pharmacy Council.

Further to the above, the following can be confirmed:

Full Name and Surname	[redacted]
Date of Registration	
Account number	
Registration No	
Status	Registered-Active
Designation	Practising - Self-designated
Supplementary training	None

I comply with legislation as I am registered as active and thus can continue to perform services under the direct supervision of a pharmacist. Links to behavioural statement (a).

Please note Council's Social Media handle is @OfficialSAPC.

Online submission of the mainstream of council applications are mandatory. You can view the online tutorials on http://www.sapc.za.org/B_CS_Guidelines.asp; and ensure we have your updated e-mail address to receive council's latest news in e-Pharmaciae (Read more on www.pharmaciae.org.za).

If you have any enquiries in this regard please contact council via e-mail on customercare@sapc.za.org or the customer care line on 0861 7272 00 or 0861 SAPC 00.

Yours faithfully

Registrar

[redacted] Signatures

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Step 3: Implementation Evidence

Evidence B: Continues.

34. Pharmacy education and training institutions.—

(1) No person shall be entitled to offer education and training for purposes of registration in terms of this Act, unless such institution or person and the education and training concerned have been approved by the council.

(2) Any person intending to offer education and training referred to in subsection (1) shall, before offering such education and training, apply to the council in the prescribed manner for the approval of such education and training, and of such institution or person.

(3) Any person who prevents a person authorised in terms of this Act to perform a function for or to act on behalf of the council from entering, at a reasonable time, an institution or premises offering education and training or who hinders such person in making therein or therefrom any investigation required to be done by the council, shall

Section 34 of the Pharmacy Act, 53 of 1974, states that only institutions that have been approved by the council may offer education and training
Links to behavioural statement (a).

List of approved providers and courses (as at April 2024)

Members of the public and the profession are advised that, as at April 2024, the below list comprises of the only approved providers of pharmacy education and training, and the courses approved/accredited by the South African Pharmacy Council.

In terms of Section 34 of the Pharmacy Act, 53 of 1974, the South African Pharmacy Council (SAPC) is responsible for approving pharmacy education/training programmes and institutions. No person or institution may provide pharmacy education and training without being approved by the SAPC. As at March 2024, the tables below enlist the only approved providers of pharmacy education and training as well as the approved/accredited courses.

BACHELOR OF PHARMACY (NQF Level 8)

Institution / Provider	Contact Person	Contact Number
Nelson Mandela Metropolitan University	Dr M Luvuno-Keele	+27 (0) 41 504 2128
North-West University (Potchefstroom Campus)	Prof. J Steenekamp	+27 (0) 18 299 2276
Rhodes University	Prof. S Khamanga	+27 (0) 46 603 8101
Sefako Makgatho Health Sciences University	Prof. PH Demana	+27 (0) 12 521 5866
Tshwane University of Technology	Dr B Komane	+27 (0) 12 382 6230
University of Limpopo	Prof. M Nkoto	+27 (0) 15 268 4060
University of KwaZulu-Natal (Westville Campus)	Dr/Rev. LJ Mathibe	+27 (0) 31 260 7030
University of the Western Cape	Prof. SF Malan	+27 (0) 21 959 2190
University of the Witwatersrand	Prof. YE Choonara	+27 (0) 11 717 2052 (2552

The North-West University of Potchefstroom is on the South African Pharmacy Council's list of approved providers of pharmacy education and training

Proof of Registration as a Pharmacy Student at the North-West University (Potchefstroom Campus)

NWU

PROOF OF REGISTRATION 2025

Names

Bachelor Of Pharmacy

Signatures

Evidence C: GPP, Chapter 3, Section 3.5 – Professional Indemnity Insurance.

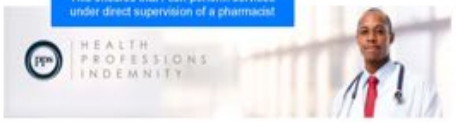
Links to behavioural statement (d): Complying with professional indemnity requirements.

3.5 PROFESSIONAL INDEMNITY

Any person registered with the South African Pharmacy Council who performs one or more of the functions relating to the scope of practice of the category in which he/she is registered must be covered by his/her own indemnity insurance.

[Section 3.5 substituted by BN 83 of 29 August 2008.]

According to the GPP, as a pharmacy student registered with the SAPC, I must be covered by my own indemnity insurance. This ensures that I can perform services under direct supervision of a pharmacist



CERTIFICATE OF INSURANCE

This certificate of insurance is issued as evidence that the Insured Professional detailed below is covered for liability stemming from his or her clinical practice under a contract of insurance issued by the Insurer. The cover provided is subject to the terms and conditions of the insurance contract referenced.

INSURER: Professional Provident Society Short-Term Insurance Company Limited
INSURED PROFESSIONAL: [redacted]
POLICY NUMBER:
INSURED ACTIVITY: Students
PERIOD OF INSURANCE: 01 July 2025 to 30 June 2026

Issued for and on behalf of PPS Health Professions Solutions at Parktown this 01 July 2025.

My certificate of insurance with PPS that proves that I have my own indemnity insurance which will cover me until June 2026.
Links to behavioural statement (d).

JACO VAN DER SANDT
Chief Executive Officer: PPS Health Professions Solutions

PPS-009/1 Health Professions Indemnity- Certificate of Insurance Page 1 of 1

PPS Health Professions Indemnity is a division of PPS Short-Term Insurance Company Ltd. an insurer licensed to conduct non-life insurance business and an authorised FSP(46274) Ts&Cs apply.

Signature

Evidence D: Medicines and Related Substances Act (No. 101 of 1965), Section 22A, Nr 5&6

Links to behavioural statement (a): Applying the Pharmacy Act (No. 53 of 1974), the Medicines and Related Substances Act (No. 101 of 1965) and any other applicable legislation in daily practice.

Links to behavioural statement (b): Practising within the scope of practice of a pharmacist, recognising own limitations of personal competency and expertise.

According to the Medicines and Related Substances Act (No. 101 of 1965), Number 5(a) and (b) states that I may sell Schedule 4 medicine upon a prescription under the direct supervision of a pharmacist.
Links to behavioural statement (a) and (b).

MEDICINES AND RELATED SUBSTANCES ACT NO. 101 OF 1965

[View Regulation]

[ASSENTED TO 19 JUNE, 1965]
[DATE OF COMMENCEMENT: 1 APRIL, 1966]

(5) Any Schedule 2, Schedule 3, Schedule 4, Schedule 5 or Schedule 6 substance shall not be sold by any person other than—

(a) a pharmacist, pharmacist intern or a pharmacist's assistant acting under the personal supervision of a pharmacist, who may sell only Schedule 2 substances without a prescription;

(b) a pharmacist or a pharmacist intern or pharmacist's assistant acting under the personal supervision of a pharmacist, upon a written prescription issued by an authorised prescriber or on the verbal instructions of an authorised prescriber who is known to such pharmacist;

(c) a manufacturer of or wholesale dealer in pharmaceutical products for sale to any person who may lawfully possess such substance;

(d) a medical practitioner or dentist, who may—

(i) prescribe such substance;

(ii) compound or dispense such substance only if he or she is the holder of a licence as contemplated in section 22C (1) (a);

(e) a veterinarian who may prescribe, compound or dispense such substance;

(f) a practitioner, a nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist, who may—

(i) prescribe only the Scheduled substances identified in the Schedule for that purpose;

(ii) compound and dispense the Scheduled substances referred to in subparagraph (i) only if he or she is the holder of a licence contemplated in section 22C (1) (a).

Signature

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Step 3: Implementation Evidence

Evidence E: Medicines and Related Substances Act (No. 101 of 1965) – General Regulations 2017, Section 33.

Links to behavioural statement (a): Applying the Pharmacy Act (No. 53 of 1974), the Medicines and Related Substances Act (No. 101 of 1965) and any other applicable legislation in daily practice.

Links to behavioural statement (b): Practising within the scope of practice of a pharmacist, recognising own limitations of personal competency and expertise.

Links to behavioural statement (c): Keeping abreast of legislation and applying relevant amendments accordingly.

PARTICULARS WHICH MUST APPEAR ON PRESCRIPTION FOR MEDICINE

33. (1) Every prescription for a medicine shall be—

(a) written in legible print;

(b) hand or typewritten; or

(c) prepared with an electronic agent as defined by and in compliance with the Electronic Communications and Transactions Act, 2002 (Act No. 25 of 2002).

(2) A prescription shall be signed—

(a) in person; or

(b) in the case of a prescription prepared in accordance with subregulation (1)(c), with an advanced electronic signature as per section 13 of the Electronic Communications and Transactions Act, 2002 (Act No. 25 of 2002),

by an authorised prescriber.

84 No. 41064 GOVERNMENT GAZETTE, 25 AUGUST 2017

(3) A prescription shall at least state the following:

(a) The name, qualification, registration number with the relevant statutory health council and address of the prescriber;

(b) the name, identification number and address of—

(i) the patient;

(ii) in the case of a prescription for a neonate, the parent or guardian; or

(iii) in the case of a prescription issued by a veterinarian, the person to whom the medicine or scheduled substance will be sold;

(c) the date of issue of the prescription;

(d) the approved name or the proprietary name of the medicine;

(e) the dosage form;

(f) the strength of the dosage form and the quantity of the medicine to be supplied: Provided that—

(i) in the case of a Schedule 6 substance the quantity to be supplied shall be expressed in figures as well as in words; and

(ii) where the prescriber has failed to express the quantity in figures as well as in words, the pharmacist dispensing the medicine may, after obtaining confirmation from the prescriber, insert the words or figures that have been omitted;

(g) instructions for the administration of the dosage, frequency of administration and the withdrawal period in the case of veterinary medicines for food producing animals;

(h) the age and gender of the patient and, in the case of veterinary medicine, the animal species; and

(i) the number of times the prescription may be repeated.

(4) The pharmacist who dispenses a prescription shall verify the authenticity of all

Government Gazette – Ammendments made to the Act since published in August 2017.

Links to behavioural statement (c).

I compiled a prescription validity checklist according to the legislation of Section 33. **See evidence F.**

Links to behavioural statement (a) and (b).

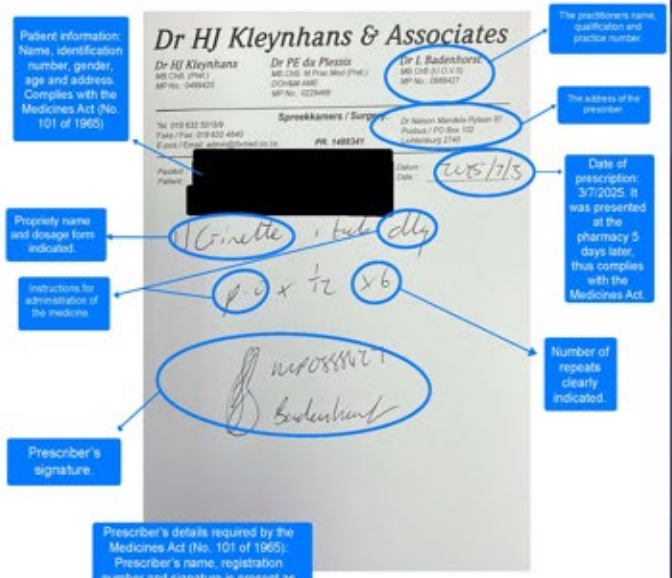
Signatures

Evidence F: Prescription

Links to behavioural statement (a): Applying the Pharmacy Act (No. 53 of 1974), the Medicines and Related Substances Act (No. 101 of 1965) and any other applicable legislation in daily practice.

Links to behavioural statement (b): Practising within the scope of practice of a pharmacist, recognising own limitations of personal competency and expertise.

Links to behavioural statement (c): Keeping abreast of legislation and applying relevant amendments accordingly.



This prescription is thus valid **(See Evidence F)** as it complies with the Medicines and Related Substances Act (No. 101 of 1965) **(See Evidence D)** and amendments thereof in August 2017. **(See Evidence E)**

Links to behavioural statement (a), (b) & (c).

Signatures

Evidence G: Prescription Validity Checklist

Links to behavioural statement (a): Applying the Pharmacy Act (No. 53 of 1974), the Medicines and Related Substances Act (No. 101 of 1965) and any other applicable legislation in daily practice.

Links to behavioural statement (b): Practising within the scope of practice of a pharmacist, recognising own limitations of personal competency and expertise.

Links to behavioural statement (c): Keeping abreast of legislation and applying relevant amendments accordingly.

Prescription Validity Checklist

Particulars which must appear on the prescription	Compliant (Yes/No)
Name, qualification, registration number, address and signature of the prescriber	Yes
Legible handwriting	Yes
Name, surname, address, ID number, age and gender of the patient	Yes
Date the prescription was issued	Yes
Approved name of the medication	Yes
Dosage form of the medication	Yes
Instructions of usage of the medication and frequency of administration	Yes
Number of repeats	Yes

The prescription validity checklist I compiled by using applicable legislation – Medicine Act **(See Evidence D)** and amendments thereof made in 2017 **(See Evidence E).**

Links to behavioural statement (a), (b) & (c).

Signatures

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Step 3: Implementation Evidence

Evidence H: Code of Conduct for Pharmacists.

Links to behavioural statement (a): Practicing and adhering to the obligations of a pharmacist in terms of the principles of the statutory Code of Conduct for Pharmacists.

1.2 HONOUR AND DIGNITY OF THE PROFESSION

Principle: *A pharmacist must uphold the honour and dignity of the profession and may not engage in any activity which could bring the profession into disrepute.*

In adhering to this principle the following should be taken into consideration:

1.2.1 A pharmacist must have due regard for the reasonably accepted standards of behaviour both within and outside his professional practice.

1.2.2 Any breach of the law, whether or not directly related to a pharmacist's professional practice, may be regarded as bringing the profession into disrepute and may be considered to be misconduct for which the council may take disciplinary steps.

1.2.3 A pharmacist must not use or permit the use of his/her qualifications or his/her position as a pharmacist to mislead or defraud.

1.2.4 While a pharmacist is encouraged to make reference to a doctorate that he/she holds as an additional qualification, care should be taken to ensure that it is not used in such a way as to lead the public to believe that the pharmacist is a medical practitioner.

1.2.5 A pharmacist or any person registered in terms of the Pharmacy Act, (Act 53 of 1974), or any registered pharmacy owner issued with a licence in terms of Section 22 of the Act shall adhere to the standards and rules set out in the Council's Rules as to Good Pharmacy Practice in South Africa, made in terms of Section 35A (b) (ii) of the Pharmacy Act, (Act 53 of 1974).

By adhering to these principles, I ensured that my conduct, both within and outside of my professional practice, met the required standards by dispensing only under the supervision of a pharmacist.

Links to behavioural statement (e).

1.3 CONFIDENTIALITY

Principle: *A pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to a patient and may not disclose such information except under certain prescribed circumstances.*

By adhering to this principle, I ensured no information regarding the patient is visible throughout this CPD. **(See Evidence F)**

Signatures

Evidence H: Continues.

By completing this CPD activity, I adhered to the principle of maintaining and enhancing my professional knowledge. I gained valuable insights into current legislation, ensuring I remain up to date and competent as a final-year pharmacy student preparing for practice. This experience supports my ongoing development and reinforces my commitment to lifelong learning as a future pharmacist.

Links to behavioural statement (e)

1.4 CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Principle: *A pharmacist must keep abreast of the progress of professional knowledge in order to maintain a high standard of competence relative to his/her sphere of activity.*

In line with the national education policy of life-long-learning, it is the responsibility of all pharmacists to:

1.4.1 keep abreast of changes in pharmacy practice;

1.4.2 remain up-to-date with the laws relating to pharmacy, the control of medicine and the knowledge and technology applicable to pharmacy; and

1.4.3 maintain competence and effectiveness as a practitioner.

Pharmacists must commit themselves to the concept of Continuing Professional Development, which is defined as the process by which pharmacists continuously enhance their knowledge, skills and personal qualities throughout their professional careers.

It encompasses a range of activities including:

(a) continuing education, which is the on-going learning that professionals need to undertake throughout their careers as a contribution towards the maintenance and enhancement of their professional development and professional competence;

(b) professional audit, which is the study of the structure, process or outcome of pharmacy practice carried out by individual pharmacists, groups of pharmacists or groups of health care practitioners, to measure the degree of attainment of agreed objectives;

(c) participation in non-pharmacy related but relevant formal post-graduate education;

(d) performance appraisal, self-assessment, identification and documentation of personal development targets;

(e) research, including practice research and the achievement of higher degrees by research;

(f) active involvement in professional organisations; and

(g) provision of training, coaching or mentoring.

Signatures

RISM DECLARATION

I _____
(full name and surname and student number) hereby declare that this assignment / paper / project / portfolio is my own work.

I further declare that:

1. the text and bibliography reflect the sources I have consulted, and
2. where I have made reproductions of any literary or graphic work(s) from someone else, I have obtained the necessary prior written approval of the relevant author(s)/publisher(s)/creator(s) of such works and/or, where applicable, from the Dramatic, Artistic and Literary Rights Organisation (DALRO).
3. sections with no source referrals are my own ideas, arguments and/or conclusions.

Signature: _____ Student number: _____

Date: _____

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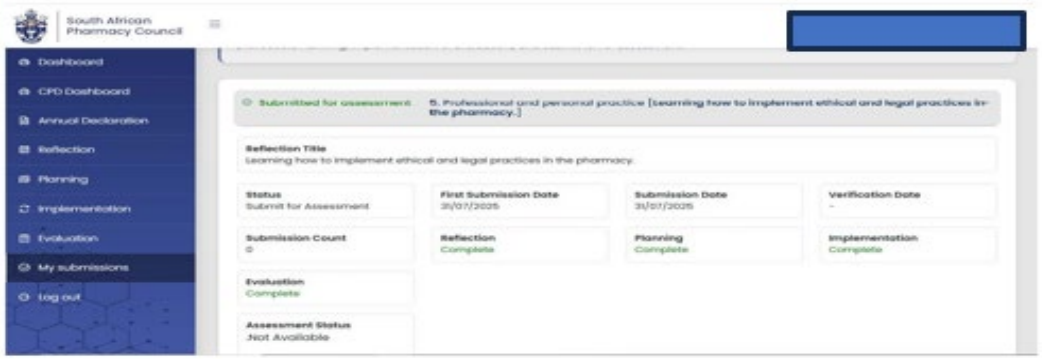
Step 3: Implementation Evidence

Proof of Submission on SAPC Website.



Proof that I uploaded my CPD on the SAPC website on 31/07/2025.

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Assessor/Moderator comments

Step 3: Implementation

Description:

- It is linked to both B.S. (75%) and Evidence.
- However, the description of the dispensing activity itself is vague (only “what” described, no “how” or “why”, e.g. no discussion as to how B.S. (b) – i.e. practising within scope/under supervision is discussed).
- Intern to show how they have applied the Acts by linking B.S. with the relevant Act.

Evidence:

- B.S. (a) not met: Your learning need related to the Dispensing of a Schedule 4 item.
- Dispensing relates to 3 Phases – you have only demonstrated how you completed part of Phase 1 – Authenticity and legality of the prescription.
- There was no clinical review of the prescription (Phase 1), no evidence for Phase 2, no evidence for Phase 3.

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Assessor/Moderator comments

Step 3: Implementation

Evidence:

- B.S. (b) not met: Outdated scope of practice applied.
- No evidence that the activity was conducted under the supervision of a pharmacist.
- B.S. (c) not met: A recent amendment (within 1-2 years) was not applied. An amendment from 2017 is not considered recent.
- B.S. (d) met: Certificate valid at the time of activity. The role of a student is noted as acceptable for this entry, as this was submitted by a student.
- B.S. (e) met: Code of Conduct principle of confidentiality accepted.

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Step 4: Evaluation

Following this learning activity, I gained a deeper understanding of the importance of ethical and legal practices when handling and dispensing Schedule 4 medicines. I recognised the necessity of working under the supervision of a pharmacist to minimise the risk of errors. Rereading the Code of Conduct for Pharmacists reminded me of the professional principles I must uphold both within and outside of pharmacy practice. This learning experience strengthened my commitment to always follow relevant legislation and to practise within my defined scope. While working in the dispensary, I applied the knowledge I had acquired by using my prescription validity checklist to ensure that all Schedule 3–5 prescriptions were legal and valid. When I encountered non-compliant prescriptions, I confidently contacted the prescribers to have them corrected. Looking ahead, my next learning objective is to familiarise myself with the handling and safe management of cytotoxic drugs.

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Assessor/Moderator comments

Step 4: Evaluation

- No specific examples of applied learning are provided. Provide examples of where the knowledge and skills acquired have been applied to a different activity.
- The evaluation lacks depth – why was it important to handle and dispense medicine in a legal manner?
- How this learning has changed your practice is vaguely described, i.e. “This learning experience strengthened my commitment to always follow relevant legislation and to practise within my defined scope.”
- Future learning is related to the handling of cytotoxic drugs, which does not align with the Domain 5. Future learning needs should align with a CS within the particular domain (Domain 5).

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Assessor/Moderator comments

Step 4: Evaluation....

You need to address the following in your Evaluation:

1. Why was it important for you to complete this entry?

2. What skill did you develop and how was it applied in practice again? Provide a specific example of how you did this.

3. How has this changed your practice?

4. What do you still need to learn? Provide an example of a future learning need (it should not be on the same skill).

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Assessor/Moderator comments

Step 4: Evaluation....

Your evaluation should relate to this domain - i.e., ethical and legal practice, the skills relate to being ethical and following regulations, etc., applying the regulations and code of conduct, etc., would be appropriate, and this should reflect in your whole evaluation.

Your applied learning and future learning need example should also relate to this domain, but the future learning need should not be another application of a law/regulation scenario, as you have met this learning need with this submission. If your future learning need is another application of law/regulation activity, it means that you have not met your learning need.

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Any questions?

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Patient counselling

is the process of providing personalised guidance and information to *patients* to help them manage their *health* conditions

CASE STUDY 2

DOMAIN 2

Safe and rational

use of medicines

Domain Competency 2.2

Patient counselling

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Reflection Title:

Effective patient counselling on Metformin therapy

Step 1: Reflection

While working in the dispensary, I observed a pharmacist providing comprehensive counselling to a patient on the use of amoxicillin. He clearly explained the importance of taking the medicine at prescribed times and completing the full course, even if symptoms improve. He also emphasised that poor adherence can lead to treatment failure and contribute to antibiotic resistance. This experience prompted me to reflect on my own counselling approach and highlighted a need to strengthen my knowledge and communication skills. Although I understand the pharmacology of many medicines, I recognise that I must improve my ability to convey key counselling points clearly and in a patient-friendly manner. I realised that effective counselling goes beyond giving instructions; it requires confirming understanding and promoting responsible medicine use. Developing this competency will enable me to educate patients effectively, improve adherence, and support safe, rational medicine use in my future practice.

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Assessor/Moderator comments

Step 1: Reflection

Learning title - Requirements met.

- The title is original, descriptive, and related to the competency standard.

Learning needs - Requirements met.

- The learning need is clearly linked to patient counselling.
- A trigger scenario: observing the pharmacist counselling a patient on Amoxicillin is included.
- It also explains what the intern hopes to achieve.

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Step 2: Planning

I plan to develop a structured counselling plan to familiarise myself with the key areas addressed during patient counselling (BSd&b). I will assess the patient's understanding of their diagnosis and prescribed medicines through appropriate questioning and active listening, identifying knowledge gaps and concerns (BSa&c). To strengthen my clinical knowledge, I will review the STG and SAMF 14th edition to better understand the condition and its treatment (BSa&b). I will prepare clear counselling points and visual aids to enhance patient comprehension (BSg&h). To clarify my responsibilities as an intern, I will review GPP Section 3.9.1.4 and Chapters 1.3, 2.7.1.3, and 2.8, reinforcing the importance of counselling and patient confidentiality (AA). I will demonstrate correct medicine use, explain side effects and precautions, ensure accurate dispensing labels (BSg), and confirm understanding through structured questioning (BSi).

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Assessor/Moderator comments

Step 2: Planning

Requirement partially met.

- The focus is more on the clinical aspects but should also focus on soft skills e.g. listening, verbal and non-verbal communication, sensitivity to cultures, etc.
- Resources provided should be specific. Which part/section of the STG and SAMF will you review?

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Step 3: Implementation

A newly diagnosed type 2 diabetic patient came with a Metformin script(E1). I asked her to fill a pre-counselling form, which showed limited understanding of diabetes, which indicated the need for counselling (BSa)(E2).He signed a confidentiality agreement(E3). I read SAMF,STG to enhance my knowledge of metformin, its role in diabetes management, dosing, and side effects (BSa&b)(E4). I adjusted my counselling plan to address diabetes and metformin therapy (BSd)(E5).To enhance patient understanding I used effective communication techniques, including active and reflective listening, and a pamphlet which emphasised the necessary lifestyle changes, (BSc,e,g,h)(E6). I counselled him in a private area to respect patient dignity and confidentiality (BSd,e,f)(E7). The supervising pharmacist created a checklist to assess my counselling skills (BSe&f)(E8). I put an appropriate dispensing label (Bse, h) (E9). I used a post-counselling questionnaire to confirm his understanding and address any concerns (BSi)(E10).

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Step 3: Implementation Evidence 1

Annexure A: Scope of Practice of a Pharmacist Intern

3.9.1.4 Pharmacist intern

The scope of practice of a pharmacist intern—

(a) A pharmacist intern may provide or perform all the services or acts pertaining to the scope of practice of a pharmacist's assistant registered in the category pharmacist's assistant (post-basic) under the direct personal supervision of a pharmacist in a pharmacy.

(b) A pharmacist intern may, for the purposes of education and training, provide or perform all of the services or acts pertaining to the scope of practice of a pharmacist under the direct personal supervision of a pharmacist in a pharmacy.

According to Good Pharmacy Practice manual, Chapter 3.9.1.4, a pharmacist intern is required to perform all the professional services pertaining to the scope of practice of a pharmacist under direct supervision of a registered pharmacist. Therefore, in accordance with phase 3 of the dispensing process, a pharmacist intern may provide medication-related information to patients, provided this is done under appropriate supervision.

Annexure A continuing: Maintaining Confidentiality as a Pharmacist Intern

1.3 CONFIDENTIALITY

Principle: *A pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to a patient and may not disclose such information except under certain prescribed circumstances.*

In adhering to this principle the following should be taken into consideration:

1.3.1 A pharmacist must restrict access to information relating to a patient to those who, in his/her professional judgment, need that information in the interests of the patient or in the public interest.

1.3.2 A pharmacist must ensure that anyone who has access to information relating to a patient—

(a) is aware of the need to respect its confidential nature;

(b) does not disclose such information without the written consent of the patient.

1.3.3 If a pharmacist judges it necessary to disclose information relating to a patient, the content should be limited to the specific matter involved. The following are guidelines regarding circumstances when information might need to be disclosed:

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Good Pharmacy Practice Manual and Associated SAPC rules

(a) Where the information is to be shared with others who participate in, or assume responsibility for, the care or treatment of the patient, and would be unable to provide that care or treatment without that information (the need-to-know concept).

(b) Where disclosure of the information is to a person or body that is empowered by statute to require such a disclosure: for example, in connection with a scheduled medicine or a notifiable disease.

(c) Where disclosure is directed by the presiding officer of a court. It should be noted that such a direction relates to disclosure only to the person presiding or to a person named by the court.

(d) Where necessary for the purpose of a medical research project, which has been approved by a recognised ethics committee.

(e) Rarely, where disclosure is justifiable on grounds of public interest; for example, to assist in the prevention, detection of or prosecution for serious crime or where disclosure could prevent a serious risk to public health.

(f) Where necessary to prevent serious injury or damage to the health of a third party.

(g) If a pharmacist is of the opinion that disclosure of the information requested might cause serious harm to the patient's physical or mental health or well-being, he/she may allow access to this information if the requester can prove to his/her satisfaction that adequate provision is made for counselling or arrangements as are reasonable before or during or after the disclosure of such information to alleviate or avoid such harm to the patient.

According to Chapter 1.3 of the Good Pharmacy Practice manual,a pharmacist is required to respect and maintain confidentiality of patient information. Such information may only be disclosed under specific,legally justified circumstances.

This reinforced the importance of safeguarding patient confidentiality during counselling session and ensuring that all patient information is handled with the utmost professionalism and discretion.

Annexure A continuing: Importance of counselling patients

2.7.1.3 Phase 3: Provision of information and instructions to the patient to ensure the safe and effective use of medicine.

2.7.1.3.1 Supply to the patient

(a) Advising a patient or the patient's agent/caregiver (physical presence is preferred) must be carried out by a pharmacist or other authorised person.

(b) A patient information leaflet, containing the information as prescribed in the General Regulations published in terms of the Medicines Act should be available at the point of dispensing.

(c) Information must be structured to meet the needs of individual patients

(d) Pharmacists must ensure that any information or services offered by a pharmacy to patients in the area of health promotion are safe, up-to-date and in accordance with the relevant local and national guidelines.

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Good Pharmacy Practice Manual and Associated SAPC rules

(e) Information provided to patients regarding their medicine use must always be done with professional judgement and the prescriber should be contacted when necessary.

This is one of the most important considerations during counselling:ensuring that the individual needs of the patient are identified and appropriately addressed. **This is linked to Behavioural Statement a&d**

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Step 3: Implementation Evidence 2

Annexure A continuing: Importance of counselling patients

[Rule 2.7.5 substituted by GenN 431 of 6 June 2017.]

2.8 MINIMUM STANDARDS FOR PATIENT INFORMATION AND ADVICE

Patient information is of vital importance in the correct use of medicines. Lack of information and misunderstanding contribute to the failure of the therapy, thus wasting resources and adding to the costs of care.

2.8.1 Purpose

Patient information must respect patient autonomy, improve health and enhance the outcome of medical treatment by:

(a) empowering consumers to make informed decisions about their medical treatments and take responsibility for their own health care;

(b) improving communication between patients and health care providers; and

(c) aiding and encouraging effective use of medicines.

2.8.2 General considerations

(a) Pharmacists and other persons registered with Council must (within their scope of practice) give advice and information to patients on how to use medicines safely and effectively to maximise therapeutic outcomes.

(b) Pharmacists must have access to as much information as they require within their ethical and professional judgement to meet the individual needs of patients. Such information should include the patient's medical/clinical records.

(c) Although specific presentation and language must be adapted to local communities and public comprehension, information presented to patients must as far as possible be nationally consistent.

(d) Pharmacists must assess and, where appropriate, comment on promotional materials for medicines and other products associated with health.

(e) Upon receipt of a prescription, or a request for dispensing of medicine on own initiative, a pharmacist must counsel each patient or patient's caregiver on matters which, in the pharmacist's professional judgement, will enhance or optimise the medicine therapy prescribed.

(g) Care must be taken to assess the wishes of the prescriber and the information and counselling needs of individual patients.

(h) Written information must be used to supplement verbal communication as appropriate.

(i) The pharmacist must assess each patient's ability to understand the information imparted by question and answer and must be able to modify his/her approach accordingly. Care should be taken with counselling where understanding is likely to be a problem.

(j) Confidentiality of the patient must be respected.

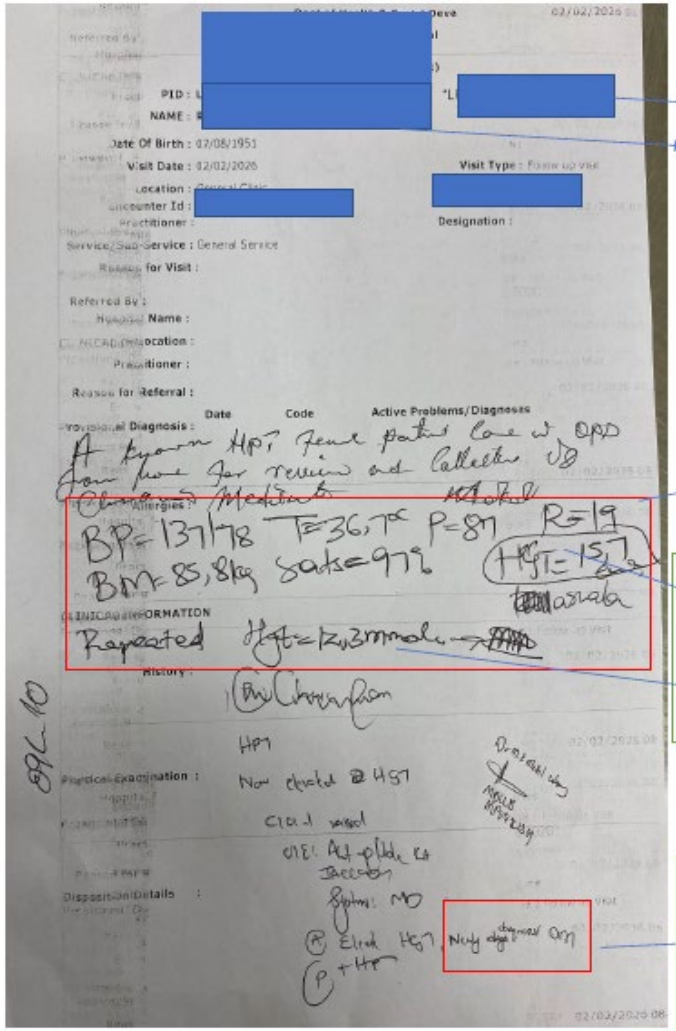
(k) The provision of advice must take place in a suitable environment and the patient should be put at ease, especially with regard to sensitive information.

From Chapter 2.8 of the Good Pharmacy Practice, I gained a clearer understanding of the purpose of patient counselling and its impact on patient outcomes. Counselling is not merely about instructing patients on how to take their medications;it also iinvolves actively engaging them in their tre atment plans. It is essential to ensure that patients feel supported,empowere d and fully informed about the correct use of their medications.

This approach promotes better understanding,adhere nce,and overall therapeutic outcomes.

This is linked to cs 2.2,bs C

Evidence 1a: Patient's progress notes from the doctor



I have concealed the patient's details to ensure confidentiality as mandated by the code of conduct in the Good Pharmacy Practice

These were the patient's vitals. She had come for review and collection of her hypertension medication.

The patient's blood glucose was 15,7mmol/L when first measured.after repeating it was 12,3mmol/L.

The patient was newly diagnosed with Diabetes Mellitus Type 2. This is linked to Competency Standard(CS)2.2,Behavioural Statement(BS)a

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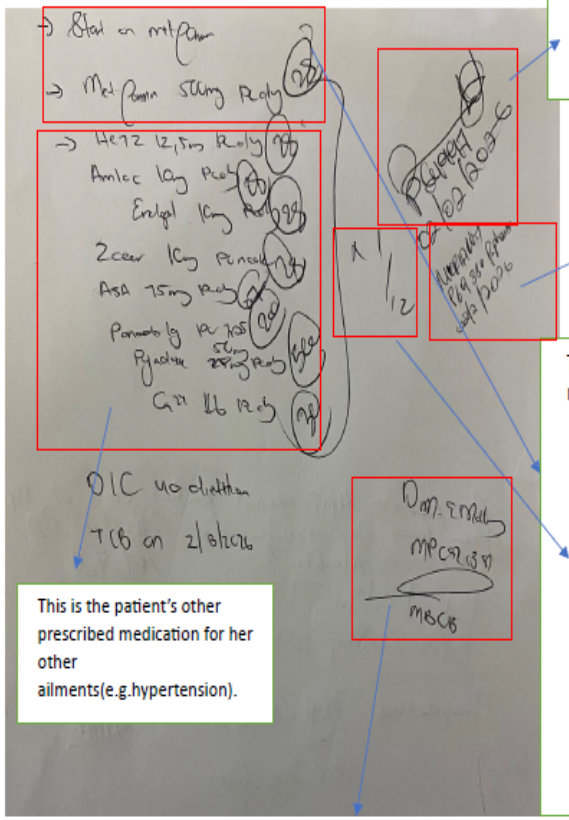
Step 3: Implementation Evidence 3

Evidence 1b: The prescription from the doctor who diagnosed the patient.



The pharmacist signed here to indicate that the dispensing was done under his supervision

My signature indicates that I dispensed the prescription and counselled the patient.

This is the patient's prescribed medication.This script indicates:

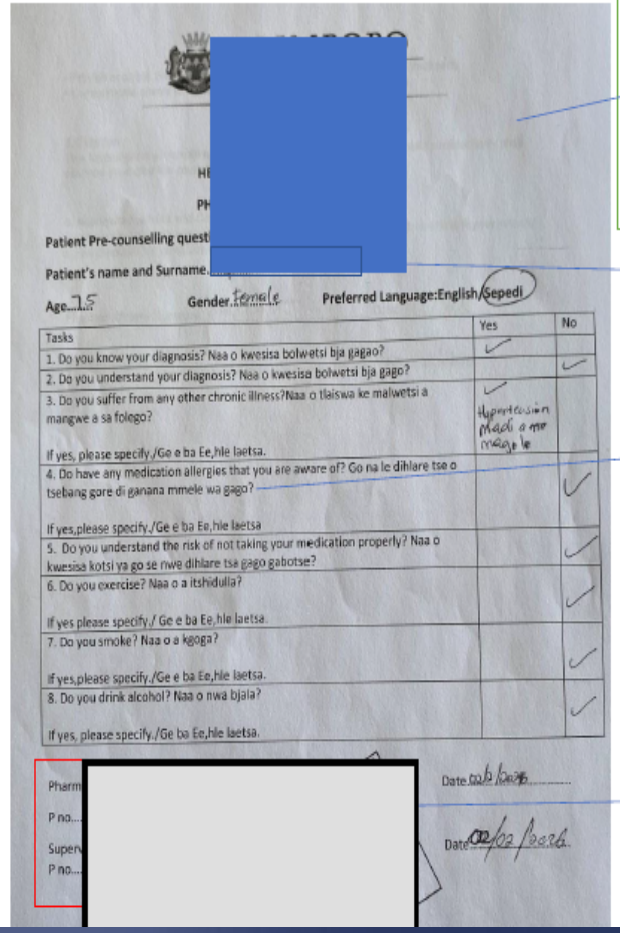
- **Medication name:**Metformin
- **Strength:**500mg
- **route of administration:**orally
- **duration:** one month
- **dosage frequency:**once a day

This confirms validity and legality of the prescription as according to SAMF 14th edition.

This is the patient's other prescribed medication for her other ailments(e.g.hypertension).

Prescriber's details(name,practice number,qualification and signature) to confirm that she made the diagnosis and prescribed the medication, this shows authenticity of the prescription.

Evidence 2: Patient Pre-counselling questionnaire



Patient Pre-counselling quest

Patient's name and Surname

Age...75 Gender.female Preferred Language:English/Sepedi

Tasks	Yes	No
1. Do you know your diagnosis? Naa o kwesisa bolwetsi bja gagao?	✓	
2. Do you understand your diagnosis? Naa o kwesisa bolwetsi bja gago?		✓
3. Do you suffer from any other chronic illness?Naa o tlaiswa ke malwetsi a mangwe a sa folego?	✓	
If yes, please specify./Ge e ba Ee,hle laetsa.	Hypertension Madi a mo magale le	
4. Do have any medication allergies that you are aware of? Go na le dihlare tse o tsebang gore di ganana mmele wa gago?		✓
If yes,please specify./Ge e ba Ee,hle laetsa		
5. Do you understand the risk of not taking your medication properly? Naa o kwesisa kotsi ya go se nwe dihlare tsa gago gabotse?		✓
6. Do you exercise? Naa o a itshidulla?		✓
If yes please specify./ Ge e ba Ee,hle laetsa.		
7. Do you smoke? Naa o a kgoga?		✓
If yes,please specify./Ge e ba Ee,hle laetsa.		
8. Do you drink alcohol? Naa o nwa bjala?		✓
If yes, please specify./Ge ba Ee,hle laetsa.		

Pharm

P no...

Super

P no...

Date 22/02/2026

Date 22/02/2026

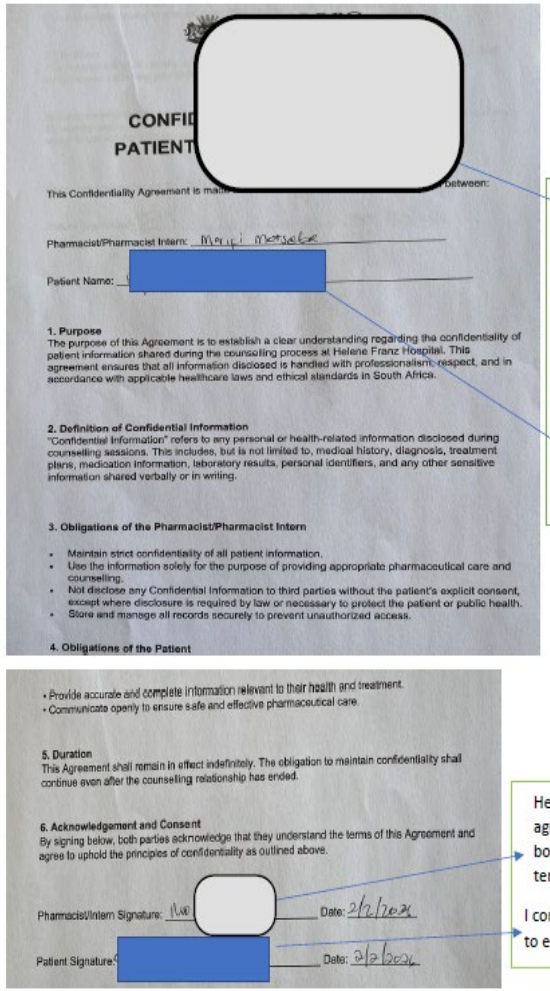
This is the Pre-counselling questionnaire that I asked the patient had to fill. I used it to establish the patient's understanding of their diagnosis so I can identify where the gap is, and to guide me in the counselling process. This is linked to CS 2.2,BSa

The patient's name is concealed to maintain confidentiality

I wrote the questions in both English and Sepedi because the hospital serves Sepedi-speaking patients mostly, also considering that this is an old patient aged 75 and might not understand English.

The supervising pharmacist signed to approve the counselling process after reading this questionnaire and having seen the need to counsel the patient.

Evidence 3: Confidentiality Agreement



CONFI
PATIENT

This Confidentiality Agreement is made between:

Pharmacist/Pharmacist Intern: Mercy Motsoeke

Patient Name:

1. Purpose
The purpose of this Agreement is to establish a clear understanding regarding the confidentiality of patient information shared during the counselling process at Helene Franz Hospital. This agreement ensures that all information disclosed is handled with professionalism, respect, and in accordance with applicable healthcare laws and ethical standards in South Africa.

2. Definition of Confidential Information
"Confidential Information" refers to any personal or health-related information disclosed during counselling sessions. This includes, but is not limited to, medical history, diagnosis, treatment plans, medication information, laboratory results, personal identifiers, and any other sensitive information shared verbally or in writing.

3. Obligations of the Pharmacist/Pharmacist Intern

- Maintain strict confidentiality of all patient information.
- Use the information solely for the purpose of providing appropriate pharmaceutical care and counselling.
- Not disclose any Confidential Information to third parties without the patient's explicit consent, except where disclosure is required by law or necessary to protect the patient or public health.
- Store and manage all records securely to prevent unauthorized access.

4. Obligations of the Patient

- Provide accurate and complete information relevant to their health and treatment.
- Communicate openly to ensure safe and effective pharmaceutical care.

5. Duration
This Agreement shall remain in effect indefinitely. The obligation to maintain confidentiality shall continue even after the counselling relationship has ended.

6. Acknowledgement and Consent
By signing below, both parties acknowledge that they understand the terms of this Agreement and agree to uphold the principles of confidentiality as outlined above.

Pharmacist/Intern Signature: Date: 2/2/2026

Patient Signature: Date: 2/2/2026

I drafted a confidentiality agreement to safeguard the privacy of discussions between the patient and myself,in full compliance with Code of Conduct for Pharmacists and other persons registered in terms of Pharmacy Act 53 of 1974.

I also concealed the patient's name to maintain confidentiality. This is linked to CS 2.2,BS f

Here the patient and I signed the agreement which shows that we both agree to comply with the terms stated

I concealed the patient's signature to ensure confidentiality.

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Step 3: Implementation Evidence 4

Evidence 4a: Standard Treatment Guidelines

8.5 DIABETES MELLITUS

DESCRIPTION
Types of diabetes:
» Type 1.
» Type 2.
» Other specific types, including pancreatic diabetes mellitus.
» Gestational diabetes mellitus: See Section 6.2: Diabetes mellitus in pregnancy.

GENERAL MEASURES
All patients require lifestyle modification.
Type 2 diabetes mellitus patients: weight loss if weight exceeds ideal weight.
Correct meal/energy distribution.
Moderate or no alcohol intake.
Encourage smoking cessation.
Increase physical activity, aim for 30 minutes per day 5 times a week.
Education about foot care is essential.
Manage comorbid depression. See Section 15.3.1: Depressive disorders.

Diagnosis
» In patients with symptoms of hyperglycaemia and any one of the following criteria:
– Random plasma glucose ≥11.1 mmol/l; or
– Fasting plasma glucose ≥7.0 mmol/l; or
– 2-hour plasma glucose in a 75 g oral glucose tolerance test ≥11.1 mmol/l.
» In asymptomatic patients any one of the following criteria, confirmed by a repeat test on a separate day within 2 weeks:
– Fasting plasma glucose ≥7.0 mmol/l; or
– 2-hour plasma glucose in a 75 g oral glucose tolerance test ≥11.1 mmol/l.

LoE:III*

Classification:
After diabetes mellitus has been diagnosed, attempts must be made to classify the patient as type 1, type 2 or one of the other specific types (including pancreatic diabetes, genetic syndromes, infection and other causes). For management of gestational diabetes, see Section 6.2: Diabetes mellitus in pregnancy.

I read these highlighted sections on Standard Treatment Guidelines(2024),Hospital level, Adults Chapter 8.5 to enhance my knowledge on Diabetes Mellitus.

I familiarised myself with the lifestyle modifications that diabetic patients should incorporate into their daily lives to ensure better managementof the condition, and I explained these measures to the patient during the counselling.

process.

This is linked to CS 2.2,BSa&b

Evidence 4a continuation

CHAPTER 8 ENDOCRINE DISORDERS

TARGETS FOR CONTROL
Glycaemic targets for control:

Patient type	Target HbA1c	Target FPG*	Target PPG*
• Young, low risk • Newly diagnosed • No CVS disease	<6.5%	4.0–7.0 mmol/L	4.4–7.8 mmol/L
• Majority of patients	<7.0%	4.0–7.0 mmol/L	5.0–10.0 mmol/L
• Elderly • High risk • Hypoglycaemic unawareness • Poor short-term prognosis	<7.5%	4.0–7.0 mmol/L	<12.0 mmol/L

*FPG: fasting plasma glucose; PPG: post prandial plasma glucose.

Non-glycaemic targets:
» BMI ≤25 kg/m².
» BP ≤140/90 mmHg and ≥120/70 mmHg.

In the elderly, the increased risk of hypoglycaemia must be weighed against the potential benefit of reducing microvascular and macrovascular complications.
In patients with severe target organ damage, therapy should be tailored on an individual patient basis and should focus on avoiding hypoglycaemia.

REFERRAL
» Inability to achieve optimal metabolic control.
» Complications that cannot be managed on site, especially ophthalmic, e.g. cataracts and proliferative retinopathy.
» Recurrent severe hypoglycaemia.

8.5.1 TYPE 2 DIABETES MELLITUS
E11.0-9/E12.0-9/E13.0-9/E14.0-9

Management includes:
» Treatment of hyperglycaemia.
» Treatment of hypertension and dyslipidaemia after risk-assessment. See Section 3.6: Hypertension.
» Prevention and treatment of microvascular complications.
» Prevention and treatment of macrovascular complications.

This is a continuation from the STG,Hospital Level,Adults(2024), Chapter 8.5.

I used this section to familiarise myself with the glycaemic targets for control and the non-glycaemic targets.I explained these to patient so she understands what our targets were for her as elderly person.

This is linked to CS 2.2,BSa&b

Evidence 4a continuation

CHAPTER 8 ENDOCRINE DISORDERS

» Titrate dose slowly depending on HbA1c and/or fasting blood glucose levels to 15 mg daily.
» When ≥7.5 mg per day is needed, divide the total daily dose into 2, with the larger dose in the morning.
» Avoid in the elderly and patients with renal impairment (i.e. eGFR <60 mL/minute).

LoE:III*

Oral agents should not be used in type 1 diabetes and should be used with caution in liver and renal impairment.
Metformin should be dose adjusted in renal impairment.
Monitor patients on sulphonylurea derivatives and concomitant rifampicin and dose-adjust sulphonylurea as required. When rifampicin is discontinued, monitor for risk of hypoglycaemia and dose adjustment is required, particularly in the elderly.

Monitor serum creatinine and estimated eGFR three monthly in patients with kidney disease.

Insulin therapy in type 2 diabetes
Indications for insulin therapy:
» Inability to control blood glucose pharmacologically, i.e. combination/substitution insulin therapy.
» Temporary use for major stress, e.g. surgery, medical illness.
» Severe kidney or liver disease.
» Pregnancy.

Note:
» At initiation of insulin therapy, give appropriate advice on self-blood glucose monitoring (SBGM) and diet.
» It is advisable to maintain all patients on metformin once therapy with insulin has been initiated.

Insulin type	Starting dose	Increment	Max. daily dose
Add on therapy: • Intermediate to long-acting insulin	10 units, (or 0.3 units/kg/day), in the evening before bedtime, but not after 22h00.	If the starting dose is not effective increase by 2-4 units per dose every 3 to 7 days until fasting glucose is in the target range.	Refer if recurrent hypoglycaemia occurs and targets for control are not met.
Substitution therapy: • Biphasic insulin (30/70 mix)	Total daily dose: 0.3 units/kg/day divided as follows: • 2/3 of total daily dose 30 minutes before breakfast. • 1/3 of total daily dose 30 minutes	4 units weekly.	Refer if recurrent hypoglycaemia occurs and targets for control are not met.

This is a continuation from the STG,Hospital Level,Adults(2024), Chapter 8.5.

I used it to familiarise myself with the treatment approach for Diabetes Mellitus Type 2. This section indicates that,should oral agents fail to control the condition when being used alone, insulin should be added to the treatment regimen and the sulphonylurea removed.

This is linked to CS 2.2,BSa&b

Evidence 4a continuation

CHAPTER 8 ENDOCRINE DISORDERS

Monitoring
At every visit: LoE:III*
» Finger-prick blood glucose.
» Weight and calculation of body mass index.
» Waist circumference.
» Blood pressure.

Baseline:
» Serum creatinine concentration (and calculate estimated glomerular filtration rate (eGFR)).
» Serum potassium concentration, if on ACE-inhibitor or eGFR <30 mL/minute.
» Urine protein by dipstick.
– If dipstick negative, request ACR, unless already on an ACE-inhibitor - microalbuminuria is defined as 2.5 to 25 mg/mmol in men, and 3.5 to 35 mg/mmol in women (see Section 8.7.2: Diabetic kidney disease).
– If dipstick positive, see Section 8.7.2: Diabetic kidney disease.
» Blood lipids (fasting total cholesterol, triglycerides, HDL and LDL cholesterol).
» Foot examination.
» Eye examination to look for retinopathy.
» Waist circumference.

Measure HbA1c:
» 6-monthly in patients who meet treatment goals, and
» 3-monthly in patients whose control is sub-optimal or if therapy has changed, until stable.
Note: Monitoring of HbA1c implies that active clinical management will be implemented if the level is sub-optimal.

Annually:
» Serum creatinine concentration (and calculate eGFR).
» Serum potassium concentration (if on ACE-inhibitor/ eGFR <30 mL/minute).
» Urine protein by dipstick. LoE:III*
– If dipstick negative, request ACR, unless already on an ACE-inhibitor - microalbuminuria is defined as 2.5 to 25 mg/mmol in men, and 3.5 to 35 mg/mmol in women (see Section 8.7.2: Diabetic kidney disease).
– If dipstick positive, see Section 8.7.2: Diabetic kidney disease.
» Eye examination to look for retinopathy.
» Foot examination.
» Assessment for peripheral neuropathy.
» Oral and dental examination.
» Assessment for macrovascular disease.
» Resting ECG.

This is a continuation from the STG,Hospital Level,Adults(2024) Chapter 8.5,here it indicates the monitoring parameters that should be done monthly,6month or at all visits.

This is linked to CS 2.2,BSa&b

Evidence 4a continuation

CHAPTER 8 ENDOCRINE DISORDERS

MEDICINE TREATMENT
Oral blood glucose lowering drugs
Metformin is the preferred initial medicine and is added to the combination of dietary modifications and physical activity/exercise. If metformin, in maximal dose, with diet and exercise fails to lower HbA1c to target, a second agent should be added. This second agent may be either a sulphonylurea, or basal insulin. The specific indication is dependent on individual circumstances.

If a combination of two agents fails to lower HbA1c to target, a third agent is added. The preferential sequence of agents to use is metformin, followed by the addition of sulphonylurea, followed by the addition of basal insulin.

If the combination of two oral agents and basal insulin fails to lower HbA1c to target, or if other reasons to adjust therapy exist (such as nocturnal hypoglycaemia), then intensified insulin therapy in consultation with a specialist is required (either twice daily pre-mix, or basal-bolus therapy) and sulphonylureas are discontinued.

Note: Secondary failure of oral agents occurs in about 5–10% of patients annually.

Metformin
• Metformin, oral, 500 mg twice daily with meals.
○ Adjust dose based on fasting blood glucose levels and/or HbA1c to a maximum dose of 850 mg 8 hourly.
○ Monitor renal function. LoE:I*
○ Dose-adjust in renal impairment as follows:

eGFR	Metformin dose
» eGFR >60 mL/min:	Normal daily dose (see above).
» eGFR 45–60 mL/min:	Standard dose, measure eGFR 3–6 monthly.
» eGFR 30–45 mL/min:	Maximum dose 1 g per day; measure eGFR 3–6 monthly.
» eGFR <30 mL/min:	Stop metformin.

○ Contra-indicated in:
– renal impairment i.e. eGFR <30 mL/minute, LoE:III*
– uncontrolled congestive cardiac failure,
– severe liver disease,
– patients with significant respiratory compromise, or
– peri-operative cases.

Sulphonylurea derivatives: glimepiride or glibenclamide.
• Glimepiride, oral, 1 mg daily.
○ Titrate the dose by 1 mg at weekly intervals up to 6 mg daily (according to blood glucose levels). LoE:III**
○ Usual dose: 4 mg daily.
○ Maximum dose: 8 mg daily.
OR
• Glibenclamide, oral, 2.5 mg daily 30 minutes before breakfast.

8.8

This is a continuation from the STG,Hospital Level,Adults(2024), Chapter 8.5.

I used it to familiarise myself with the treatment approach for Diabetes Mellitus Type 2. This section indicates which medication to initiate newly diagnosed patients on as first line therapy, followed by second-line agents if patients do not show optimal response. It also outlines the contraindications and drug monitoring parameters for each drug used for Diabetes Treatment.

This is linked to CS 2.2,BSa&b

Evidence 4a continuation

CHAPTER 8 ENDOCRINE DISORDERS

Insulin type	Starting dose	Increment	Max. daily dose
	before supper. LoE:III**	Second increment is added to dose before supper.	
Basal bolus insulin therapy	Start with 0.4 to 0.6 units/kg and divide this total daily dose into 50% basal and 50% bolus, using equal pre-meal doses	Basal insulin is adjusted according to fasting glucose levels and bolus insulin is adjusted according to pre- and post-meal glucose, using the patient's home glucose record as a guide.	Refer if recurrent hypoglycaemia occurs and targets for control are not met.

Also see insulin protocols as in Section 8.5.2: Type 1 diabetes mellitus. LoE:III**

Note: Insulin requirements decrease in patients with chronic renal impairment. In these situations, blood glucose monitoring must be done regularly (at least daily) in order to reduce the dose appropriately, reducing the risk of hypoglycaemia.

To reduce cardiovascular risk
See Section 8.8: Dyslipidaemia.

Renal impairment
If urine ACR ≥2.5 mg/mmoL (men) or >3.5 mg/mmoL (women):
Start treatment with a low dose of ACE-inhibitor and titrate up to the maximum tolerated dose.
ADD LoE:I**
• ACE-inhibitor, e.g.:
• Enalapril, oral.
○ Start with 5 mg 12 hourly and titrate to 20 mg 12 hourly, if tolerated (depending on BP and ACR). LoE:III**
See Section 7.1.1: Chronic Kidney Disease.

If an ACE-inhibitor is not tolerated due to intractable cough, consider an angiotensin II receptor blocker. See Section 7.1.1: Chronic Kidney Disease.

8.5.2 TYPE 1 DIABETES MELLITUS
E10.0-9/ E12.0-9/E13.0-9/E14.0-9

Management includes:
» Maintenance of glycaemic control within acceptable limits.

This is a continuation from the STG,Hospital Level,Adults(2024), Chapter 8.5.

I with the treatment approach for Diabetes Mellitus. used it to familiarise myself

This is linked to CS 2.2,BSa&b

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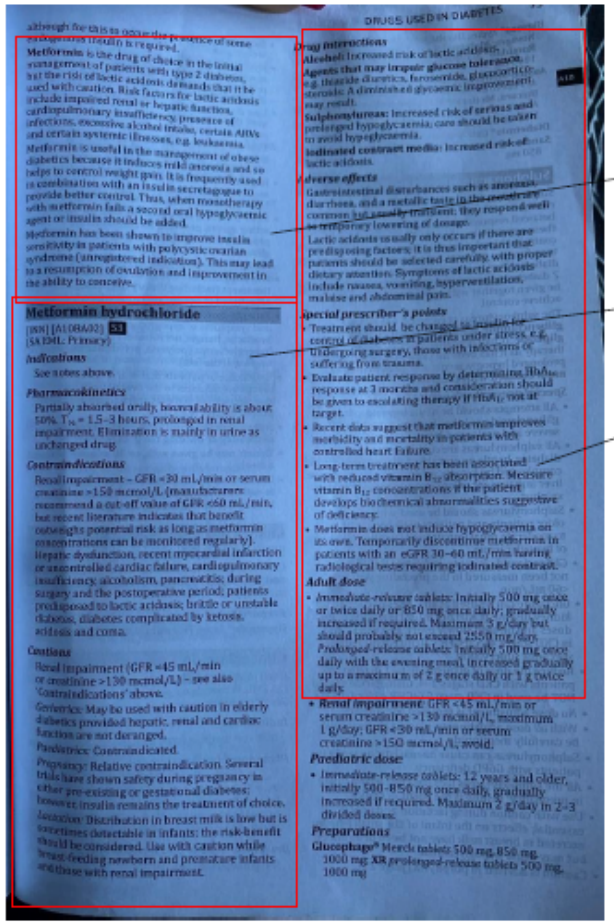
Step 3: Implementation Evidence 5

Evidence 4b: South African Medicines Formulary



DRUGS USED IN DIABETES

Metformin hydrochloride

Indications

Pharmacokinetics

Contraindications

Cautions

Special prescriber's points

Adult dose

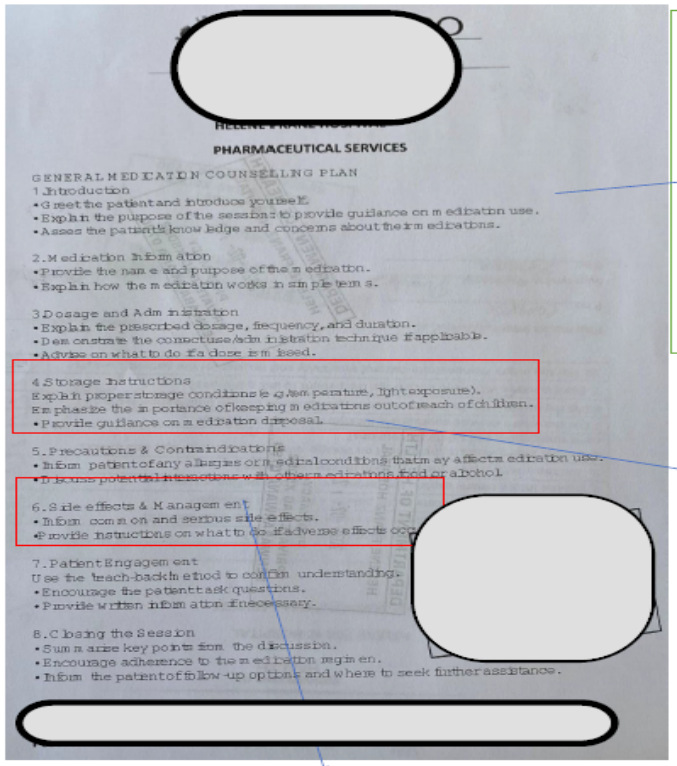
Paediatric dose

Preparations

I read this highlighted section on South African Medicines Formulary (13th Edition,page 77-78) about Metformin which,according to the recent STG is the first line treatment for all newly diagnosed Diabetes Mellitus Type 2 patients. This helped me enhance my knowledge of the side effects,the contraindications,the special populations,drug interactions and adverse effects as well as the adult dose adjustments and special prescriber's points.I incorporated all this information into the counselling process to ensure optimal furnishing of correct and relevant information to the patient.

This is linked to CS 2.2,BSa&b

Evidence 5a: General Counselling Plan



PHARMACEUTICAL SERVICES

GENERAL MEDICATION COUNSELLING PLAN

1. Introduction
   - Greet the patient and introduce yourself.
   - Explain the purpose of the session: to provide guidance on medication use.
   - Assess the patient's knowledge and concerns about their medications.

2. Medication Information
   - Provide the name and purpose of the medication.
   - Explain how the medication works in simple terms.

3. Dosage and Administration
   - Explain the prescribed dosage, frequency, and duration.
   - Demonstrate the correct use/administration technique if applicable.
   - Advise on what to do if a dose is missed.

4. Storage Instructions
   Explain proper storage conditions (e.g., temperature, light exposure).
   Emphasize the importance of keeping medications out of reach of children.
   - Provide guidance on medication disposal.

5. Precautions & Contraindications
   - Inform patient of any allergies or medical conditions that may affect medication use.
   - Discuss potential interactions with other medications, food or alcohol.

6. Side effects & Management
   - Inform common and serious side effects.
   - Provide instructions on what to do if adverse effects occur.

7. Patient Engagement
   Use the 'teach-back' method to confirm understanding.
   - Encourage the patient to ask questions.
   - Provide written information if necessary.

8. Closing the Session
   - Summarize key points from the discussion.
   - Encourage adherence to the medication regimen.
   - Inform the patient of follow-up options and where to seek further assistance.

This is the generalised medication counselling plan which I had created which incorporated all the aspects that I was going to cover when counselling. **This is linked to CS 2.2,BS d**

I generalised it as I created this plan prior and by that time I did not know the condition and the medication that I was going to counsel the patient on.

Most crucial part of counselling is providing the patient with the duration of treatment, dose to be administered and frequency to prevent errors that could be threatening life and ensure correct medicine use and optimal response.

This is linked to CS 2.2,BS b.

On the counselling plan I included the side effects & management section so they can be aware of common side effects associated with their medication and which ones they have to immediately report if they occur. **This is linked to CS 2.2,BS b.**

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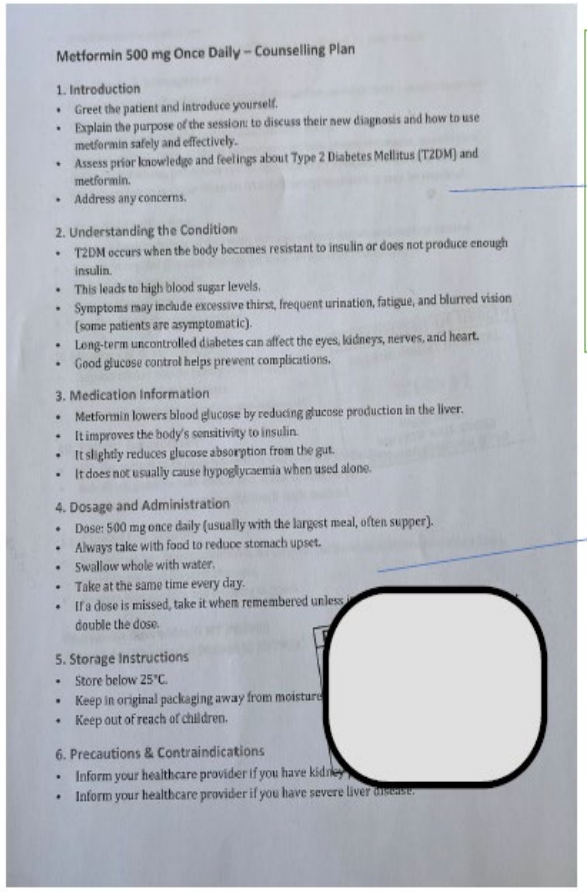
Step 3: Implementation Evidence 6

Evidence 5b: Adjusted Patient counselling plan



Metformin 500 mg Once Daily – Counselling Plan

1. Introduction
- Greet the patient and introduce yourself.
- Explain the purpose of the session: to discuss their new diagnosis and how to use metformin safely and effectively.
- Assess prior knowledge and feelings about Type 2 Diabetes Mellitus (T2DM) and metformin.
- Address any concerns.

2. Understanding the Condition
- T2DM occurs when the body becomes resistant to insulin or does not produce enough insulin.
- This leads to high blood sugar levels.
- Symptoms may include excessive thirst, frequent urination, fatigue, and blurred vision (some patients are asymptomatic).
- Long-term uncontrolled diabetes can affect the eyes, kidneys, nerves, and heart.
- Good glucose control helps prevent complications.

3. Medication Information
- Metformin lowers blood glucose by reducing glucose production in the liver.
- It improves the body's sensitivity to insulin.
- It slightly reduces glucose absorption from the gut.
- It does not usually cause hypoglycaemia when used alone.

4. Dosage and Administration
- Dose: 500 mg once daily (usually with the largest meal, often supper).
- Always take with food to reduce stomach upset.
- Swallow whole with water.
- Take at the same time every day.
- If a dose is missed, take it when remembered unless [redacted] double the dose.

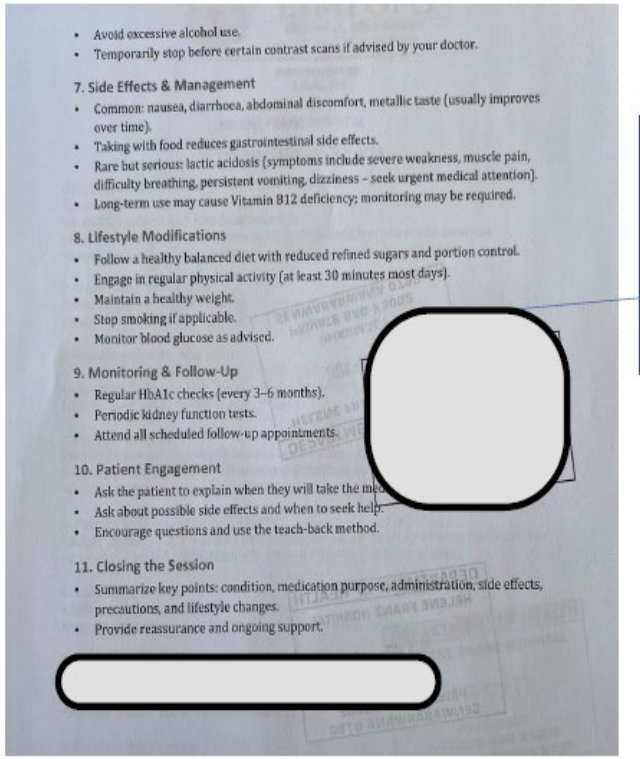
5. Storage Instructions
- Store below 25°C.
- Keep in original packaging away from moisture
- Keep out of reach of children.

6. Precautions & Contraindications
- Inform your healthcare provider if you have kidney [redacted]
- Inform your healthcare provider if you have severe liver disease.

After finding out that the patient was diabetic, I quickly adjusted the counselling plan to include information about the Metformin that I was going to counsel her about. **This is linked to CS 2.2,BS d**

I used this adjusted plan to maximise the counselling of the patient based on her needs. Counselling took place in a private area to provide the patient a space where they could comfortably share sensitive information with me as the counsellor. **This is linked to CS 2.2,BS d&e**

Evidence 5b continuation: Counselling plan



- Avoid excessive alcohol use.
- Temporarily stop before certain contrast scans if advised by your doctor.

7. Side Effects & Management
- Common: nausea, diarrhoea, abdominal discomfort, metallic taste (usually improves over time).
- Taking with food reduces gastrointestinal side effects.
- Rare but serious: lactic acidosis (symptoms include severe weakness, muscle pain, difficulty breathing, persistent vomiting, dizziness – seek urgent medical attention).
- Long-term use may cause Vitamin B12 deficiency; monitoring may be required.

8. Lifestyle Modifications
- Follow a healthy balanced diet with reduced refined sugars and portion control.
- Engage in regular physical activity (at least 30 minutes most days).
- Maintain a healthy weight.
- Stop smoking if applicable.
- Monitor blood glucose as advised.

9. Monitoring & Follow-Up
- Regular HbA1c checks (every 3–6 months).
- Periodic kidney function tests.
- Attend all scheduled follow-up appointments.

10. Patient Engagement
- Ask the patient to explain when they will take the me
- Ask about possible side effects and when to seek help.
- Encourage questions and use the teach-back method.

11. Closing the Session
- Summarize key points: condition, medication purpose, administration, side effects, precautions, and lifestyle changes.
- Provide reassurance and ongoing support.

This is a continuation of the counselling plan I used. **This is linked to CS 2.2,BS d**

Evidence 6a: Counselling Guide

IN CONSULTATION

A counselling checklist will help you provide the information your patients need to take their medications properly. The more pharmacists educate their patients, the more likely those patients are to comply with their treatment regimens.

Effective patient counselling

by Bruce Berger

Effective patient counselling is not simply the provision of information. Information is prerequisite to compliance, but the timing and organization of the message and involvement of the patient are also critical in determining what the patient understands and remembers.

The counselling encounter should be thought of as an opportunity for information exchange. You are the expert on drug therapy, but patients are experts on their daily routines, how they understand their illness and its treatment, whether they anticipate any problems taking the medicine as prescribed, and so forth. Each of these points needs to be assessed if counselling is to be effective. The counselling checklist provided here was developed to increase the probability that the patient will comply with the treatment regimen. It is assumed that before the pharmacist counsels the patient, he or she will first assess the appropriateness of the drug therapy.

Patient counselling checklist

✓ **Introduce yourself:** It is important for patients to know they are speaking to the pharmacist. They may be reluctant to ask questions or express concerns if they believe they are speaking to a technician or clerk. Pharmacists should greet the patient. Extend your hand, and state your name: 'Hello, I'm James Smith, your pharmacist.' This begins the relationship.

✓ **Identify to whom you are speaking:** If you are talking to the patient directly, information is less likely to be confused or distorted than if you are talking to the patient's agent, who must pass the information on to the patient. In third party communication, written information becomes even more important than when directly communicating with the patient. Pharmacists may need to call patients if they believe that the information truly needs to be communicated directly to them.

✓ **Ask if the patient has time to discuss the medicine:** If patients do not have time to listen, the information will be ineffective. The information should be written and/or the patient should be contacted at a more convenient time. For a new patient, a data-base should be established so that appropriate decisions may be made in the future.

✓ **Explain the purpose/importance of the counselling session:** People listen and learn more effectively when they are given reasons for what is being asked of them. For example, patients are less likely to take tetracycline with food or dairy products if they are told that decreased absorption and effectiveness of the drug may result. For new patients, it will be necessary to explain why the information being gathered is needed.

✓ **Ask the patient what the doctor told him/her about the drug and what condition it is treating:** Find out what the patient knows or understands about his or her disease. There

Often, patients will not vocalize concerns about the drug(s) they are about to take or the condition the doctor is treating unless they are asked.

About the author
Bruce Berger, PhD is professor, School of Pharmacy, Auburn University, Auburn, USA.

I read this article on to provide effective patient counselling. This was to develop my communication skills and active listening skills.This helped me enhance my ability to deliver high-quality counselling and appropriately advise the patient on the safe and proper use of her medication.

This is linked to CS 2.2,BS c& f

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Step 3: Implementation Evidence 7

Evidence 6b: listening skills/techniques

3. COUNSELLING SKILLS
In order to learn how to be helpful to someone in distress, there are some useful counselling skills outlined below. The more the skills are practised, the easier they are to use.

3.1 Listening skills

"Diagnosis helps the doctor, but for the patient, the crucial thing is the story."
Carl Jung

"A good listener is not only popular everywhere, but after a while he knows something."
Wilson Mizner

"There is none so blind as those who will not listen."
William Slater

Activity: *Listening*
Have you ever had a helpful experience when you talked with someone about a problem? It could have been a friend or family member who simply listened to you. They did not give you a solution, give advice or tell you what to do. They simply listened while you talked about your thoughts and feelings. Afterwards you felt better, just because you talked about it and felt heard. **Sometimes, just the experience of talking to someone who listens can be healing.**

3.1.1 Active listening
Active listening happens when you "listen for meaning". The listener says very little but conveys empathy, acceptance and genuineness. The listener only speaks to find out if they have heard or understood correctly.

Key points about empathic listening:
- Listening is *active*.
- There is more to listening then simply not talking, or lending your ears to somebody.
- There are *verbal* and *non-verbal* components to listening. You can listen without saying anything.
- Listening involves more than just one *sense*. It is not just hearing with your ears, but also involves observing with your eyes and saying things at times. It can include touch as well.
- Active listening is also *communicating* what you have heard and understood.

Why should we use active or empathic listening?
- Empathic listening encourages the woman to talk more about her issues. This allows you as a helper to gain a better understanding of the difficulties and her view of the world.
- It leaves the woman with the understanding that she has been heard. Just the experience of being heard can be healing.
- Active listening helps establish a relationship between client and helper.

Empathic or active listening involves:
- Participating in the world of the other person and being a part of what that person is experiencing.
  - Hearing words but also listening to how the words are being said.
  - What tone of voice is being used?
  - What words are being used to describe the experience?
  - What body language is the person displaying?
  - What shows on their face?
  - What do their hand movements show?
  - Do the words flow or are there lots of hesitations?
- Listening to what is **not** being said, or listening to the silences.
- In counselling, caring or empathic listening is an experience where your whole being becomes tuned into the world and experience of another person.
- A combination of empathy and listening is a basic requirement for all counselling behaviour and in **itself** is often very therapeutic for the client.
- There is healing power in being listened to, and in being able to talk and be heard by another.

Additionally I read the journal article titled *Basic Counselling Skills in the South African Medical Journal (pages 8-13).* This section enhanced my understanding of active listening techiques,which I subsequently applied when communicating with patients.

This is linked to CS 2.2.BS c & g

This is a continuation of my reading of the journal article *Basic Counselling Skill(pages 8-13) in the South African Medical Journal,* which further guided me on how to practice active listening during patient counselling.

This is linked to CS 2.2.BS c & g

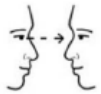
Evidence 5b Continuation

What gets in the way of active or empathic listening?
- Being selective: not listening to the full message of what is being said, but "hearing" only what you want to hear.
- Being distracted: appearing to listen when really your mind is a million kilometres away and you have not actually heard a word that has been said.
- Personal values (what we believe to be important): each of us has different values.
- What is happening in your own life: this may change your perspective about what the woman is going through.
- Preparing a response: if you are preparing what you will say next, you cannot be listening to the woman.
- Feeling threatened by what the woman is saying.
- Culture: sometimes the woman's culture is different to ours.
- Language: many times we are not speaking in our own language and there can be communication difficulties with this.

3.1.2 Verbal listening
Minimal verbal response: These are verbal responses showing that you are listening. Verbal responses include: "mmm...mmm," "uh-huh," or "yes."

These minimal responses show the woman that you are listening to her, and encourages her to continue talking.

3.1.3 Non-verbal listening
The SOLERF method is a useful way to "listen" without speaking.



S	**Squarely** face person - not turned to the side.
O	use **Open** posture without crossed arms and legs.
L	**Lean** slightly toward the person rather than sitting back in the chair.
E	use **Eye** contact instead of staring off into deep space.
R	**Relax**, keep it natural instead of sitting like a board.
F	look **Friendly** and welcoming rather than neutral or scowling.

Remember:
Communication is 55% body language, 38% tone and 7% words. Your client may not remember what was **said**, but they will remember how you made them **feel**.

Learning Point: Active listening means that you concentrate on what is being said – **not** on what you need to say or do.

This is a continuation of my reading of the journal article *Basic Counselling Skill(pages 8-13) in the South African Medical Journal.*

The article increased my awareness of the importance of non-verbal cues when communicating with patients. I therefore applied both verbal and non-verbal listening techniques during counselling to demonstrate attentiveness and ensure patients felt heard and understood.

This is linked to CS 2.2.BS c & g

Evidence 5b Continuation

3.2 Asking questions
The questions we ask - open and closed - are important for counselling. They can help a person open up or close them down.

Open question: is used in order to gather lots of information – you ask it when you want to get a long answer.

Closed question: is used to get specific information - it can normally be answered with either a single word or a short phrase.

3.2.1 Open questions
Open-ended questions have no correct answer and require an explanation.

For example:
- What brought you in here today?
- How do you feel about this pregnancy?
- How does that make you feel?

Open Ended Questions are good for:
- Starting the information gathering part of the session
- Keeping the client talking

3.2.2 Closed questions
Closed questions are those that can easily be answered with a "yes" or a "no" or brief information.

For example:
- What is your name and date of birth?
- Is this pregnancy planned?
- Where do you work?
- Are you ready to stop doing that?

Closed questions are useful for:
- For getting necessary information
- To help the woman to focus their discussion.

This is a continuation of my reading of the journal article *Basic Counselling Skill(pages 8-13) in the South African Medical Journal.*

This section of the journal guided me on how to ask appropriate and open-ended questions during counselling session,enabling the patient to feel comfortable and encouraging her to share their concerns more openly.

This is linked to CS 2.2.BS c & g

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Step 3: Implementation Evidence 8

Evidence 6c lifestyle modification pamphlet

LIVING WELL WITH TYPE 2 DIABETES

Simple Daily Habits to Keep Your Blood Sugar Under Control

Healthy Eating
- Eat regular meals, avoid sugary foods & drinks.
- Avoid sugary foods & drinks.
- Choose whole grains.
- Fill half your plate with veggies.
- Include lean proteins.
- Watch portion sizes.

Physical Activity
- At least 30 mins most days.
- Start slowly, increase gradually.
- Be consistent.

Monitor Blood Sugar
- Check your levels.
- Keep a log book.
- Attend clinic visits.

Weight Management
- Lose 5–10% of your weight.
- Eat healthy & exercise.

Take Medication
- Take as prescribed.
- Don't skip doses.

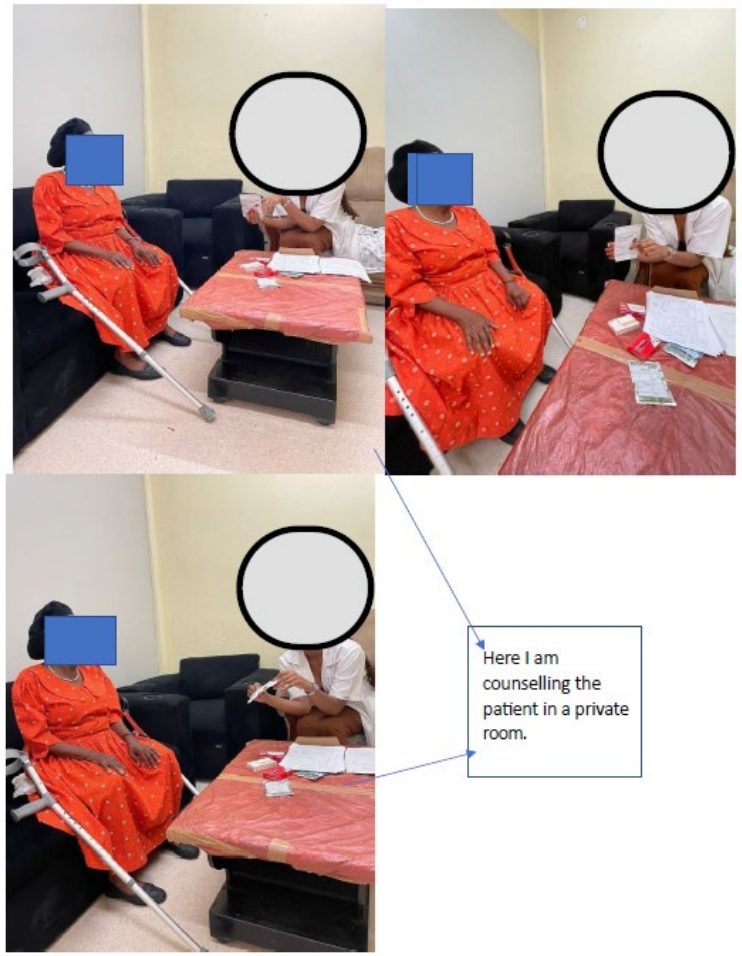
Reduce Health Risks
- Quit smoking.
- Limit alcohol.
- Check your feet daily for cuts or wounds.
- Wear comfortable, well-fitting shoes.

When to Seek Medical Help
- Very high blood sugar.
- Blurred vision or fatigue.
- Non-healing wounds.

***Diabetes** can be controlled.*
Healthy choices protect your heart, kidneys, eyes, eyes & nerves.

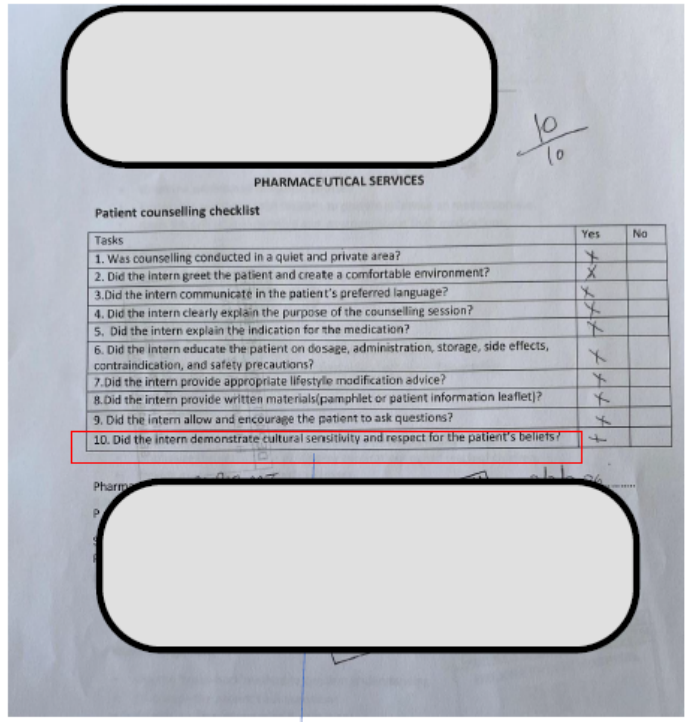
I printed out this pamphlet and used it as a visual aid to emphasise the necessary lifestyle modifications required to achieve and maintain normal blood sugar levels. **This is linked to CS 2.2.BS e & h**

Evidence 7a: counselling the patient.



Here I am counselling the patient in a private room.

Evidence 8:Counselling checklist



PHARMACEUTICAL SERVICES

Patient counselling checklist

Tasks	Yes	No
1. Was counselling conducted in a quiet and private area?	✓	
2. Did the intern greet the patient and create a comfortable environment?	✓	
3.Did the intern communicate in the patient's preferred language?	✓	
4. Did the intern clearly explain the purpose of the counselling session?	✓	
5. Did the intern explain the indication for the medication?	✓	
6. Did the intern educate the patient on dosage, administration, storage, side effects, contraindication, and safety precautions?	✓	
7.Did the intern provide appropriate lifestyle modification advice?	✓	
8.Did the intern provide written materials(pamphlet or patient information leaflet)?	✓	
9. Did the intern allow and encourage the patient to ask questions?	✓	
10. Did the intern demonstrate cultural sensitivity and respect for the patient's beliefs?	✓	

This checklist was completed by the supervising pharmacist to assess my counselling performance and ensure that I adhered to the counselling plan in order to maximise the effectiveness of each session.

The supervising pharmacist confirmed that I respected the patient's unique background,,values and beliefs about health,and that I communicated in a manne that demonstrated cultural sensitivity and professionalism.

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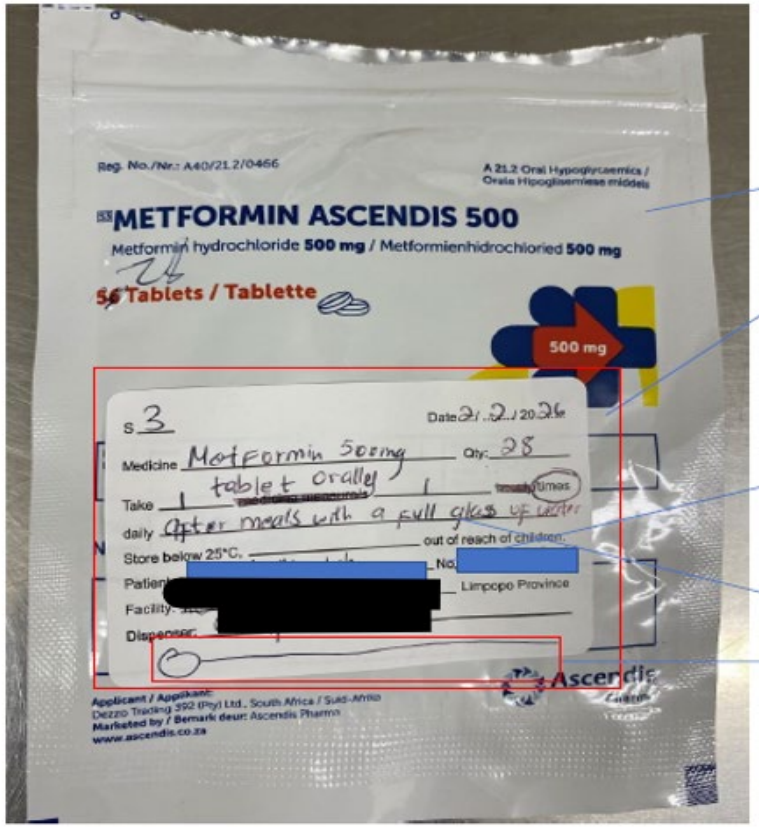
Step 3: Implementation Evidence 9

Evidence 9: labelled metformin



This is the labelled Metformin that I dispensed to the patient.

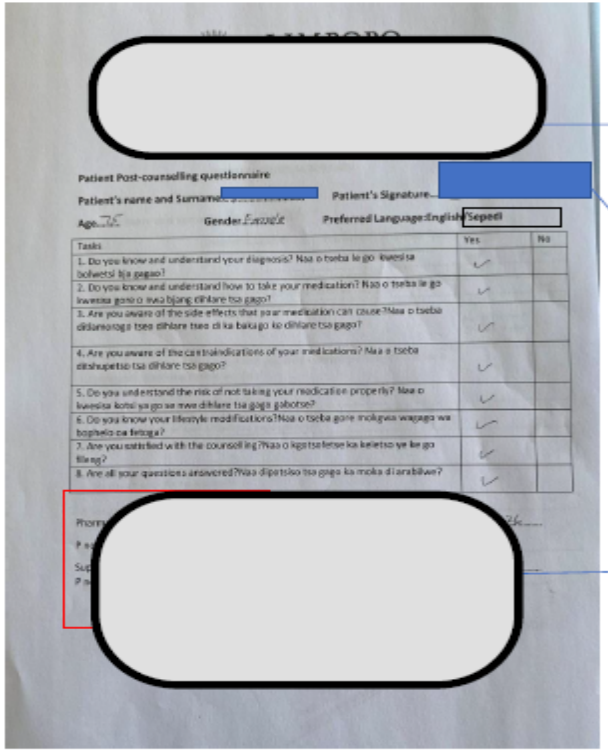
The schedule,name,strength,and quantity of the diabetes medication,the label also indicates storage conditions.

I concealed the patient's name and file number to maintain confidentiality

I wrote the instructions and drew one circle as a visual cue to help the patient understand how to take the medication.

This is linked to CS 2.2,BS e,h

Evidence 10: Post-counselling checklist



I used this questionnaire to obtain feedback from the patient and confirm that the patient fully understood the information I shared with her.

From the feedback,it shows that she understood everything that was discussed during the counselling.

I concealed the patient's details to maintain confidentiality.

The supervising pharmacist signed show that everything was done under her supervision. I also signed to show that I was the one doing whole counselling to the

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Assessor/Moderator comments

Step 3: Implementation

Requirement met.

- The description is clear and describes what, where, how, and when it was done. It also refers to evidence items E1–E10 and links activities to behavioural statements.
- In your description, you refer to a male patient (he), but your evidence shows a female patient.
- How do the extracts from the SAMF and STG determine the need for counselling (behavioural statement (a)?
- There is also no clear evidence of how you have used effective communication techniques (such as active and reflective listening).
- Although the intern was successful for this submission, to further improve, one should consider adding evidence on softer skills, e.g., listening effectively, using active and reflective listening techniques, eye contact, and establishing rapport.

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Assessor/Moderator comments

Step 3: Implementation

Requirement partially met.

- How the pamphlet was used to support counselling.
- History taking is necessary to have a basic understanding of other diseases the patient has.
- Outdated resource (GPP) for the scope of practice was included in the evidence. Always use the most recent resource.
- Pharmacist Interns practice the scope of a pharmacist under supervision, not that of a PT.

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Step 4: Evaluation

This deepened my understanding of diabetes and use of metformin, particularly the importance of explaining treatment in a way that is meaningful to a newly diagnosed patient. Through reviewing the evidence and counselling the patient, I realised that effective counselling is not only about medicine information, but also about listening, reassurance, and supporting patients as they adjust to a new diagnosis. I have since applied this learning by taking more time to assess patients' understanding, addressing their concerns, and adapting my counselling approach to suit individual needs. This has improved my confidence and helped me build better rapport with patients. As a result, my practice has become more patient-centred and thoughtful, with more emphasis on clear communication, confidentiality, and adherence support. I have identified a further learning need to improve my time management during counselling and to continue developing my knowledge of chronic disease management and patient education.

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Assessor/Moderator comments

Step 4: Evaluation

Requirement met.

- The focus should be on the skills learned rather than the activity.
- You need to give a specific example of how you applied your learning in a new situation.

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Any questions?

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Time for a quick break

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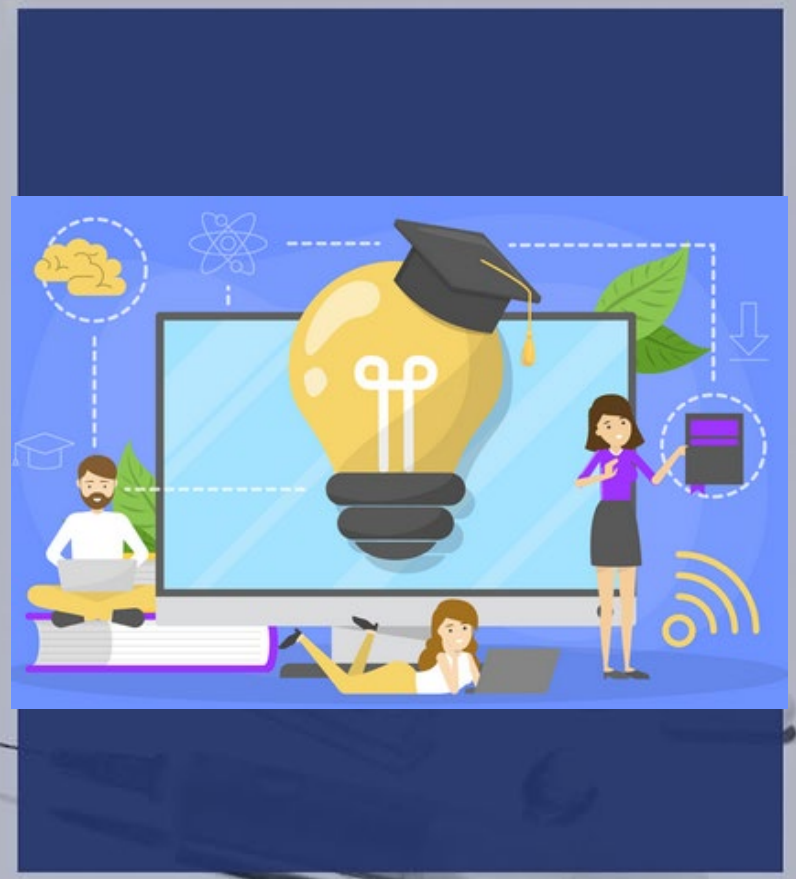

CASE STUDY 3

DOMAIN 6

Education, research, and critical analysis Practice

Domain Competency 6.2

Provision of education and training

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Reflection Title:

Providing education and training on hand hygiene to KwaMagwaza Pharmacy Staff

Step 1: Reflection

I was instructed by my supervisor to train pharmacy staff on the importance of hand hygiene and washing techniques for infection prevention and control. I recognised the need to improve my ability to educate and train effectively within a professional setting as I have limited experience in structuring and delivering educational sessions to people. This highlighted the necessity for me to develop stronger communication, presentation, and teaching skills to ensure that the information I share is engaging, clear, and impactful. Enhancing these skills is essential as a future pharmacist, as I may be required to train staff, interns, or even patients. By addressing this need I aim to gain confidence in facilitating discussions, organising content effectively, and responding to questions with clarity. My goal is to become a proficient educator, capable of delivering structured, engaging, and informative training sessions that contribute to a more knowledgeable and efficient pharmacy team.

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Assessor/Moderator comments

Step 1: Reflection

Requirement met.

- An authentic learning trigger has been described, and the learning need and intended outcome are clearly stated through the aim.
- Provide more background on what prompted the supervisor to identify this as a training need in the first place.
- Keep the focus on the skills required to provide education and training, rather than on the subject (hand hygiene), which is the activity's topic.

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Step 2: Planning

I will get guidance from an experienced pharmacist on structuring a training plan, including the timeframe, and key learning objectives (6.2.a). I will create a PowerPoint presentation using the WHO Guidelines on Hand Hygiene in Health Care (2009) and Centre for Disease Control articles which highlight the role of hand hygiene to reduce infection, Good Pharmacy Practice (GPP) guidelines which highlights the importance of hygiene standards (pages 38, 83,162) and the hospital infection prevention and control policies thus developing my learning (6.2c). By self-assessment, I will identify and outline my learning goal, action plan, strengths, weaknesses, and strategies to overcome them (6.2.b). I will also assess the staff understanding through a question and answer session and have them repeat the handwash process (6.2.c) and develop forms to gather feedback for my own training assessment. I will notify the staff that the session will be scheduled for 25/03/2025 at the pharmacy.

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Assessor/Moderator comments

Step 2: Planning

Requirement met.

- The planning is linked to the behavioural statements, and sufficient resources to develop the training material have been consulted.
- State every resource in full (title, chapter, section, page numbers, web addresses), as some are incomplete; clarify how you will self-assess your knowledge or skill (B.S. (b)); and consider adding resources specifically on how to conduct effective training and on communication and presentation skills.

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Step 3: Implementation

I outlined my learning goals, strengths, and weaknesses, and identified strategies to improve my training skills (E1/6.2.b). I compiled a training plan with guidance from an experienced pharmacist, where we discussed the training timeframe (30 minutes), key objectives, and structure of the session (E2/6.2.a). Staff were notified about the training (E11). I created a PowerPoint using various resources (E3-6/BS 6.2a,c). I printed my PowerPoint presentation covering hand hygiene techniques, contamination risks, and infection prevention strategies (E7/6.2.a, c) which I used on 25/03/2025 and conducted the training at the Hospital pharmacy (E13/6.2a, b). I demonstrated the hand washing technique, made staff demonstrate it and held a question and answer session to assess staff understanding (E8 BS6.2.a, c).The staff were asked to sign a register for attendance (E12,BS6.2 a, c) and fill an evaluation form to assess my performance (E10/6.2.b). I then evaluated my own performance (E9, BS6.2b).

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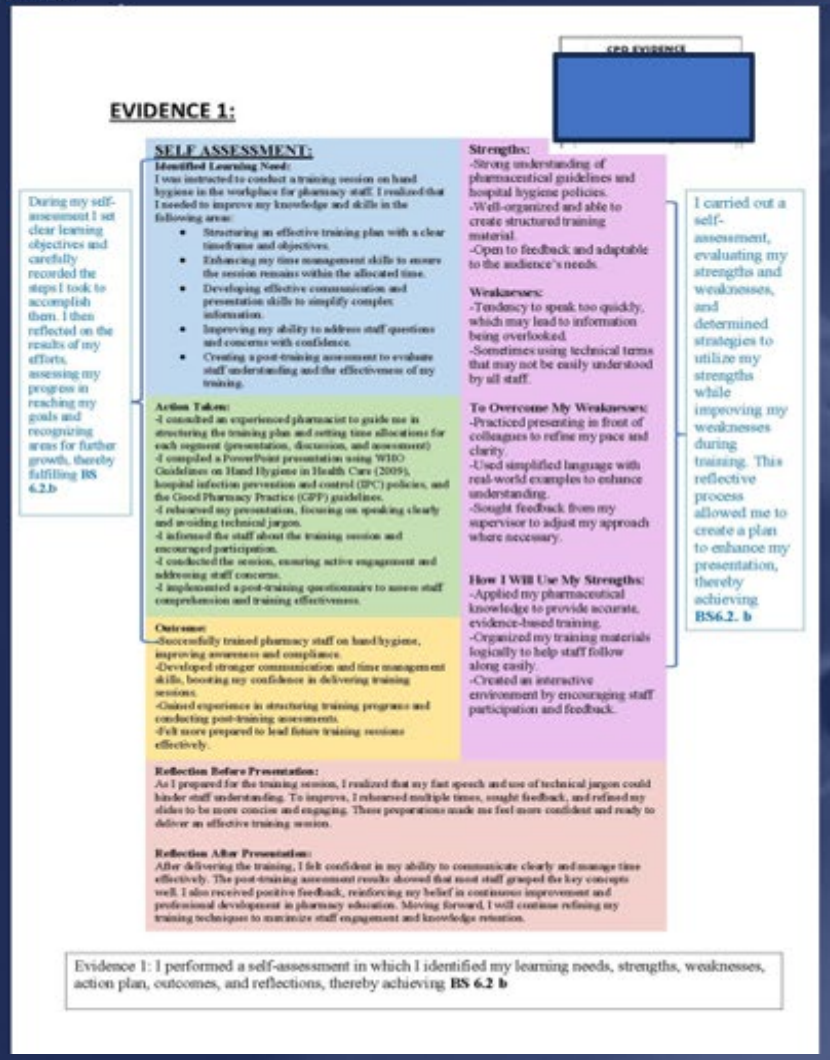
Step 3: Implementation Evidence



EVIDENCE 1:

CPD EVIDENCE [redacted]

SELF ASSESSMENT:

Identified Learning Need:
I was instructed to conduct a training session on hand hygiene in the workplace for pharmacy staff. I realized that I needed to improve my knowledge and skills in the following areas:

- Structuring an effective training plan with a clear timeframe and objectives.
- Enhancing my time management skills to ensure the session remains within the allocated time.
- Developing effective communication and presentation skills to simplify complex information.
- Improving my ability to address staff questions and concerns with confidence.
- Creating a post-training assessment to evaluate staff understanding and the effectiveness of my training.

During my self-assessment I set clear learning objectives and carefully recorded the steps I took to accomplish them. I then reflected on the results of my efforts, assessing my progress in reaching my goals and recognizing areas for further growth, thereby fulfilling **BS 6.2.b**

Action Taken:
-I consulted an experienced pharmacist to guide me in structuring the training plan and setting time allocations for each segment (presentation, discussion, and assessment)
-I compiled a PowerPoint presentation using WHO Guidelines on Hand Hygiene in Health Care (2009), hospital infection prevention and control (IPC) policies, and the Good Pharmacy Practice (GPP) guidelines.
-I rehearsed my presentation, focusing on speaking clearly and avoiding technical jargon.
-I informed the staff about the training session and encouraged participation.
-I conducted the session, ensuring active engagement and addressing staff concerns.
-I implemented a post-training questionnaire to assess staff comprehension and training effectiveness.

Outcome:
-Successfully trained pharmacy staff on hand hygiene, improving awareness and compliance.
-Developed stronger communication and time management skills, boosting my confidence in delivering training sessions.
-Gained experience in structuring training programs and conducting post-training assessments.
-Felt more prepared to lead future training sessions effectively.

Strengths:
-Strong understanding of pharmaceutical guidelines and hospital hygiene policies.
-Well-organized and able to create structured training material.
-Open to feedback and adaptable to the audience's needs.

Weaknesses:
-Tendency to speak too quickly, which may lead to information being overlooked.
-Sometimes using technical terms that may not be easily understood by all staff.

To Overcome My Weaknesses:
-Practiced presenting in front of colleagues to refine my pace and clarity.
-Used simplified language with real-world examples to enhance understanding.
-Sought feedback from my supervisor to adjust my approach where necessary.

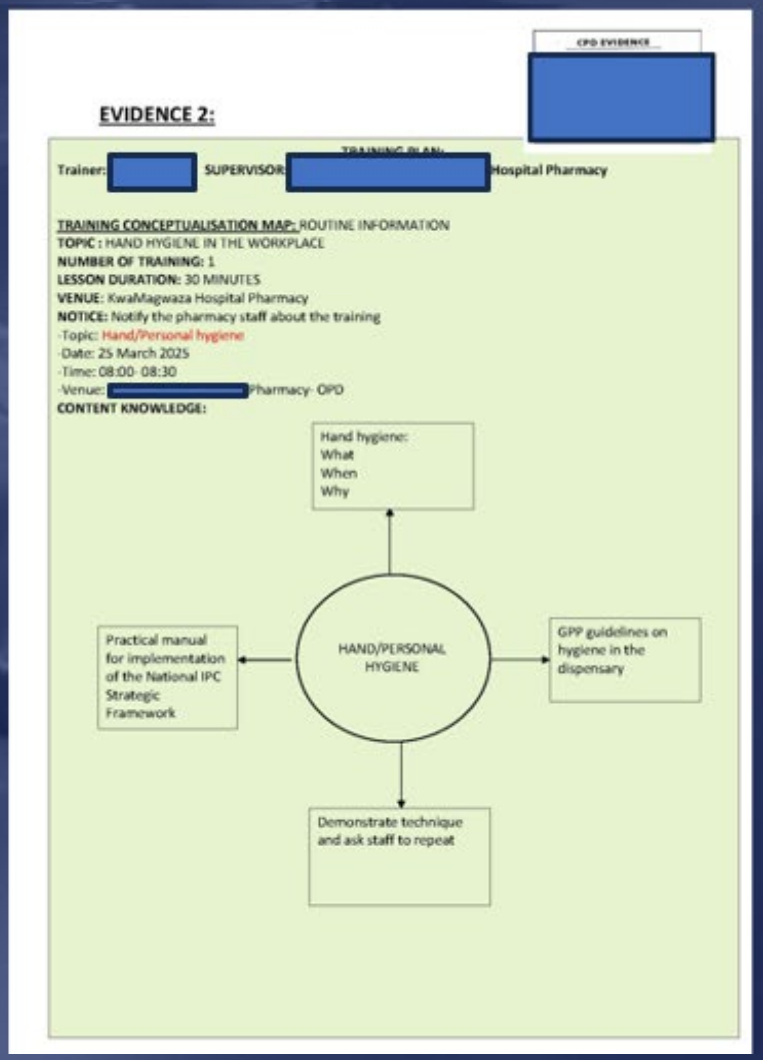
How I Will Use My Strengths:
-Applied my pharmaceutical knowledge to provide accurate, evidence-based training.
-Organized my training materials logically to help staff follow along easily.
-Created an interactive environment by encouraging staff participation and feedback.

I carried out a self-assessment, evaluating my strengths and weaknesses, and determined strategies to utilize my strengths while improving my weaknesses during training. This reflective process allowed me to create a plan to enhance my presentation, thereby achieving **BS6.2. b**

Reflection Before Presentation:
As I prepared for the training session, I realized that my fast speech and use of technical jargon could hinder staff understanding. To improve, I rehearsed multiple times, sought feedback, and refined my slides to be more concise and engaging. These preparations made me feel more confident and ready to deliver an effective training session.

Reflection After Presentation:
After delivering the training, I felt confident in my ability to communicate clearly and manage time effectively. The post-training assessment results showed that most staff grasped the key concepts well. I also received positive feedback, reinforcing my belief in continuous improvement and professional development in pharmacy education. Moving forward, I will continue refining my training techniques to maximize staff engagement and knowledge retention.

Evidence 1: I performed a self-assessment in which I identified my learning needs, strengths, weaknesses, action plan, outcomes, and reflections, thereby achieving **BS 6.2 b**



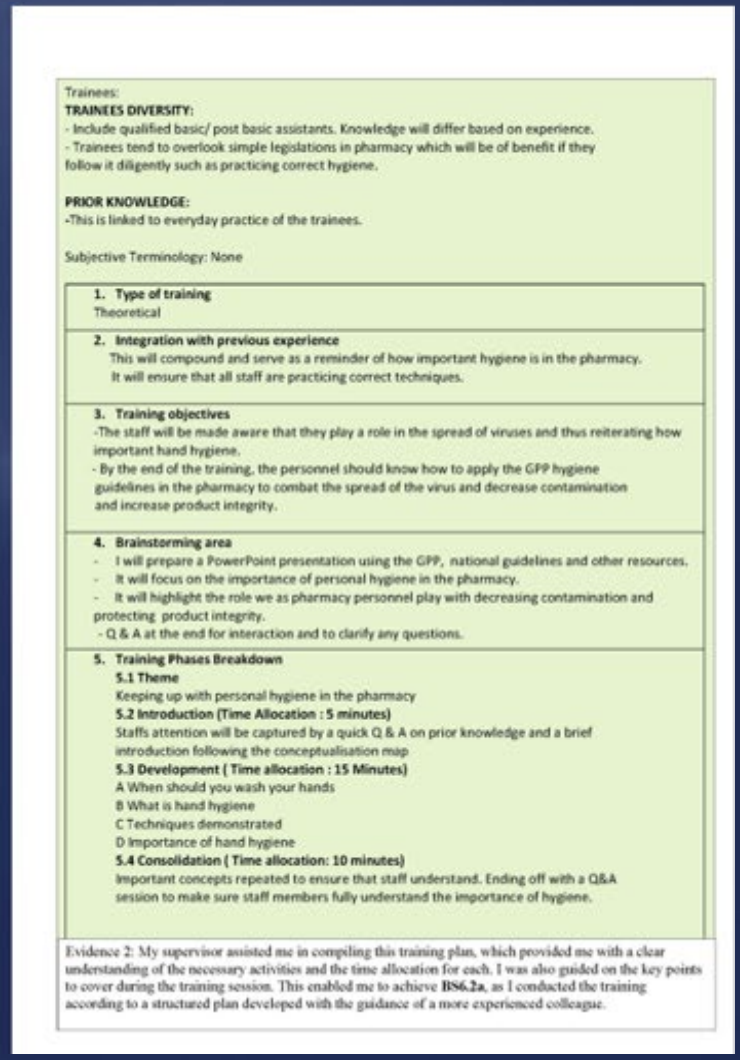
CPD EVIDENCE [redacted]

EVIDENCE 2:

TRAINING PLAN: [redacted]

Trainer: [redacted] SUPERVISOR: [redacted] Hospital Pharmacy

TRAINING CONCEPTUALISATION MAP: ROUTINE INFORMATION
TOPIC : HAND HYGIENE IN THE WORKPLACE
NUMBER OF TRAINING: 1
LESSON DURATION: 30 MINUTES
VENUE: KwaMagwaza Hospital Pharmacy
NOTICE: Notify the pharmacy staff about the training
-Topic: Hand/Personal hygiene
-Date: 25 March 2025
-Time: 08:00- 08:30
-Venue: [redacted] Pharmacy- OPD
CONTENT KNOWLEDGE:



Trainees:
TRAINEES DIVERSITY:
- Include qualified basic/ post basic assistants. Knowledge will differ based on experience.
- Trainees tend to overlook simple legislations in pharmacy which will be of benefit if they follow it diligently such as practicing correct hygiene.

PRIOR KNOWLEDGE:
-This is linked to everyday practice of the trainees.

Subjective Terminology: None

1. **Type of training**
   Theoretical
2. **Integration with previous experience**
   This will compound and serve as a reminder of how important hygiene is in the pharmacy. It will ensure that all staff are practicing correct techniques.
3. **Training objectives**
   -The staff will be made aware that they play a role in the spread of viruses and thus reiterating how important hand hygiene.
   - By the end of the training, the personnel should know how to apply the GPP hygiene guidelines in the pharmacy to combat the spread of the virus and decrease contamination and increase product integrity.
4. **Brainstorming area**
   - I will prepare a PowerPoint presentation using the GPP, national guidelines and other resources.
   - It will focus on the importance of personal hygiene in the pharmacy.
   - It will highlight the role we as pharmacy personnel play with decreasing contamination and protecting product integrity.
   - Q & A at the end for interaction and to clarify any questions.
5. **Training Phases Breakdown**
   5.1 Theme
   Keeping up with personal hygiene in the pharmacy
   5.2 Introduction (Time Allocation : 5 minutes)
   Staffs attention will be captured by a quick Q & A on prior knowledge and a brief introduction following the conceptualisation map
   5.3 Development (Time allocation : 15 Minutes)
   A When should you wash your hands
   B What is hand hygiene
   C Techniques demonstrated
   D Importance of hand hygiene
   5.4 Consolidation (Time allocation: 10 minutes)
   Important concepts repeated to ensure that staff understand. Ending off with a Q&A session to make sure staff members fully understand the importance of hygiene.

Evidence 2: My supervisor assisted me in compiling this training plan, which provided me with a clear understanding of the necessary activities and the time allocation for each. I was also guided on the key points to cover during the training session. This enabled me to achieve **BS6.2a**, as I conducted the training according to a structured plan developed with the guidance of a more experienced colleague.

Step 3: Implementation Evidence 3&4

EVIDENCE 3

CPD EVIDENCE

Good Pharmacy Practice Manual and Associated SAPC rules

1.2.8 Environment in pharmacy premises

(a) Storage of thermolabile medicines must be in accordance with the storage instructions of the manufacturer.

(b) Refrigerators used for the storage of thermolabile medicine must be calibrated regularly.

(c) Products must be protected from the adverse effects of light, freezing or other temperature extremes and dampness.

(d) Levels of heat, light, noise, ventilation, etc., must exert no adverse effects on pharmaceutical stock as well as personnel.

(e) All parts of the premises must have suitable and effective means of heating or cooling, lighting and ventilation. If windows can be opened, they must be locked securely when the pharmacy is closed.

(f) Background music or other broadcasts in the pharmacy must not be played at such a volume so as to cause distraction.

1.2.9 Hygiene in pharmacy premises

(a) There must be an area where equipment and other utensils can be washed which has a source of hot and cold tap water.

(b) There must be a suitable, clean wash hand basin made of a smooth, washable and impermeable material which is easy to maintain in a hygienic condition and has a source of hot and cold tap water and a closed drainage system.

(c) Toilet facilities must be kept clean and in good order.

(d) Hand-washing facilities must be provided in the toilet area or the lobby together with a conspicuous notice requesting users to wash their hands. Facilities must include readily available hot water, soap and clean towels or other satisfactory means of drying the hands.

(e) Toilet areas must not be used for storage, or as a source of water for dispensing.

1.2.10 Storage areas in pharmacy premises

(a) Storage areas must have sufficient shelving constructed from a smooth, washable and impermeable material, which is easy to maintain in a hygienic condition for the keeping of medicines above floor level.

(b) Storage areas for Pharmaceuticals must be self-contained and secure.

(c) Storage areas must be large enough to allow for orderly arrangement of stock and proper stock rotation.

1.2.11 Dispensary

1.2.11.1 Size of dispensary

(a) The size of the dispensary must reflect the volume of prescriptions dispensed and allow a safe and efficient flow of work and effective communication and supervision for the number of persons working in the dispensary.

(b) The minimum area for the dispensary necessary to allow a safe and efficient flow of work and effective communication and supervision, will depend on a number of factors, which include the number of prescriptions dispensed, the daily pattern of prescription

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I read section 1.2.9(b) of the *Good Pharmacy Practice in South Africa* guidelines helped me understand the essential requirements for hand-washing facilities in a pharmacy setting. It highlighted the need for a smooth, washable, and impermeable hand basin with hot and cold tap water and a closed drainage system. This information guided me in emphasizing the importance of proper hand-washing stations in my training session, ensuring staff are aware of the necessary infrastructure for maintaining hygiene.

I read Section 1.2.9(d) reinforced the importance of having clear hand-washing facilities in toilet areas or lobbies, along with visible notices reminding staff to wash their hands. It also specified that hot water, soap, and clean towels or other drying methods must be readily available. This helped me design learning activities that focused on ensuring staff not only follow hand hygiene protocols but also understand the role of proper facilities in infection control.

3.7.5 Hygiene

(a) Detailed programmes relating to hygiene must be established and adapted to the different needs within the wholesale, distribution and manufacturing pharmacy. They must include procedures relating to the health, hygiene practices and clothing of personnel.

(b) Steps must be taken to ensure as far as is practicable that no person affected by an infectious disease or having open lesions on an exposed surface of the body is engaged in the handling of medicine or scheduled substances.

(c) Eating, drinking, chewing or smoking in the pharmacy, or the storage of food, drink, smoking materials or personal medication in the storage areas must be prohibited. In general, any unhygienic practice within the facility where medicine or scheduled substances might be adversely affected, must be forbidden.

(d) Personnel must be instructed to use the hand-washing facilities regularly.

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Section 3.7.5(d) of the *Good Pharmacy Practice in South Africa* guidelines emphasizes that personnel must be instructed to use hand-washing facilities regularly. This helped me design my training session to not only educate staff on when and how to wash their hands but also to reinforce the importance of habitual compliance with hand hygiene protocols. By integrating this into my learning activities, I ensured that pharmacy staff recognize handwashing as a routine and essential practice rather than an occasional task.

Good Pharmacy Practice Manual and Associated SAPC rules

(c) A pharmacist must actively participate in any arrangements made for warning the profession of problems associated with medicines, and must inform appropriate bodies of hazards which come to their attention.

2.7.3.8 Personal hygiene

(a) High standards of personal cleanliness must be observed in dispensing.

(b) Direct contact between the dispensed product and the operator's hands must be avoided.

(c) Cuts or abrasions must be covered with a suitable occlusive dressing. A person with an open lesion or readily transmittable infection must report to the pharmacist who will decide whether they may be engaged in the dispensing process.

(d) No personnel may smoke or prepare or consume food in any area where medicines are dispensed, sold or supplied.

Section 2.7.3.8(a) highlights the need for high standards of personal cleanliness during dispensing. This reinforced the importance of proper hand hygiene before handling medication, ensuring patient safety by reducing the risk of contamination. I incorporated this into my training by focusing on how personal hygiene directly impacts pharmaceutical practice and patient outcomes.

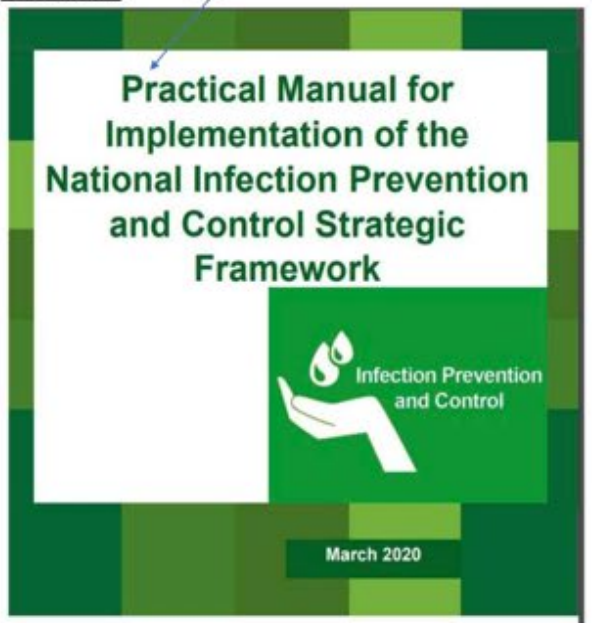
By including these guidelines in my training, I contributed to developing structured learning activities, aligning with BS 6.2C

Evidence 3 shows I referred to the sections Personal Hygiene and Hygiene in the pharmacy to improve my knowledge enabling me to participate in the provision of learning activities achieving **BS 6.2 C.**

The *Good Pharmacy Practice (GPP) in South Africa* guidelines provided a foundation for my training activities on hand hygiene in the workplace. They emphasized the need for proper hand-washing facilities (1.2.9b & **d**), the importance of regular handwashing by pharmacy personnel (3.7.5d), and the role of personal hygiene in dispensing (2.7.3.8a). Using these guidelines, I developed structured learning activities that reinforced hand hygiene compliance, ensuring pharmacy staff understood its role in patient safety and infection control. This allowed me to achieve **BS 6.2 C**

I referred to the Practice manual for the implementation of the National IPC Strategic Framework.

EVIDENCE 4:



CPD EVIDENCE

Step 3: Implementation Evidence 4, 5& 6

8.2 Hygienic hand wash technique

Method:

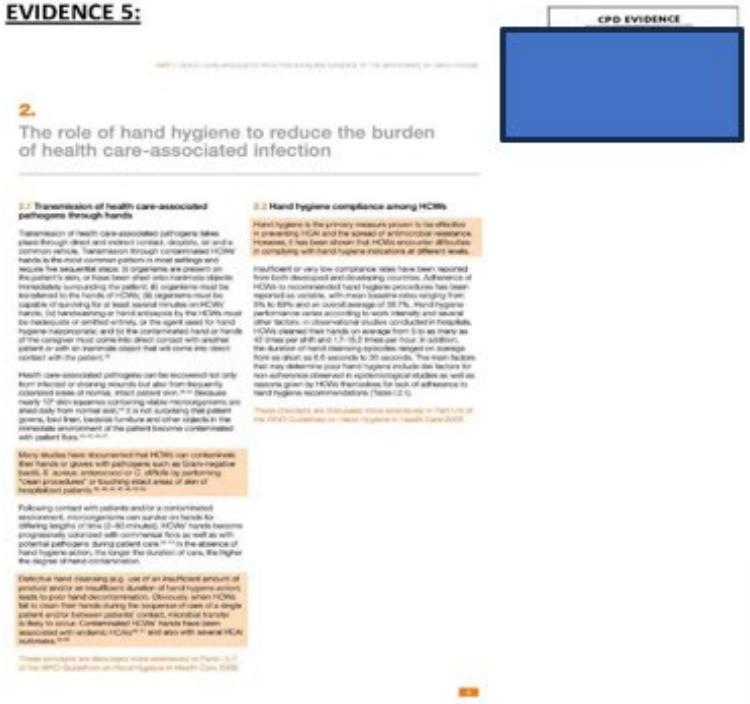
Figure 7: Hygienic hand wash technique[47] 'Note, hand washing still begins with palm to palm rubbing

I utilized the hand-washing technique outlined in the National IPC Practice Manual as a reference for my training session. This resource provided a standardized approach to effective hand hygiene, ensuring I demonstrated the correct procedure to staff members. To reinforce learning, I had them repeat the steps as I performed them, incorporating practical learning to enhance understanding. This hands-on approach ensured that they grasped the technique effectively. By using this evidence to develop my training activity, I successfully achieved **BS6.2c.**

Evidence 4 shows I used the National IPC Practice Manual to learn to demonstrate the correct hand-washing technique to staff. To reinforce learning, I had them repeat the steps as I performed them, ensuring they understood the procedure. This practical approach helped me develop an effective learning activity, achieving **BS6.2c.**

EVIDENCE 5:

CPD EVIDENCE



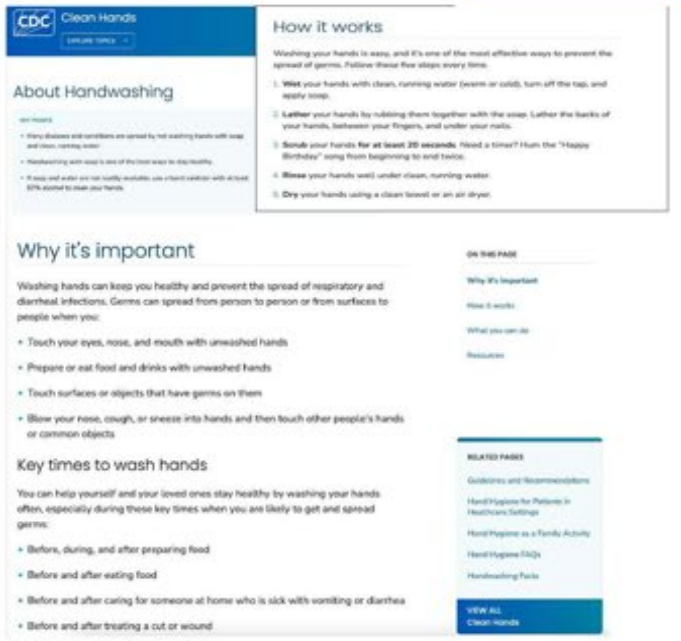
2.

The role of hand hygiene to reduce the burden of health care-associated infection

Evidence 5 shows I used the WHO Guidelines on Hand Hygiene in Health Care to learn the importance of proper hand hygiene in reducing infections. These guidelines helped me structure my training content, ensuring staff understood the critical role of hand hygiene in preventing the spread of disease. By incorporating this evidence into my learning activity, I successfully developed an informed and effective training session, achieving **BS6.2c.**

EVIDENCE 6:

CPD EVIDENCE



CDC Clean Hands

About Handwashing

How it works

Why it's important

Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to people when you:

- Touch your eyes, nose, and mouth with unwashed hands
- Prepare or eat food and drinks with unwashed hands
- Touch surfaces or objects that have germs on them
- Blow your nose, cough, or sneeze into hands and then touch other people's hands or common objects

Key times to wash hands

You can help yourself and your loved ones stay healthy by washing your hands often, especially during these key times when you are likely to get and spread germs:

- Before, during, and after preparing food
- Before and after eating food
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- Before and after treating a cut or wound

Evidence 6 shows I used the CDC article on hand hygiene to define the concept, explain its importance, how it works, and when it should be performed. This information formed part of my PowerPoint presentation, ensuring my training session was well-structured and evidence-based. By incorporating this resource into my learning activity, I successfully developed an engaging and informative session, achieving **BS6.2c.**

Step 3: Implementation Evidence 7

EVIDENCE 7:

Power point presentation:

I prepared a PowerPoint presentation to educate the pharmacy personnel at KwaMagwaza Hospital Pharmacy on when, how, and why hand hygiene is important. I presented it at the pharmacy at 8:30 AM on 25/03/2025, ensuring that staff understood the significance of proper hand hygiene in preventing infections.

This demonstrated that I taught effectively according to the plan developed by myself and approved by my supervisor, Eric Mbuyazi, thereby achieving **BS 6.2a**.

After identifying my learning needs **(BS6.2b) (EI)**, I bridged the gap by researching the topic using the CDC guidelines and GPP standards. I then participated in developing this learning activity by compiling this presentation to educate the pharmacy personnel, thus achieving **BS 6.2c**.

Pre-Training Quiz: Hand Hygiene Awareness

KwaMagwaza Hospital Pharmacy
Date: _25/3/2025_____
Facilitator: Salla Sharifi
Supervisor: Eric Mbuyazi

Instructions: This is a short quiz to assess your current knowledge of hand hygiene in the workplace.

1. Why is hand hygiene important in a healthcare setting?

a) To remove dirt from hands
b) To prevent the spread of infections
c) To make hands smell better
d) Because it is a hospital rule

2. When should healthcare personnel perform hand hygiene?

a) Before and after patient contact
b) Only when hands are visibly dirty
c) Once at the start and end of a shift
d) Only after using the toilet

3. What is the recommended duration for proper handwashing with soap and water?

a) 5 seconds
b) 10 seconds
c) 20-30 seconds
d) 1 minute

4. Which of the following is the most effective method for killing germs?

a) Washing hands with water only
b) Using alcohol-based hand rub or soap and water
c) Wiping hands with a tissue
d) Rinsing hands quickly under running water

5. Which part of the hands are most often missed during handwashing?

a) Palms
b) Fingertips and thumbs
c) Wrists
d) Back of hands

6. True or False: Hand sanitizers can replace handwashing in all situations.

____True
____False

Thank You for Your Participation!

Followed my training plan by creating a pre training mini quiz to capture attention and assess prior knowledge, this was the learning activity that my supervisor suggested will be effective in determining staff knowledge thereby achieving **BS6.2 c.**

Step 3: Implementation Evidence 7 & 8

I demonstrated to the staff the correct way of hand washing and made them repeat as I did it to ensure that they fully grasped the technique BS 6.2 a

Lastly, I had a Question and Answer session to clarify any misunderstandings that any pharmacy personnel may not have understood. This made the presentation more interactive

Evidence 7 shows I created and presented a PowerPoint training session on hand hygiene at KwaMagwaza Hospital Pharmacy, ensuring staff understood its importance. By researching CDC guidelines and GPP standards, I taught according to the approved training plan which allowed me to achieve **BS 6.2a**.

EVIDENCE 8:

The questions I was asked by staff and my answers.

[redacted]

Q&A Discussion – Staff Questions and My Responses

Question 1: *Why is hand hygiene important even if we wear gloves?*
My Answer: Gloves can develop microscopic tears, and they do not eliminate the risk of contamination. Bacteria and viruses can transfer when removing gloves or if they are worn for too long. Hand hygiene before and after wearing gloves is essential to prevent infections.

Question 2: *How long should we wash our hands for effective cleaning?*
My Answer: According to WHO guidelines, hands should be washed for at least **40-60 seconds** with soap and water, while alcohol-based hand rub should be used for at least **20-30 seconds** for proper decontamination.

Question 4: *When exactly should we perform hand hygiene in the pharmacy setting?*
My Answer: There are **five key moments** when healthcare workers should perform hand hygiene:
1. **Before** touching a patient or handling medication.
2. **Before** a clean or aseptic procedure (e.g., compounding medication).
3. **After** exposure to bodily fluids or potential contamination.
4. **After** touching a patient.
5. **After** touching the patient's surroundings (e.g., surfaces, prescription counters).

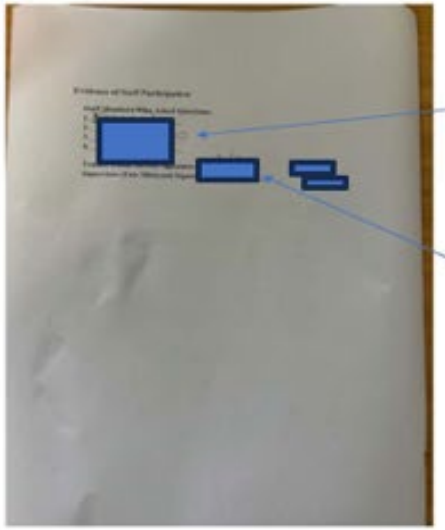
Question 5: *Which is better: handwashing with soap and water or using an alcohol-based hand rub?*
My Answer: Both are effective, but their use depends on the situation:

- **Soap and water** should be used when hands are visibly soiled, after using the toilet, or after handling food.
- **Alcohol-based hand rub** is preferred when hands are not visibly dirty, as it is quick and effective in killing germs.

Question 6: *Can we use the sink in the dispensary to wash our hands?*
My Answer: No, pharmacy sinks are meant for dispensing and medication preparation. According to **Good Pharmacy Practice (GPP) guidelines**, handwashing facilities should be separate from dispensing areas, and dedicated sinks must be used for personal hygiene.

Question 7: *How do we encourage patients to practice hand hygiene?*
My Answer: Educate them using **visual prompts**, posters, and verbal reminders. We can also provide **hand sanitizer stations** at the pharmacy entrance and during patient counseling, highlight the importance of hand hygiene in preventing infections.

Question 8: *What should we do if a colleague is not following hand hygiene protocols?*
My Answer: Encourage a culture of safety and remind them politely about the importance of hand hygiene. If the issue persists, report it to a supervisor so corrective action can be taken to maintain hygiene standards.



I asked the staff who asked the questions to sign as evidence that they participated.

I the intern [redacted] signed as proof that I answered their questions, under the supervision of my supervisor. [redacted]

Evidence 8: At the end of the presentation, I offered a Question and Answer session which ensured staff understanding, and by doing so following my training plan and participated in the learning activity therefore achieving **BS 6.2 a and c.**

Step 3: Implementation Evidence 9 &11

EVIDENCE 9:

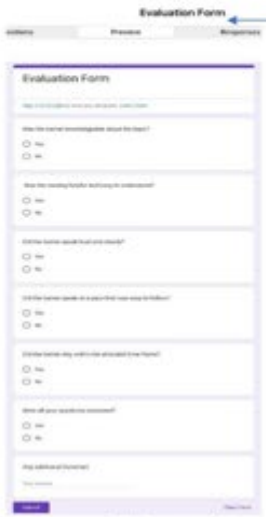
CPD EVIDENCE

Education and Training session feedback

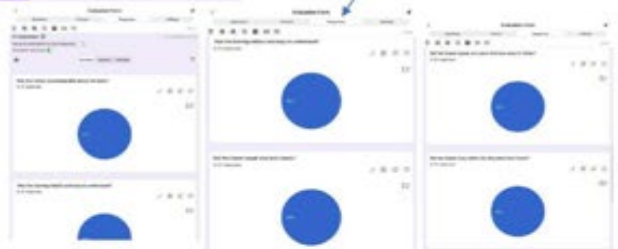
Questions	No	Partially	Yes
Was the content of my presentation accurate and well-researched?			✓
Did I present the information in a clear and logical sequence?			✓
Did I provide relevant examples and practical applications?			✓
Did I engage my audience and maintain their interest throughout the presentation?			✓
Did I speak clearly and at an appropriate pace?			✓
Was I able to convey enthusiasm and confidence in my topic?			✓
Were my slides clear, well-organized, and free of clutter?			✓
Was I able to answer questions from the audience accurately and confidently?			✓
Did the audience appear to understand and absorb the material?			✓
Did I feel prepared and confident going into the presentation?			✓

Evidence 9 shows I asked myself these questions which allowed me to reflect on my performance during the training session and pinpoint areas for improvement. This self-assessment process helped me evaluate the effectiveness of my teaching methods and identify ways to enhance future sessions. Thus, I successfully achieved **BS 6.2b.**

I created an evaluation form to assess my performance as a trainer. This helped me do a self-assessment on my performance thus achieving **BS6.2b** and **BS6.2a** as this was according to my Training plan.



Results of evaluation form confirm that my training was successful, results stated that I spoke loud and clearly, my presentation was organised, I answered everyone questions and I was knowledgeable about the subject. I also completed the training within the specified timeframe. This helped me do a self assessment on my performance thus achieving **BS 6.2 b**



CPD EVIDENCE

EVIDENCE 11:

NOTICE: HAND HYGIENE TRAINING SESSION

Date: 25/03/2025
Time: 08:00-8:30
Venue: KwaMagwaza Hospital Pharmacy- OPD department

Dear Pharmacy Personnel,

You are invited to attend an important **Hand Hygiene Training Session** aimed at enhancing our infection prevention practices. This session will cover:

- ✅ Proper hand-washing techniques
- ✅ When and why hand hygiene is crucial
- ✅ Guidelines from WHO, CDC, and GPP
- ✅ Practical demonstration and Q&A session

Your participation is essential to maintaining high hygiene standards in our workplace. Let's work together to ensure a safer environment for both staff and patients.

For any inquiries, please contact **Safia Sheriff**.

Prepared by: Safia Sheriff
Supervised by: Eric Mbuyazi

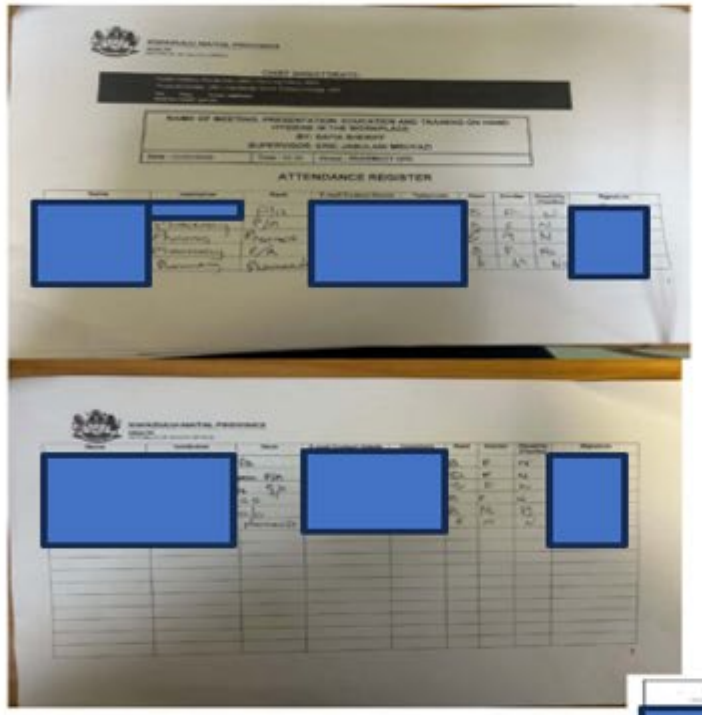
We look forward to your attendance!

CPD EVIDENCE

Evidence 11 shows I notified the pharmacy personnel with this notice to make them aware of the training session, thus achieving **BS 6.2 a** as this was part of my training plan.

Step 3: Implementation Evidence 12 &13

EVIDENCE 12:



Evidence 12 shows the attendance register of the pharmacy personnel that attended the training session I held, thus achieving **BS 6.2 a and c.**

EVIDENCE 13:

I, [redacted] (intern), led the **Hand Hygiene Training Session** for the [redacted] personnel at [redacted] Hospital. I started with a quick questionnaire session and continued using my PowerPoint presentation by explaining the importance of hand hygiene in infection prevention, referencing guidelines from the WHO, CDC, and GPP.

To enhance engagement , I conducted a Q&A session, allowing staff to ask questions and clarify any uncertainties. This session allowed me to effectively teach according to the training plan achieving **BS6.2a** and actively participate in the development of a learning activity achieving **BS 6.2c.**

[redacted]

To reinforce understanding, I demonstrated the proper hand-washing technique step by step using the chart to ensure practical learning and made staff repeat this process, achieving **BS 6.2c.**

Evidence 13: As the intern, Safia Sheriff, I successfully led a comprehensive Hand Hygiene Training Session for the pharmacy personnel. I explained the importance of hand hygiene in preventing infections, and covered essential aspects such as when, how, and why hand hygiene should be performed in a healthcare setting.

To reinforce understanding and encourage participation, I incorporated a demonstration of proper hand-washing techniques and made staff repeat this, as a learning need therefore achieving **BS 6.2c**. Following this, I facilitated a discussion session, fostering active engagement, and addressed any questions and provided further clarification where needed, successfully achieving **BS 6.2a and 6.2c.**

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Assessor/Moderator comments

Step 3: Implementation

Description: Requirements met.

- The activities are logically explained and address all three (3) behavioural statements.
- Indicate clearly where the training was held and who attended and consider including more detail on the training skills applied, how the information was presented, and the communication, presentation, and material development skills used.

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Assessor/Moderator comments

Step 3: Implementation

Evidence: Requirements met.

- The annotation correctly links each piece of evidence to the relevant behavioural statement, and the evidence speaks to all three statements.
- The self-assessment should focus on what was identified and planned before the activity (move outcomes and reflections to the evaluation step); the tutor verification shown is a screenshot of a previous verification and is not acceptable, the verification should carry the date, facility stamp, signature, name and P-number of the supervising pharmacist; the attendance register is of concern (similar handwriting and signatures), though the images of genuine engagement with the audience provide sufficient proof.
- Additional resources could have been included specifically pertaining to how one can conduct effective training, effective communication and presentation skills etc.

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Step 4: Evaluation

Through this experience, I developed the skill of training colleagues effectively, which was previously unfamiliar to me. I learned the importance of structuring a training session, managing time efficiently, and using clear communication techniques to ensure engagement. By adapting my approach to match my audience's needs, I improved my ability to simplify complex information and present it in a concise, understandable manner. Since this session, I have applied my training skills when educating staff on the proper reconstitution and administration of powdered antibiotics, ensuring they follow correct dilution techniques to maintain drug efficacy. I believe this experience has strengthened my confidence in educating healthcare professionals. Moving forward, I aim to refine my training techniques further, incorporating interactive learning methods to improve knowledge retention and engagement in future sessions.

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Assessor/Moderator comments

Step 4: Evaluation

Requirements met.

- You have reflected on what you learned about providing education and training and provided a clear, practical example of applying the skill to a different scenario.
- Elaborate on the impact on your practice rather than simply stating that your confidence has been strengthened, and identify a future learning need that is genuinely different from this activity while remaining within the domain.

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Any questions?

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A policy does not provide a method or procedure for carrying out a task.

It is created to **achieve** specific objectives, maintain order, standardise practices, promote consistency, manage risks, provide a basis for accountability and transparency, as well as ensure compliance with laws, regulations, and ethical standards

CASE STUDY 4

DOMAIN 4

Organisation and management skills

Domain Competency 4.6

Policy development

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Reflection Title:

Learning how to accurately apply policies at all times, which are relevant to any current practice

Step 1: Reflection

Describe the learning need that you have identified to improve your knowledge and skills, and what you hope to achieve after addressing this learning need?

A gentleman came in the pharmacy to deliver couple of boxes from DSV for the ready-made parcel for pickup CCMDD parcels and he asked to sign for him since I was the only one free at that moment and he said he'll help since I was clueless. I needed to learn how to accurately apply and adhere to SOP's and policies of the dispensary especially on stock management. Since I have realised there is a knowledge gap on me. I hope to be more familiar with the steps to be followed when dealing with guardians or partners who are collecting on someone's behalf and what happens to the uncollected parcels. I hope to familiarise myself with SOP's and policies, so I can at all times put the needs and rights of patients first and conduct myself in a professional manner and avoid misconduct. Learning title: Learning on how to accurately apply policies at all times which are relevant to any current practice.

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Assessor/Moderator comments

Step 1: Reflection

Reflection - Requirement not met.

- Learning title
  - It is too vague and general and does not describe a specific activity you intend to learn or undertake;
  - It should also not be a near-copy of the competency standard.
- Learning trigger
  - The trigger, what you intend to learn, and what you hope to achieve are not aligned:
  - The trigger concerns receiving CCMDD parcels and what to do when someone other than the patient collects, yet the stated learning need shifts to applying SOPs and policies on dispensary stock management.
- Clarify the specific knowledge gap and identify the specific policy and SOP relevant to the activity, so that title, trigger, learning need and intended outcome form one coherent reflection.

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Step 2: Planning

I plan to visit the dispensary SOPs, especially stock policies, with the help of my colleagues who are more familiar with them than I am. I will include information on: policies (a) and SOPs (b). I plan to participate in other areas/roles in the dispensary so I can improve my knowledge. I plan to make my own notes so I can learn the managing of stock on my spare time. I did all this in order for me to be able to handle or manage the receiving of stock from the driver or delivered stock. I plan to do some work shadowing of the pharmacist learner basic during their management of tock tasks. I plan to visit the dispensary SOPs on delivery of stock.

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Assessor/Moderator comments

Step 2: Planning

Requirement partially met.

- State the specific resources you will consult with full details and refer to the specific policy and SOP relevant to the activity, rather than mentioning the behavioural statements in passing.
- Link each planning element to the B.S. (a) (apply policies) and B.S. (b) (apply SOPs) and show how it addresses the identified knowledge gap.
- Distinguish clearly between a policy and an SOP. Write the plan consistently in the future tense and confirm that the chosen resources cover the activity, for example, whether the dispensary SOP on delivery of stock, and stock-management policies, in fact apply to receiving a CCMDD parcel and to someone collecting on a patient's behalf.

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Step 3: Implementation

I consulted the CCMDD SOP for guidance on receiving stock in the system and dispensing it to the patient. I managed to capture a couple of invoices for the stock received. I consulted the stock SOP for capturing stock and ordering stock and managed to perform both tasks on my own. I consulted the cold chain management SOP on how to receive, store and dispense it. On 15th of January 2025, I received training from my colleague in the pharmacy on how to capture stock on the system using the streamlined receiving SOP. I reviewed the guidelines and policies of the management and conduct of a pharmacy.

Step 3: Implementation Evidence 1

health

	• Select the appropriate protocol (the medicines that are in the protocol will appear next to the "Protocol" drop-down menu). • Check that the medicines and dosages in the protocol are appropriate for the individual patient. Click **'ADD Selected Protocol'** to add all the medicines to the prescription.	
41	Certain **medication interactions and/or contraindications** have been programmed into SyNCH. If a possible drug interaction exists, a "Drug Interaction" pop-up box will appear. A description of the medicine interaction will be displayed for the prescriber: • If an alternate medicine is available on the respective CCMDD formulary, a recommendation is given to the prescriber. The prescriber has the choice to either: • "Substitute" with the recommended medicine. The substituted medicine will appear on the prescription and the original medicine will not appear on the prescription. • "Override & Continue" – If the prescriber clicks this option the original medicine that was prescribed will be loaded on the prescription.	Authorised Prescriber
42	• Select the correct **months' supply** from the drop down (1-month, 2-months or 3-months) If 1 month is selected, the "Number of repeats" defaults to 5 repeats. If 2 months is selected, the "Number of repeats" defaults to 4 repeats. • Choose the **prescription validity period.** • Indicate the number of months of medicine supplied by the health facility. • Mark first issue and indicate the place of dispensing.	Authorised Prescriber
43	Once the prescriber is satisfied with the prescription, click on "**Submit**" to transmit the prescription to the SP. If the prescription is saved and not submitted, the SP will not receive the prescription.	Authorised Prescriber
44	If any error was made on the prescription (including incorrect record of dispensing), after the prescriber clicked "Submit", the prescriber will not be allowed to submit another prescription without first cancelling the submitted prescription.	Authorised Prescriber

TOOLS

SOP 2: Annexure A - Health Facility CCMDD Patient Registration and Prescription Record

SOP 2: Process flow of registration of a patient onto CCMDD

Support material:
- Provincial CCMDD medicine list
- Approved PUP list
- Authorised prescriber list
- NSD calendar
- CCMDD prescription template
- SyNCH access and training

refers to 4.6 subsection (a-b) evidence (b)

this is the original work of my intern (Kevin) I personally witnessed him do this. 15/01/2025

Signature of the Intern and Tutor

2.3.5.6 Receiving

Thermolabile pharmaceutical products must be identified on receipt and be stored in accordance with written instructions for purposes of stock management within the shortest possible time from offloading.

(a) The receiving area must protect deliveries from bad weather during the unloading of thermolabile pharmaceutical products;

(b) The receiving area must be separated from the storage area;

(c) Upon arrival of thermolabile pharmaceutical products, the receiving personnel must do spot checks and inspect the delivery vehicle to ensure product integrity with regards to the following:

(i) product security,

(ii) that the product has not been tampered with and that there are no damaged containers,

(iii) that products were protected from weather,

(iv) and that there is no risk for contamination of products.

(d) The delivery document must be reviewed for evidence that transportation requirements, *inter alia* temperature control, have been met;

(e) Check temperature data loggers, refrigeration tags, freezer tags, log tags or cold chain monitoring cards to ensure the temperature history of the transport and the temperature history of the thermolabile pharmaceutical product being transported were maintained within in limits.

(f) If any discrepancies are identified, they must all be documented. In addition the supplier must be notified immediately and the thermolabile pharmaceutical products must be identified and segregated.

(g) A Standard Operating Procedure for receiving of thermolabile pharmaceutical products must be used to ensure these products are within manufacturer specific temperature range during the receiving process.

(h) Quality assessment sampling requiring laboratory testing is required for the received thermolabile pharmaceutical products within a manufacturing pharmacy before they are taken to the main store facility.

(i) Quality assessment sampling requiring observation for damaged products is required for the received thermolabile pharmaceutical products within a wholesale, community or institutional pharmacy before they are taken to the main store facility.

refers to 4.6 subsection (a-b) evidence (a)

Signature of the Intern and Tutor

health

refers to 4.6 subsection (a-b) evidence (b)

this is original work of my intern (Kevin) I personally witnessed him do this. 15/01/2025

STANDARD OPERATING PROCEDURE

TITLE	**REGISTRATION (ENROLMENT) OF PATIENTS ON THE CCMDD PROGRAMME AND PRESCRIPTION RENEWAL PROCESS**		
INSTITUTION	NATIONAL DEPARTMENT OF HEALTH		
REFERENCE NUMBER	CCMDD SOP 2	**EFFECTIVE DATE**	MAY 2018

PURPOSE

Outline the process of identifying and registering patients on the Central Chronic Medicine Dispensing and Distribution (CCMDD) programme.

PERSONS AFFECTED

- Facility pharmacy personnel (pharmacist/PA)
- Authorised Prescriber (doctor/nurse)
- CCMDD service provider

APPLICABLE POLICIES/LEGISLATION

- Medicines and Related Substances Act 101 of 1965 as amended, and the regulations and guidelines published in terms of this Act (the **'Medicines Act'**)
- Pharmacy Act 53 of 1974 as amended, and the regulations and rules published in terms of this Act (the **'Pharmacy Act'**)
- National Health Act 61 of 2003 as amended, and regulations issued in terms of the Act
- The South African Nursing Act 50 0f 1978 as amended, and the regulations and guidelines in terms of this Act (the **'Nursing Act'**)
- The Disaster Management Act 57 of 2002, and relevant Regulations
- Protection of Personal Information Act, 2013
- The Electronic Communications and Transactions Act 25 of 2002 (ECT Act) South Africa
- Standard Treatment Guidelines, Essential Medicine List
- CCMDD SOP 1: Facility readiness and roll out

ABBREVIATIONS

- **ART:** Antiretroviral Therapy
- **CCMDD:** Central Chronic Medicine Dispensing and Distribution
- **COPD:** Chronic Obstructive Pulmonary Disease
- **DOB:** Date of Birth
- **FPG:** Fasting Plasma Glucose
- **GORD:** Gastro-oesophageal reflux disease
- **HRT:** Hormone Replacement Therapy
- **NCDs:** Non Communicable Diseases
- **NSD:** Next Schedule Date
- **PA:** Post-Basic Pharmacist Assistant
- **PMP:** Patient medicine parcel
- **PuP:** Pick-up-Point
- **SP:** Service provider
- **STG:** Standard Treatment Guideline
- **SyNCH:** Synchronised National Communication for Health
- **TPT:** TB Preventative Treatment
- **VL:** Viral Load

Signature of the Intern and Tutor

NOTES / SAFETY WARNINGS

a) Only prescriptions by authorised prescribers are valid and can be submitted to the SP.

Step 3: Implementation Evidence 1

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28	Verify the patient details to ensure it is recorded correctly. If patient details differ from the previous CCMDD history, ensure the following: • Note the correct information on the prescription. • Inform the SP to update the details on their system. • Inform the SyNCH helpdesk to correct the patients details on SyNCH.	Authorised Prescriber
29	If a CCMDD patient is no longer stable and the prescription cannot be renewed, submit a **deactivation form** to the SP (Refer to CCMDD SOP-8: Deactivation and deregistration of patients).	Prescriber / health facility
Patient registration and consent on SyNCH		
30	On the SyNCH home screen, select "Prescriptions" then "Manage scripts", "All Prescriptions (create new)", select "Create New Prescription".	Data capturer/ Authorised Prescriber
31	**Patient consent & Patient specification:** • After obtaining consent from the patient to register onto CCMDD, select "Yes" under the "Patient has acknowledged CCMDD registration" field. Complete the patient specification field by choosing one of the following fields: • New on CCMDD & New on SyNCH (Patient is joining CCMDD for the first time, and SyNCH is utilized to register patient). • An existing CCMDD patient, information captured on SyNCH for the first time (previous paper-based). • An existing CCMDD patient, information already captured on SyNCH (repeat).	Data capturer/ Authorised Prescriber
32	**Patient Details tab:** Patient details to be captured into the electronic system (Compulsory fields are marked with *): Identification number and or asylum/passport number * | Clinic File reference | Name and surname * Date of birth * (Auto-populated if SA ID number is used) | Patient address * | Language Pregnant * | Gender * | Weight Ward number | Contact number * (10-digit cell phone number) | Access to smart phone Alternate number | Medical history | Allergies • If the patient has already been registered on SyNCH, the system will automatically notify once the patient's identification number is entered into the **"Patient Details"** tab. (Scan barcoded ID). An "Existing Patient" pop-up box will appear. Select option as appropriate: ○ "Use Patient Record" – If this option is selected, the prescription will have to be entered. ○ "Use Patient Record & Prescription" - If this option is selected, the existing patient details and prescription will automatically be generated.	Data capturer /Authorised Prescriber
33	**Next of Kin Tab (Non-compulsory details)** Enter Next of Kin Details: First name, surname, relation & contact number.	Data capturer/ Authorised Prescriber
34	**Nominated Collector Tab** A patient is allowed to nominate up to two (2) nominated collectors (proxy's) to collect their PMP on their behalf.	Data capturer/ Authorised Prescriber

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refers to 4.6 subsection (a-s) evidence (a)

This is original work by intern (Klein) I personally witnessed her do this.
15/01/2025

CCMDD SOP 2 ANNEXURE A: HEALTH FACILITY CCMDD PATIENT REGISTRATION AND PRESCRIPTION RECORD

Province: District: Facility:

No	Date of Script	New/ Repeat patient (N/R)	Patient Surname	Patient Name	Patient ID /Passport /Asylum Seeker No	Patient Facility File No.	ART/ or ART & NCD/ or NCD only (A/A&N/NCD)	NSD	Next Patient Review Date	Selected Pick-up point (PUP) for collection	Type of PUP (Ex PuP, Facility PuP, OP, AC)
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Signature of the Intern and Tutor

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Assessor/Moderator comments

Step 3: Implementation

Requirements not met.

- The implementation describes several unrelated SOPs without aligning them to the behavioural statements or to annotated evidence, and it is inconsistent with the reflection.
- The reflection concerns an already-dispensed CCMDD parcel collected by another person, whereas the implementation describes receiving CCMDD stock and capturing invoices.
- Because the learning needs and knowledge gap were not clearly defined, the activity is not linked to a single, coherent outcome.
- The evidence is not sufficient and should be annotated clearly.

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Assessor/Moderator comments

Step 3: Implementation

- For B.S. (a) (apply policies): there is no policy from your own work setting in the evidence, and no evidence that a policy was applied. Board Notice 49 of 2015 (minimum standards for thermolabile products, a GPP update) is not a policy of your pharmacy and is not related to receiving a CCMDD parcel.
- For B.S. (b) (apply SOPs): include the complete SOP and evidence that you applied most of it; the four pages submitted from the 12-page DOH CCMDD SOP deal with enrolling a patient and do not correspond to the activities described.
- Select one clear activity, refer to the specific policy and SOP that govern it, annotate the evidence, and demonstrate actual application of each. A new entry must be submitted.

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Step 4: Evaluation

I learned how to accurately apply workplace policies relevant to the task or current practise. I have subsequently managed cold chain medications, from receiving them to packing them in the fridge. I have subsequently managed to capture stock on the real-time system after ordering stock the previous week. I have also subsequently learned about the CCMD program via SOPs on how to receive a parcel into the system, how to issue the parcel or mark it as collected, as the system indicates, for the patient, guardian, or partner in some cases, and what to ask for from a patient. I am more aware of handling stock policies and SOPs. I have subsequently managed to control the fridge's temperature monitoring. I would like to improve my knowledge in managerial areas, e.g. HR policies. I am more confident to volunteer to participate in dealing with deliveries than before.

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Assessor/Moderator comments

Step 4: Evaluation

Does not meet requirements.

- The evaluation describes general principles rather than specific knowledge or skills acquired, and because no policy or SOP was applied in the evidence, the intended outcome of the entry has not been met.
- Once a coherent activity with a specific policy and SOP has been completed and evidenced, and you state specifically what you learned about applying policies and SOPs, how this has influenced your practice (with a concrete example), and a future learning need aligned to the domain and to the skills acquired, then only can your evaluation text be assessed.

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Any questions?

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"**Health promotion**

is the process of enabling people to increase control over, and to improve their health."

CASE STUDY 5

DOMAIN 1

Public health

***Domain Competency* 1.1**

Promotion of health and wellness

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Reflection Title:

Conducting a public health campaign on vaccines at XXXX Hospital

Step 1: Reflection

During my internship at XXXX Hospital, I observed that many patients were unaware of the importance of vaccinations in preventing serious illnesses. One patient believed vaccines were only for children, highlighting a significant need in public education on immunisation for all age groups. Additionally, I noticed frequent prescriptions for preventable diseases, reinforcing the need for proactive healthcare. Recognising this gap, I took the initiative to initiate a vaccination awareness campaign within the hospital. I hope that by providing accurate information, addressing misconceptions, and promoting vaccine adherence, this empowers individuals to take charge of their health. I see it as my duty to educate the community on disease prevention strategies, including the role of vaccines. Through this, I aim to learn to enhance my ability to educate the public, promote disease prevention, and build confidence in providing health-related information.

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Assessor/Moderator comments

Step 1: Reflection

Learning title

Requirement met - the title is original and descriptive.

Learning need

Requirement partially met.

- The learning trigger is present, but the learning need is framed too narrowly around vaccine awareness, and around what you did rather than what you hope to learn.
- State a general learning need that relates to the competency standard and its behavioural statements, and that could be applied across any health-promotion activity and clearly identify the knowledge or skills you need to improve.

Note that Domain 1 emphasises the promotion of community health and the provision of information and advice to communities, not to individual patients or small groups; elaborate on how your learning needs align with behavioural statements (a–d).

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Step 2: Planning

I will seek approval from my supervisor to conduct a vaccination awareness campaign focused on educating patients about the importance of vaccines, encouraging their use, and addressing misconceptions. To ensure accuracy, I will refer to the STG and EML (Chapter 22, pages 451-455) for vaccine schedules, the National Immunisation Guidelines (2023, Section 4, pages 32-40) for disease prevention recommendations, and the CDC and WHO for vaccine safety, efficacy, and benefits and healthy lifestyle habits. I will design an educational pamphlet covering: • The role of vaccines in preventing infectious diseases (BS1.1b). • Common vaccine-preventable diseases (BS1.1b). • Vaccine schedules and eligibility by age (BS1.1a). • Healthy lifestyle habits to support immunity and overall wellness (BS1.1c). Additionally, I will create posters for hospital areas to maximize outreach (BS1.1d) and develop a feedback form to assess patient understanding post-intervention (BS1.1a-d).

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Assessor/Moderator comments

Step 2: Planning

Requirement partially met.

- The plan is in the future tense and lists resources, but it lacks sufficient detail to demonstrate that a public-health campaign can be delivered successfully.
- Add the specifics of the activity: when and where the campaign will take place, who the target audience is and why the topic is suitable for them, how and on what you will present, where the posters will be placed and why those areas are appropriate, to whom the pamphlets will be distributed.
- Explain how you will verify that you have reached a sufficient number of members of the public.
- For each resource, give the full reference (title, section/page, date/version) and the reason for its use. Ensure that your planning is sufficient to achieve at least 75% the behavioural statements.

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Step 3: Implementation

I researched and gathered evidence-based information to ensure my vaccination pamphlet and posters were informative (E1-6/BS 1.1a-d). Once satisfied with the accuracy, I designed and compiled the pamphlet (E9) and posters (E7-8), incorporating key details on vaccine-preventable diseases, schedules, and the importance of immunization (BS 1.1a-d). After obtaining my supervisor's approval, I conducted a vaccination awareness campaign at XXXX Hospital (E11/BS 1.1a, d). On 14 February 2025, I presented to patients, explained vaccine importance, addressed concerns, promoted adherence, and distributed pamphlets (E12/BS 1.1a-d). Posters in high-traffic areas reinforced key messages (E10/BS 1.1a, d).To evaluate effectiveness, I distributed feedback forms to assess patient understanding. Responses showed many gained new knowledge on vaccine-preventable diseases and the importance of adherence (E13/BS 1.1a-d)

Step 3: Implementation Evidence 1

EVIDENCE 1 :

CPD EVIDENCE

Signatures of the Intern and Tutor

I read through this article from the World Health Organization (WHO), which explains the science behind vaccinations, how they stimulate the immune system, and their role in preventing infectious diseases. The knowledge gained from this article was applied directly during the campaign. It helped me engage with patients, answer their questions, and deliver evidence-based information to encourage vaccination uptake achieving **BS 1.1 d.**

The article gave me a strong foundation in vaccine science, which allowed me to educate the public on why vaccinations are essential for personal and community health. This knowledge enabled me to confidently promote the benefits of immunization and address vaccine hesitancy, helping me achieve **BS 1.1 a.**
By understanding how vaccines prevent diseases, I was able to explain their role in reducing the spread of infections, lowering the burden of preventable illnesses, and achieving herd immunity. This helped me provide factual advice on how vaccinations protect individuals and communities helping me achieve **BS 1.1b**

This infographic from the **American Academy of Family Physicians (AAFP)** provides key facts about vaccines for children, including their safety, effectiveness, and role in preventing diseases. It highlights how vaccines protect not just individuals but entire communities through herd immunity. The infographic also addresses common concerns about side effects and emphasizes the importance of following vaccination schedules.
I used this to create a poster as part of my campaign materials to educate parents, helping them make informed decisions about vaccinating their children fulfilling **BS 1.1d**.

This resource helped me educate the public by providing reliable information about vaccines, reinforcing their importance in disease prevention achieving **BS 1.1a.** The infographic clearly outlines how vaccines reduce infection risks, supporting my role in advising parents about protecting their children from vaccine-preventable diseases completing **BS 1.1b**

I read through this infographic I found online , which explains how vaccines are biological products designed to protect against serious infections. It highlights the importance of routine vaccination schedules and special vaccines required for specific populations, such as the chronically ill and travellers. This information was incorporated into my pamphlet under the **"Vaccine schedules and eligibility criteria for different ages"** section.

By understanding vaccine schedules and eligibility, I was able to provide accurate advice on health promotion related to vaccinations achieving **BS 1.1a**. This evidence also helped me give informed advice on disease prevention and control by ensuring patients are aware of vaccine requirements achieving **BS 1.1b**.

Evidence 1 demonstrates the resources I used to develop the content for my vaccination pamphlet. The information gathered from these sources was incorporated into my pamphlet (E9), which I then used to educate and advise patients during my self-initiated campaign. This allowed me to promote health by providing accurate vaccine-related information, achieving **BS 1.1a.** Additionally, by using my pamphlet as an educational tool during the campaign, I actively engaged in public health promotion, achieving **BS 1.1d.**

Step 3: Implementation Evidence 2

CPD EVIDENCE

Signatures for intern and tutor

EVIDENCE 2:

Vaccines protect against diseases

Different vaccines work in different ways, but every vaccine helps the body's immune system learn how to fight germs. It typically takes a few weeks for protection to develop after vaccination, but that protection can last a lifetime. A few vaccines, such as those for tetanus or seasonal flu, require occasional booster doses to maintain the body's defenses.

Vaccines help the body's immune system learn how to fight germs.

I read through this article from the CDC, which explains how vaccines protect against diseases by training the immune system to recognize and fight harmful germs. It highlights that vaccination is a key part of disease prevention, especially for babies and children who are more vulnerable to infections. The article also addresses common concerns about vaccine side effects, explaining that mild reactions are expected, while serious ones are extremely rare due to strict monitoring by health authorities.

I used this information in my pamphlet (E9) to educate the public on why vaccination is essential for health promotion, disease prevention, and maintaining a healthy lifestyle. The section on vaccine safety and side effects helped me address common myths and reassure people about vaccine effectiveness. This was particularly useful for public health campaigns, where I provided clear, evidence-based advice to encourage vaccine uptake and reduce hesitancy in the community.

This statement acknowledges that germs are an unavoidable part of daily life, but some of them can cause severe or life-threatening infections. The immune system naturally fights off many of these germs, but some diseases require additional protection—which is where vaccines come in. Part of promoting healthy lifestyles involves teaching patients that vaccination works alongside other healthy behaviors like good hygiene, proper nutrition, and regular medical check-ups. The article reinforces that vaccines are an essential component of a healthy life, helping prevent serious illnesses and supporting overall wellness. During my presentation , I use this to emphasize that staying healthy isn't just about daily habits but also about taking preventive medical steps like vaccination, achieving **BS 1.1c**

Strengthening your baby's immune system

Immunity is the body's way of preventing disease. Because a baby's immune system is not fully developed at birth, babies face a greater risk of becoming infected and getting seriously ill. Vaccines help teach the immune system learn how to defend against germs. Vaccination protects your baby by helping build up their natural defenses.

- Children are exposed to thousands of germs every day. This happens through the food they eat, the air they breathe, and the things they put in their mouth.
- Babies are born with immune systems that can fight most germs, but some germs cause serious or even deadly diseases a baby can't handle. For those, babies need the help of vaccines.
- Vaccines use very small amounts of antigens to help your child's immune system recognize and learn to fight serious diseases. Antigens are the parts of a germ that cause the body's immune system to go to work.

Vaccines are safe

Before a new vaccine is ever given to people, extensive lab testing is done. Once testing in people begins, it can still take years before clinical studies are complete and the vaccine is licensed.

After a vaccine is licensed, the Food and Drug Administration (FDA), CDC, National Institutes of Health (NIH), and other federal agencies continue routine monitoring and investigate any potential safety concerns.

Keep in mind

CDC and the FDA take great care to make sure that a vaccine is safe both before it is licensed and after the public begins using it. Making sure that all vaccines are safe is a top priority for CDC.

Evidence 2 shows the resource I used to explain the role of vaccines in disease prevention and safety for my pamphlet. I incorporated information from the CDC article to educate the public on the importance of vaccination, addressing common concerns and promoting it as part of a healthy lifestyle. This effort helped me achieve **BS 1.1c** by advising patients on disease prevention and supporting health promotion during my campaign.

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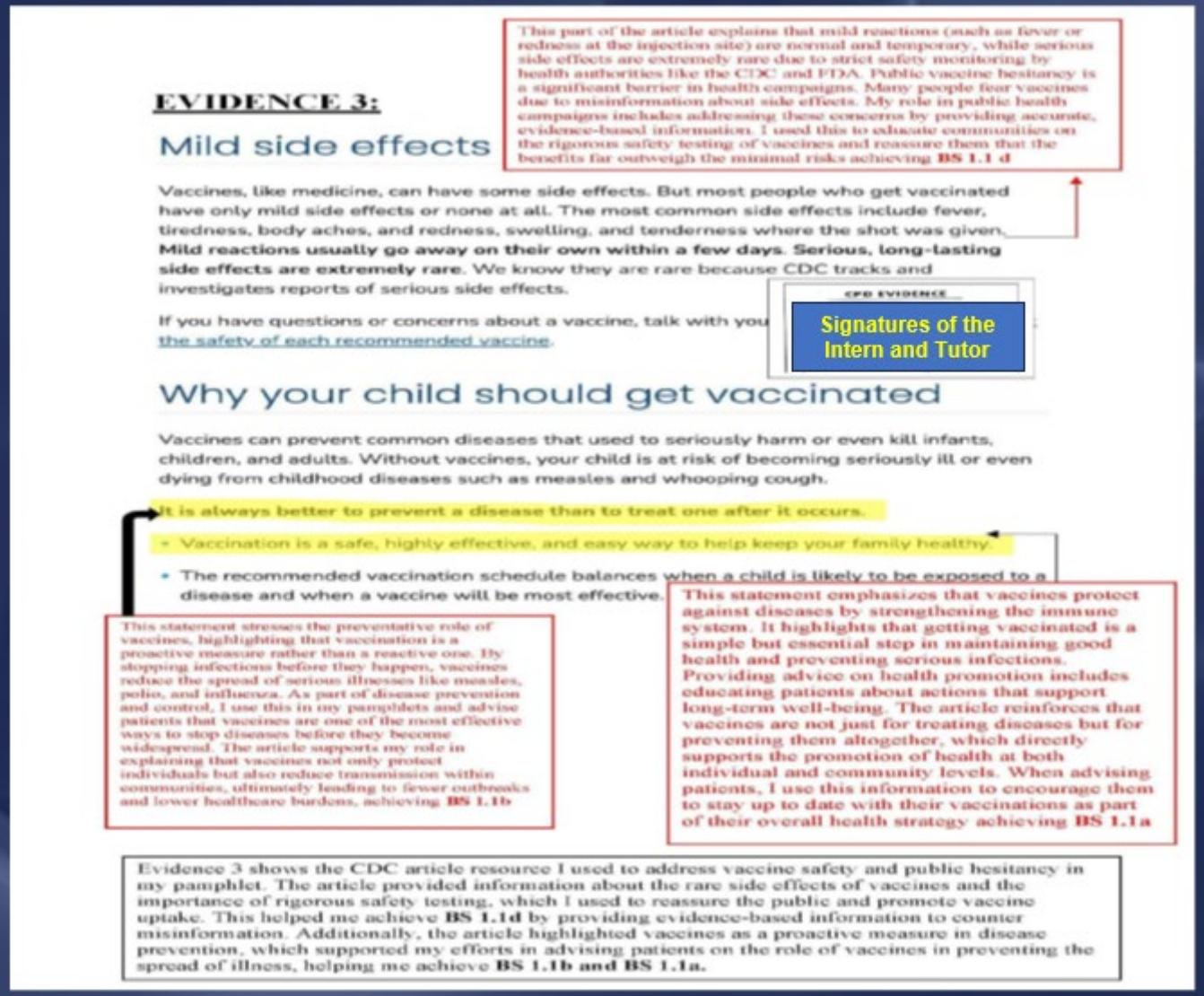
Step 3: Implementation Evidence 3



EVIDENCE 3:

Mild side effects

This part of the article explains that mild reactions (such as fever or redness at the injection site) are normal and temporary, while serious side effects are extremely rare due to strict safety monitoring by health authorities like the CDC and FDA. Public vaccine hesitancy is a significant barrier in health campaigns. Many people fear vaccines due to misinformation about side effects. My role in public health campaigns includes addressing these concerns by providing accurate, evidence-based information. I used this to educate communities on the rigorous safety testing of vaccines and reassure them that the benefits far outweigh the minimal risks achieving **BS 1.1 d**

Vaccines, like medicine, can have some side effects. But most people who get vaccinated have only mild side effects or none at all. The most common side effects include fever, tiredness, body aches, and redness, swelling, and tenderness where the shot was given. **Mild reactions usually go away on their own within a few days. Serious, long-lasting side effects are extremely rare.** We know they are rare because CDC tracks and investigates reports of serious side effects.

If you have questions or concerns about a vaccine, talk with you
the safety of each recommended vaccine.

CPD EVIDENCE

Signatures of the Intern and Tutor

Why your child should get vaccinated

Vaccines can prevent common diseases that used to seriously harm or even kill infants, children, and adults. Without vaccines, your child is at risk of becoming seriously ill or even dying from childhood diseases such as measles and whooping cough.

It is always better to prevent a disease than to treat one after it occurs.

- Vaccination is a safe, highly effective, and easy way to help keep your family healthy.
- The recommended vaccination schedule balances when a child is likely to be exposed to a disease and when a vaccine will be most effective.

This statement stresses the preventative role of vaccines, highlighting that vaccination is a proactive measure rather than a reactive one. By stopping infections before they happen, vaccines reduce the spread of serious illnesses like measles, polio, and influenza. As part of disease prevention and control, I use this in my pamphlets and advise patients that vaccines are one of the most effective ways to stop diseases before they become widespread. The article supports my role in explaining that vaccines not only protect individuals but also reduce transmission within communities, ultimately leading to fewer outbreaks and lower healthcare burdens, achieving **BS 1.1b**

This statement emphasizes that vaccines protect against diseases by strengthening the immune system. It highlights that getting vaccinated is a simple but essential step in maintaining good health and preventing serious infections. Providing advice on health promotion includes educating patients about actions that support long-term well-being. The article reinforces that vaccines are not just for treating diseases but for preventing them altogether, which directly supports the promotion of health at both individual and community levels. When advising patients, I use this information to encourage them to stay up to date with their vaccinations as part of their overall health strategy achieving **BS 1.1a**

Evidence 3 shows the CDC article resource I used to address vaccine safety and public hesitancy in my pamphlet. The article provided information about the rare side effects of vaccines and the importance of rigorous safety testing, which I used to reassure the public and promote vaccine uptake. This helped me achieve **BS 1.1d** by providing evidence-based information to counter misinformation. Additionally, the article highlighted vaccines as a proactive measure in disease prevention, which supported my efforts in advising patients on the role of vaccines in preventing the spread of illness, helping me achieve **BS 1.1b and BS 1.1a.**

South African

Step 3: Implementation Evidence 4

CPD EVIDENCE

Signatures of the Intern and Tutor

EVIDENCE 4:

The contents of this chapter are based on the cur
Vaccinators Manual, the current COVID-19 Vaccine Im
Guide and Toolkit and recommendations from
Advisory Group on Immunisation (NAGI).

13.1 IMMUNISATION SCHEDULE

Any medical incident that takes place after immunisation and may be potentially related to immunisation should be reported (See Section 13.6).

- Every clinic day is an immunisation day.
- Never miss a chance to immunise – never turn a child away if an immunisation is needed, even if it means opening a multi-dose vial for just one child.
- Check the Road to Health Booklet every time the child visits the clinic, and give missed immunisations. These should be given according to the catch-up schedule which is shown in the table on page 13.4.
- Mild illnesses are not a contra-indication to immunisation – most children who are well enough to be sent home, are well enough to be immunised. Do not immunise a sick child if the mother seriously objects, but encourage her to bring the child for immunisation on recovery.
- Give an extra dose if in doubt whether a child has had a certain dose or not, as extra doses are not harmful.
- The currently used measles vaccine must not be given with other childhood vaccines. All other vaccines listed in the table below can be given safely at the same time, but should not be given in the same syringe.
- Serious adverse events following immunisation are uncommon. All adverse events other than mild systemic symptoms (irritability, fever < 38°C) and minor local reactions (redness/swelling at infection site) should be reported.
- For management of anaphylaxis associated with vaccinations, See Section 22.2.10: Anaphylaxis.
- As COVID vaccination recommendations are being updated regularly as new evidence emerges, please consult the latest National Department of Health vaccine policy recommendations.
- **Note:** COVID-19 vaccines may be administered without regard to timing of other vaccines. This includes simultaneous administration of COVID-19 vaccine and other vaccines on the same day. If multiple vaccines are administered at a single visit, administer each injection in a different injection site (different arm), with the COVID-19 vaccine administered on the LEFT arm.

LoE: IVb

There are very few contra-indications, but many missed opportunities.

Adverse events requiring reporting

Local reactions

- Pain, redness and / or swelling of more than 3 days' duration.
- Swelling more than 5 cm from injection site.
- BCG lymphadenitis following immunisation.
- Injection site abscesses following immunisation.

I read through a section from the National Immunisation Guidelines, section 4, Chapter 13.1 and 13.2 (below) which focuses on the immunization schedule. This chapter provides guidance on vaccination procedures, including ensuring that no child is turned away from immunization, the importance of keeping up with missed doses, and managing potential adverse events. It also outlines that mild illnesses are not a contraindication to immunization and highlights the necessity of reporting any adverse reactions, such as pain, redness, swelling, and injection site abscesses. It emphasizes the necessity of immunization to prevent infectious diseases, ensuring that vaccines are administered even if the child has mild illnesses. I included this in pamphlets helping me achieve **BS 1.1b.**

13.2 CHILDHOOD IMMUNISATION SCHEDULE

Immunisation schedule

Age of child	Vaccine
At birth	OPV0 BCG
6 weeks	OPV1 RV1 Hexavalent (DTaP-IPV-HB-Hib)1 PCV1
10 weeks	Hexavalent (DTaP-IPV-HB-Hib)2
14 weeks	RV2 Hexavalent (DTaP-IPV-HB-Hib)3 PCV2
6 months	Measles1
9 months	PCV3
12 months	Measles2
18 months	Hexavalent (DTaP-IPV-HB-Hib)4
6 years	Td
12 years	Td

Note:

2020-3 13.3

This table provides a structured timeline for vaccine administration from birth to 12 years, detailing which vaccines should be given at each stage. It includes essential vaccines.

I used this **Childhood Immunisation Schedule** in my pamphlet to educate parents and caregivers on when their children should receive each vaccine, ensuring timely immunization for optimal protection. By sharing this structured schedule, I promote the importance of early and complete vaccination to prevent serious illnesses fulfilling **BS 1.1a.**

I read through the **World Health Organization's (WHO) list of available and pipeline vaccines**, which provides an overview of the diseases for which vaccines are currently in use and ones which are developing.

I used this information in my pamphlet to educate the public on the diseases that can be prevented by using vaccines, achieving **BS 1.1b**

Evidence 4 shows the resources I used from the National Immunisation Guidelines and the WHO list of vaccines. The guidelines provided detailed information on the immunization schedule, vaccine administration procedures, and the importance of timely vaccinations, which I included in my pamphlet and posters to educate parents about when their children should receive each vaccine, helping me achieve BS 1.1a. Additionally, I used the WHO's information to inform the public about vaccine-preventable diseases, supporting disease prevention efforts and achieving **BS 1.1b.**

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Step 3: Implementation Evidence 5

EVIDENCE 5:

CPD EVIDENCE

Signatures of the Intern and Tutor

Standard Treatment Guidelines and Essential Medicines List for South Africa

Hospital Level, Adults
2019 Edition

» The following vaccines should be administered:

LoE: IV

VACCINE	SCHEDULE
• Polyvalent pneumococcal vaccine, 0.5 mL, SC.	○ PCV13, SC, 2 weeks before surgery. ○ PPS23, SC, 8 weeks later. ○ Revaccinate with PPS23 after 5 years and then at 65 years. LoE: II
• Haemophilus influenza type B, 0.5 mL, intramuscular.	—
• Meningococcal polysaccharide vaccine ($ACW_{135}Y$), 0.5 mL, SC	Revaccinate every 5 years.
• Influenza vaccine, 0.5 mL, IM.	Revaccinate annually.

I read through the Standard Treatment Guidelines (STGs) and Essential Medicines List (EML) 2019, (Chapter 22, pages 451–455) which includes a vaccination schedule table outlining the administration of specific vaccines. The table details the recommended dosage, route of administration (subcutaneous or intramuscular), and revaccination intervals for vaccines such as pneumococcal, Haemophilus influenzae type B, meningococcal polysaccharide, and influenza vaccines. For example, it specifies that the influenza vaccine should be given annually, while meningococcal polysaccharide vaccine requires revaccination every five years.

I will use this information in my pamphlet to provide accurate vaccine recommendations and emphasize the importance of timely immunization. This supports **BS 1.1 b** as it highlights how vaccines can help prevent

Evidence 5 shows the resource I used from the Standard Treatment Guidelines (STGs) and Essential Medicines List (EML) 2019 to provide accurate vaccine recommendations in my pamphlet. The vaccination schedule outlined dosage, administration routes, and revaccination intervals, which I used to educate the public on the importance of timely immunization. This helped me achieve **BS 1.1b** by promoting disease prevention through proper vaccination.

Step 3: Implementation Evidence 6

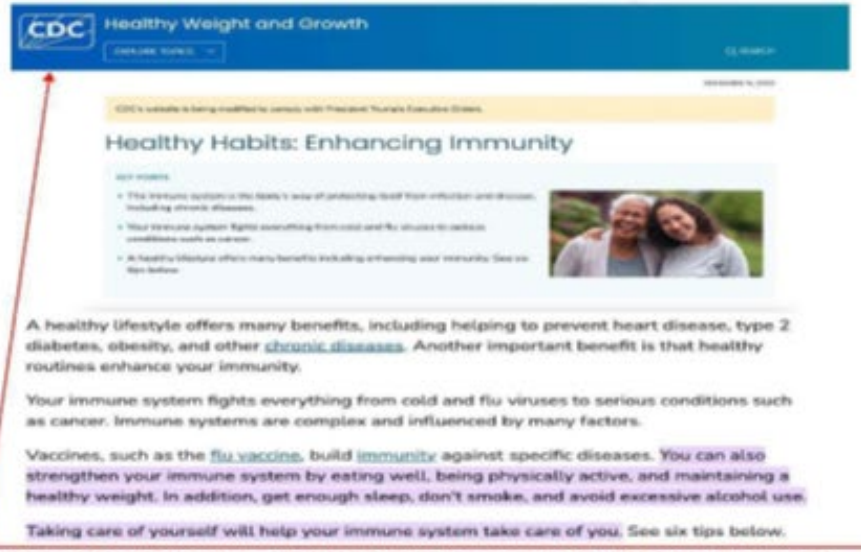
EVIDENCE 6:

CPD EVIDENCE

Signatures of the Intern and Tutor

I read through this WHO guideline, which outlines 10 key steps to healthy eating. It emphasizes the importance of a balanced diet rich in plant-based foods, whole grains, fruits, and vegetables while limiting unhealthy fats, sugar, and salt intake. Additionally, it highlights maintaining a healthy weight and engaging in regular physical activity. This information was incorporated into my poster under the "Healthy Lifestyle Tips" section.

By understanding key dietary recommendations, I was able to provide accurate advice on healthy eating habits to promote overall well-being achieving **BS 1.1c.** This evidence also helped me educate individuals on lifestyle modifications, such as physical activity and balanced nutrition, to prevent chronic diseases like obesity, diabetes, and hypertension **BS 1.1d**



I reviewed this CDC webpage, which highlights the importance of healthy habits in enhancing immunity. It explains that the immune system protects the body from infections and chronic diseases and that maintaining a healthy lifestyle plays a critical role in supporting immune function. Key recommendations include eating well, staying physically active, maintaining a healthy weight, getting enough sleep, avoiding smoking, and limiting alcohol intake. This information was incorporated into my poster under the "Ways to Strengthen Your Immune System" section.

By understanding and promoting these key lifestyle habits, I was able to provide accurate advice on maintaining a healthy immune system achieving **BS 1.1 c**.
This evidence supported my ability to provide guidance on disease prevention by educating individuals on how lifestyle choices influence immunity achieving **BS 1.1a**.

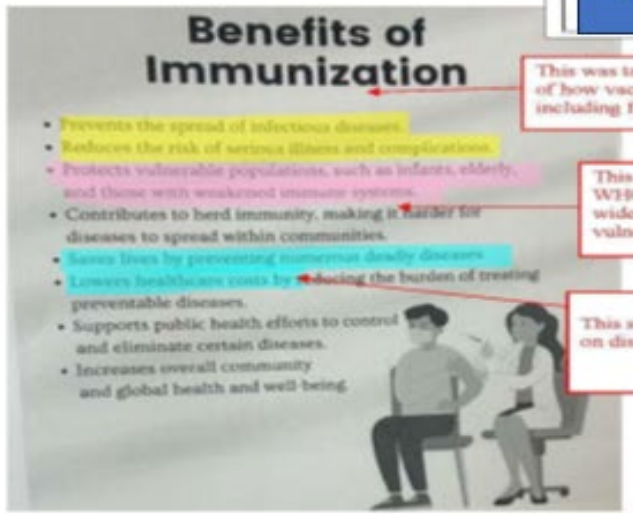
Evidence 6 shows the resources I used from the WHO guidelines on healthy eating and a CDC webpage on immune health to develop my poster. The WHO guidelines provided key dietary recommendations, which I included in the "Healthy Lifestyle Tips" section to educate individuals on balanced nutrition, physical activity, and weight management, achieving **BS 1.1c.** The CDC resource highlighted lifestyle habits that support immune function, such as proper nutrition, sleep, and exercise, which I incorporated into the "Ways to Strengthen Your Immune System" section. This helped me provide guidance on disease prevention, supporting **BS 1.1a,** while also promoting overall well-being through healthy lifestyle choices, achieving **BS 1.1c.**

Step 3: Implementation Evidence 7 & 8

CPD EVIDENCE

Signatures of the Intern and Tutor

EVIDENCE 7:



This was taken from the CDC's explanation of how vaccines help fight serious diseases, including flu and chronic conditions.

This aligns with prior evidence from the WHO articles emphasizing that widespread immunization protects vulnerable populations.

This statement relates to WHO's guidelines on disease control through vaccination.

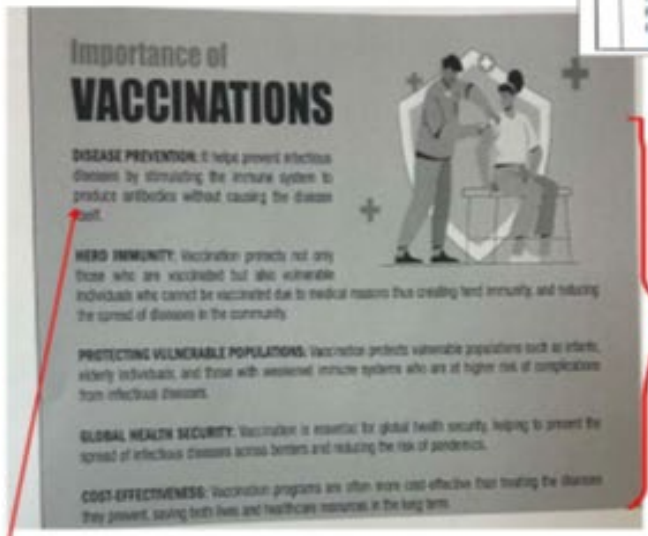
Evidence 7 refers to a poster I created, which focuses on the benefits of immunization, emphasizing its role in preventing infectious diseases, reducing complications, and contributing to public health efforts. It aligns with previous evidence, particularly the infographic that explained how vaccines protect against serious infections and the CDC page that highlighted how vaccination builds immunity.

This poster provides advice on health promotion by educating individuals on how vaccines contribute to overall well-being allowing me to achieve **BS 1.1a**
It supports disease prevention and control by explaining the protective benefits of immunization, achieving **BS 1.1b**
The poster itself serves as a public health campaign tool, reinforcing the importance of vaccination within the community helping me achieve **BS 1.1d**

CPD EVIDENCE

Signatures of the Intern and Tutor

EVIDENCE 8:



The information aligns well with my previous evidence on immunization benefits and immunity-enhancing habits from CDC sources.

The CDC document (E1-3) discussed how the immune system fights off diseases, the importance of vaccines like the flu vaccine, and lifestyle factors that strengthen immunity. I expanded on this by breaking down how vaccines contribute to public health beyond individual immunity.

Evidence 8 shows another poster I created that emphasizes the critical role of vaccinations in disease prevention, herd immunity, protecting vulnerable populations, global health security, and cost-effectiveness. The poster educates on how vaccines contribute to better public health and prevent the spread of disease which is **BS 1.1 a.** Disease prevention is explicitly covered in the first section, explaining how vaccines stimulate the immune system to fight diseases before they occur fulfilling **BS 1.1 b.** I actively educated the public about vaccines, their benefits, and their role in preventing illness completing **BS 1.1 d.**

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Step 3: Implementation Evidence 9 & 10

EVIDENCE 9:

The pamphlet educates about **disease prevention through vaccines** and their role in **public health security** , thereby allowing me to achieve **BS 1.1a.**

I used the scientific evidence (WHO, CDC, STG/EML) to emphasize herd immunity, vaccine-preventable diseases, vaccine schedules and protection of vulnerable groups, allowing me to provide advice on disease prevention and control **BS 1.1b** The vaccine schedules align with the STG/EML immunization schedule for different age groups, ensuring accuracy in the recommended vaccines for infants, children, teenagers, adults, and the elderly.

I promoted nutrition, exercise, hydration, and hygiene as immunity boosters, per WHO health guidelines, this allowed me to provide advice on healthy lifestyles **BS 1.1c** .

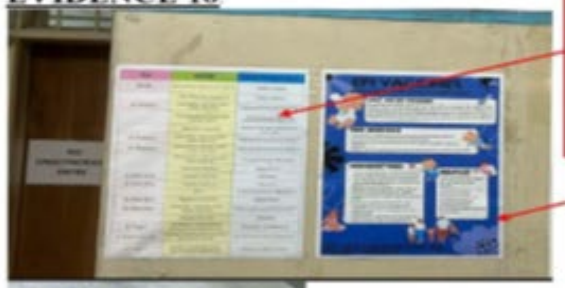
CPD EVIDENCE

Signatures of the Intern and Tutor

Evidence 9 shows I created a pamphlet and handed this out , which includes all the information I acquired. It is evidence-based and aligned with international and national health policies. It effectively translates scientific guidelines into accessible public health messaging.

This was presented in my campaign, it encourages **vaccination awareness and accessibility**, supporting **government and global immunization efforts** , helping me achieve **BS 1.1 a,b,c,d.**

EVIDENCE 10



This poster presents the vaccine schedule, is based on South African STG & EML guidelines, and the disease it prevents and when to take it. By ensuring accuracy in vaccine timing and disease coverage, it simplifies crucial information for parents and caregivers. This poster organises complex immunization schedules into a clear format, making it easier for the public to follow. It aligns with **BS 1.1b** as I provide advice on disease prevention and control, and educate the public on the critical role of vaccines in preventing infectious diseases.

This poster educates on what EPI vaccines are, their importance, and common misconceptions, I used the CDC for this information. It directly addresses vaccine hesitancy, allowing me to provide advice on health promotion thereby achieving **BS 1.1 a**

These posters are based on WHO guidelines on nutrition and lifestyle for disease prevention, promoting balanced diets, hydration, and physical activity to support immune function. It encourages individuals to adopt sustainable, healthy habits that reduce the risk of chronic diseases and improve overall well-being. This aligns with **BS 1.1c** as I provide advice on healthy lifestyles, and educate the public on the link between daily health choices and long-term disease prevention.

CPD EVIDENCE

Signatures of the Intern and Tutor

Evidence 10 shows the above posters I created which were evidence-based, visually engaging, and strategically placed in high-traffic areas, ensuring maximum impact. I explained them for the campaign which strengthened my competency in health promotion, patient education, and public health advocacy.

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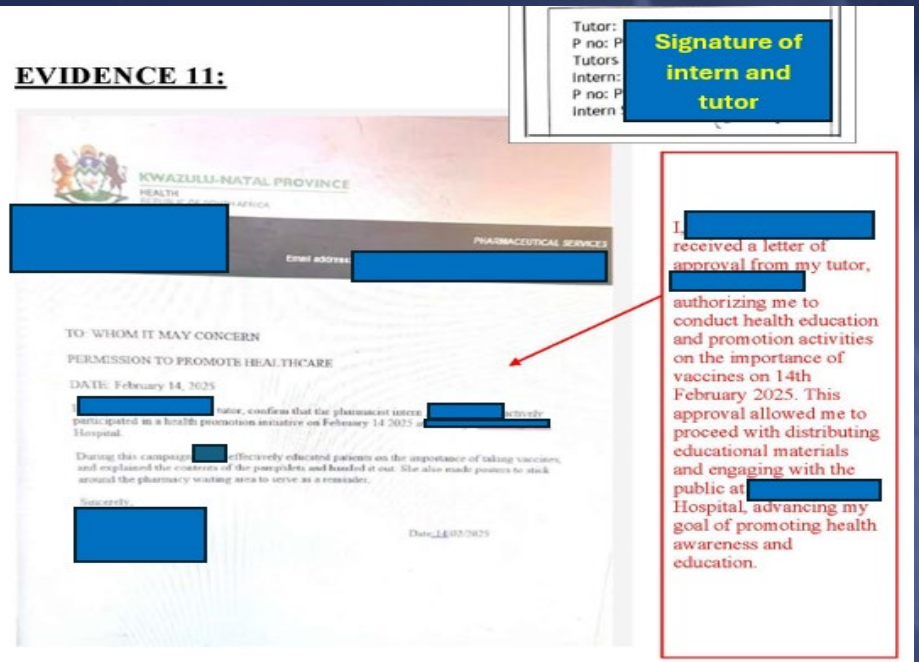
Step 3: Implementation Evidence 11 & 12

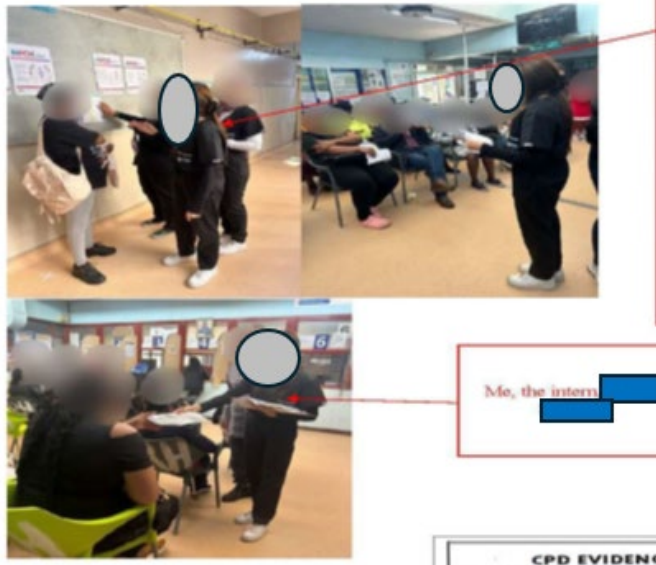
EVIDENCE 11:



I received a letter of approval from my tutor, authorizing me to conduct health education and promotion activities on the importance of vaccines on 14th February 2025. This approval allowed me to proceed with distributing educational materials and engaging with the public at Hospital, advancing my goal of promoting health awareness and education.

Evidence 11 confirms that my tutor, granted me permission to participate in my self-initiated campaign and educate patients on the importance of vaccines at Hospital, enabling me to promote health through education. This aligns with **BS 1.1d**, as it demonstrates authorization to engage in health promotion activities regarding vaccinations under supervision.

EVIDENCE 12:



On February 14, 2025, I had the opportunity to educate the public at Hospital pharmacy on the importance of vaccines, distributing pamphlets, explaining vaccination benefits, and addressing the public's questions through my self-initiated campaign. I documented the experience by taking photos while ensuring patient confidentiality by blocking their faces. This experience was incredibly rewarding and impactful.

Me, the intern

Evidence 12 records my involvement as an intern, Hospital pharmacy, where I took the initiative to run a public health campaign on the importance of vaccines. During this campaign, I distributed informative pamphlets, educated individuals on the benefits of immunization, and addressed any questions or concerns they had (fulfilling **BS 1.1d**). By actively engaging in health education, I contributed to raising awareness about vaccines, aligning with behavioral statement 1.1a by providing advice on their role in preventing illness. Furthermore, by emphasizing disease prevention strategies and the role of a healthy lifestyle in maintaining immunity, I successfully met BS **1.1b and 1.1c**.

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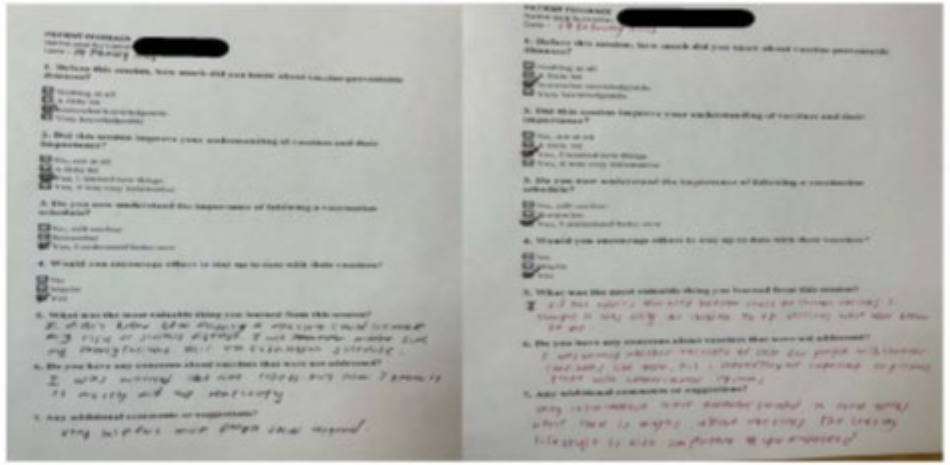
Step 3: Implementation Evidence 13

CPD EVIDENCE

Signatures of the Intern and Tutor

EVIDENCE 13:



Evidence 13 highlights the positive feedback received from my self-initiated public health campaign on the importance of vaccines at [redacted] Hospital on 14 February 2025 (achieving **BS 1.1d**). This feedback serves as proof of my role in educating patients and promoting health awareness about immunization, successfully meeting **BS 1.1a, 1.1b, 1.1c, and 1.1d**. Through this campaign, I provided essential health education on vaccines **(BS1.1a)**, explained how vaccination prevents the spread of infectious diseases **(BS 1.1b)**, and advised the public on maintaining a healthy lifestyle to support immunity **(BS 1.1c)**. The feedback form validates my efforts in empowering individuals with knowledge, encouraging informed health decisions, and promoting proactive disease prevention strategies.

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Assessor/Moderator comments

Step 3: Implementation

Requirement partially met.

Describe the activity in full:

- To whom did you present?
- Where did the presentation take place?
- Where were the posters placed?
- What did the presentation consist of? (and whether it extended beyond the pamphlet content)
- What questions or concerns did patients raise?
- Which resources did you use?
- State clearly which legislation relates to a public-health campaign conducted by an intern.

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Assessor/Moderator comments

Step 3: Implementation

Evidence: Not yet met the requirement.

- The evidence does not yet demonstrate:
  - that at least 75% of the behavioural statements were performed,
  - that enough members of the public were reached.
- References are aids only and are not accepted as actual evidence.
- A properly headed attendance register is required; two feedback forms and an affidavit are insufficient to show reach.
- The presentation itself must be submitted.
- Your own posters and pamphlets should have the presenter's name and date.
- The pamphlet uses technical terms (e.g., meningococcal, papillomavirus) that should be made accessible.
- Would benefit from references and an immunisation schedule.
- Some parts are not legible.
- Provide evidence of poster placement.
- The poster shown is small and illegible alongside other prominent posters.
- A single, clear, plain-language poster may be more effective.

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Assessor/Moderator comments

Step 3: Implementation

.....

Evidence: Not yet met the requirement.

- Correct the factual points raised (e.g., influenza is not fully preventable by vaccination; confirm current COVID-19 vaccine availability; additional preventable diseases could be listed) and consider addressing vaccine hesitancy.
- Per behavioural statement:
  - (a) explain what vaccines are and contain, to support health promotion and counter hesitancy;
  - (b) give more detail on disease prevention through vaccination and lifestyle, and on the preventable diseases themselves;
  - (c) actively guide attendees to healthy-lifestyle and other prevention messaging (e.g., hand hygiene, mask use), not only via a separate poster;
  - (d) demonstrate genuine public engagement across cohesive, mutually supporting media (presentation, posters, pamphlet) reaching a verifiable, suitable audience.
- A new implementation description and Portfolio entry will need to be submitted, as this entry cannot be corrected with the current evidence.

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Step 4: Evaluation

Participating in this campaign was an enriching experience that reinforced the importance of public health education. By designing an informative pamphlet and engaging with patients, I addressed misconceptions, promoted vaccine adherence, and empowered individuals to make informed health decisions. This experience strengthened my communication skills, enhanced my ability to educate the public, and deepened my understanding of pharmacists' role in health promotion. The campaign was successful, as more patients were now coming in for immunisation. Inspired by this, I have contributed to discussions on other public health initiatives at XXXX Hospital, including TB awareness. Moving forward, I aim to improve my ability to create engaging educational materials and to incorporate interactive elements such as Q&A sessions. By continuously refining my health promotion efforts, I am confident in my ability to enhance vaccination uptake and overall public health awareness

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Assessor/Moderator comments

Step 4: Evaluation

Requirement met.

- The impact on your practice and an example of application are clear.
- To strengthen the entry, make each of the four (4) evaluation points speak to what you learned about the competency standard (promotion of health and wellness) and its behavioural statements, rather than about the campaign topic, and focus on what you learned rather than what you did.
- Provide specific details of how you have subsequently applied the acquired knowledge and identify a clearer future learning need that relates to the domain rather than to this specific activity.

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Any questions?

CASE STUDY 6

DOMAIN 3

Supply of medicines and medical devices

Domain Competency 3.5

Medicine compounding

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Reflection Title:

The application of pharmaceutical knowledge in compounding oral vancomycin 25mg/ml syrup using vials of vancomycin powder.

Step 1: Reflection

On 02/05/2025, I observed our pharmacist who was compounding Magic Mouthwash. I watched her as she applied different compounding techniques based on the knowledge she had of the API and excipients. This experience triggered my learning need to improve my competence in applying the information we learnt in pharmaceutics lectures and from research on APIs, excipients and compounding techniques to make stable, safe and patient-friendly dosage forms. I hope to be able to apply the information on the physical and chemical properties of APIs and excipients that I find in pharmacopoeias and other resources to ensure that compatible excipients are used in the compounding process for stable dosage forms to be made. I also hope to learn effective compounding techniques and to sharpen my calculation skills when working with different master formulas. I also want to be able to apply the knowledge on the stability of APIs to determine the storage conditions of the compounded products.

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Assessor/Moderator comments

Step 1: Reflection

Learning title - Requirements met.

Learning needs - Requirements met.

- The learning need and an authentic trigger have been identified. Observing the pharmacist compound Magic Mouthwash prompted the need to strengthen your application of pharmaceutical knowledge (API and excipient properties, compounding techniques and calculations) to produce stable, safe dosage forms, and what you hope to achieve is clearly stated.

- To strengthen it further, frame the trigger explicitly as a situation in which you needed to apply CS 3.5 yourself, rather than only observing it, so that the personal knowledge gap is clear.

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Step 2: Planning

I will read the XXXX guidelines for compounding and Section 2.18 of the GPP, which focuses on compounding. The guidelines will provide useful information on the procedures followed when compounding and Section 2.18 of the GPP on p131 will help me compound medicines following regulatory guidelines, which ensure quality assurance and patient safety. Using this information, I plan on making a checklist that I will use when compounding to ensure that I follow the correct procedure. I plan on also reading journal articles and Pharmacy Practice textbooks on different compounding techniques. Before compounding, I will look for information on the physical and chemical properties of the API and excipients on the PubChem website to apply during the compounding process. I also plan on applying the compounding techniques I have learnt in pharmaceutics and asking pharmacists about the techniques they find to be effective when compounding a specific dosage form.

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Assessor/Moderator comments

Step 2: Planning

Requirement partially met.

- The plan is in the future tense, provides the rationale for the resources, and links to the behavioural statement.
- The details of some resources are incomplete: give the full reference for the Pharmacy Practice textbooks on compounding techniques and the exact PubChem source (entry/compound name and date of access).
- The plan should also state specifically what you intend to compound and how you intend to do it.

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Step 3: Implementation

On 08/05/2025, we received a prescription for vancomycin 25mg/ml syrup for a patient at XXXX Hospital. I validated and interpreted the prescription and asked the pharmacist, since I was unfamiliar with the procedure. I then compounded the vancomycin syrup based on the formula provided in the pharmacy records. Before compounding, I looked at vancomycin's solubility to ensure that it would truly dissolve in water. I also refreshed my knowledge on the reconstitution of powders in vials. I washed my hands and cleaned the work area and the compounding equipment. I reconstituted the vancomycin vials using sterile water, applying the 45-90° technique of puncturing the vial's rubber bung. I then drew the solution from the vials using the milking technique, then mixed the vancomycin solution with syrup simplex and sterile water to make the syrup. I also used vancomycin's stability information to determine storage conditions. I labelled the bottle and completed the compounding records.

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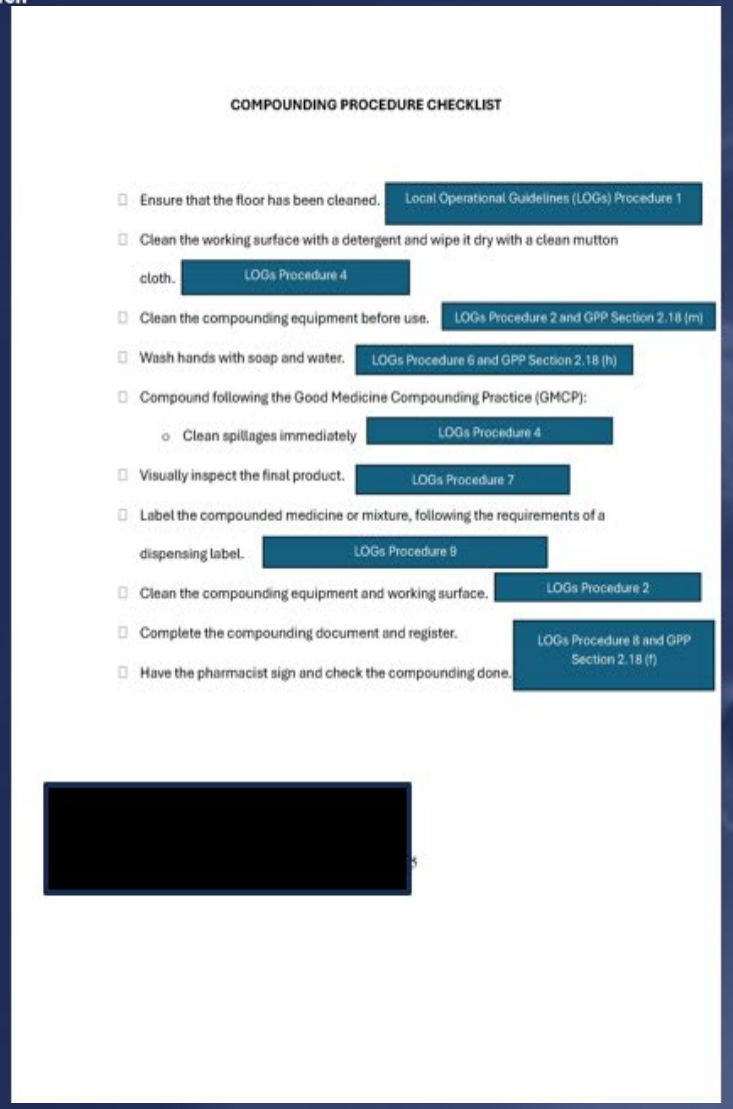
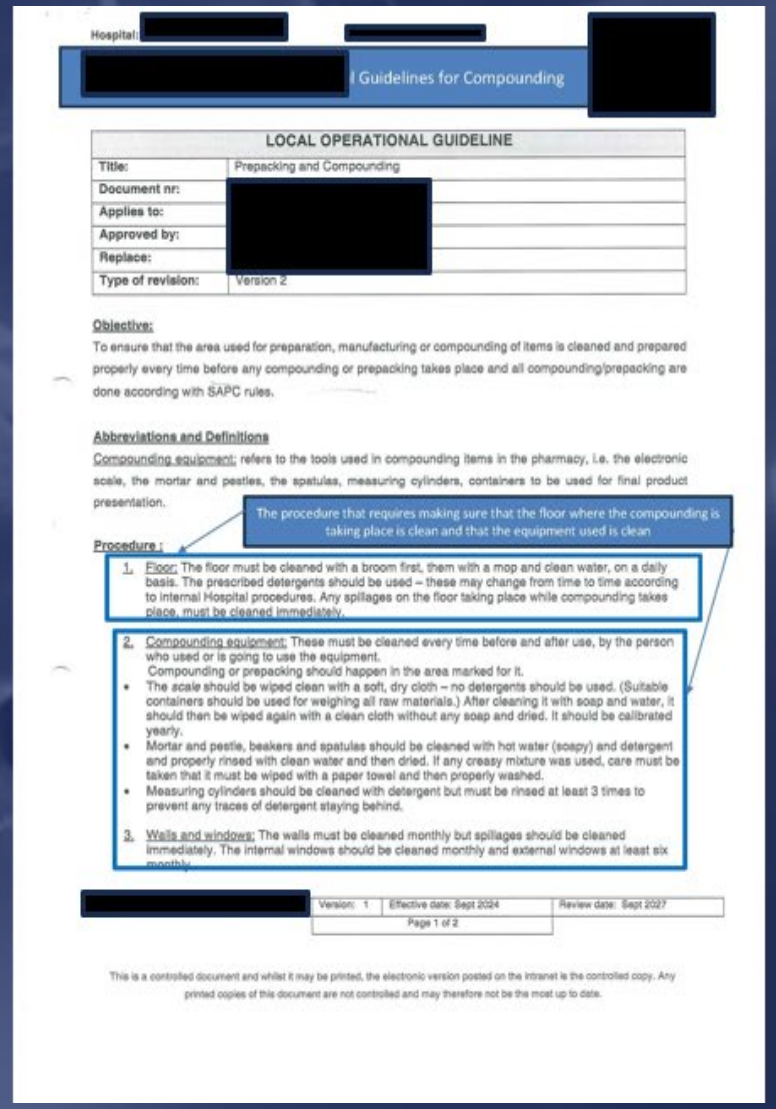
Step 3: Implementation Evidence



COMPOUNDING PROCEDURE CHECKLIST

- ☐ Ensure that the floor has been cleaned. — Local Operational Guidelines (LOGs) Procedure 1
- ☐ Clean the working surface with a detergent and wipe it dry with a clean mutton cloth. — LOGs Procedure 4
- ☐ Clean the compounding equipment before use. — LOGs Procedure 2 and GPP Section 2.18 (m)
- ☐ Wash hands with soap and water. — LOGs Procedure 6 and GPP Section 2.18 (h)
- ☐ Compound following the Good Medicine Compounding Practice (GMCP):
  - o Clean spillages immediately — LOGs Procedure 4
- ☐ Visually inspect the final product. — LOGs Procedure 7
- ☐ Label the compounded medicine or mixture, following the requirements of a dispensing label. — LOGs Procedure 9
- ☐ Clean the compounding equipment and working surface. — LOGs Procedure 2
- ☐ Complete the compounding document and register.
- ☐ Have the pharmacist sign and check the compounding done. — LOGs Procedure 8 and GPP Section 2.18 (f)

[redacted]



Hospital: [redacted]

[redacted] l Guidelines for Compounding [redacted]

LOCAL OPERATIONAL GUIDELINE	
Title:	Prepacking and Compounding
Document nr:	[redacted]
Applies to:	
Approved by:	
Replace:	
Type of revision:	Version 2

Objective:

To ensure that the area used for preparation, manufacturing or compounding of items is cleaned and prepared properly every time before any compounding or prepacking takes place and all compounding/prepacking are done according with SAPC rules.

Abbreviations and Definitions

Compounding equipment: refers to the tools used in compounding items in the pharmacy, i.e. the electronic scale, the mortar and pestles, the spatulas, measuring cylinders, containers to be used for final product presentation.

The procedure that requires making sure that the floor where the compounding is taking place is clean and that the equipment used is clean

Procedure :

1. Floor: The floor must be cleaned with a broom first, them with a mop and clean water, on a daily basis. The prescribed detergents should be used – these may change from time to time according to internal Hospital procedures. Any spillages on the floor taking place while compounding takes place, must be cleaned immediately.

2. Compounding equipment: These must be cleaned every time before and after use, by the person who used or is going to use the equipment.
   Compounding or prepacking should happen in the area marked for it.
   - The scale should be wiped clean with a soft, dry cloth – no detergents should be used. (Suitable containers should be used for weighing all raw materials.) After cleaning it with soap and water, it should then be wiped again with a clean cloth without any soap and dried. It should be calibrated yearly.
   - Mortar and pestle, beakers and spatulas should be cleaned with hot water (soapy) and detergent and properly rinsed with clean water and then dried. If any creasy mixture was used, care must be taken that it must be wiped with a paper towel and then properly washed.
   - Measuring cylinders should be cleaned with detergent but must be rinsed at least 3 times to prevent any traces of detergent staying behind.

3. Walls and windows: The walls must be cleaned monthly but spillages should be cleaned immediately. The internal windows should be cleaned monthly and external windows at least six monthly.

[redacted] | Version: 1 | Effective date: Sept 2024 | Review date: Sept 2027

Page 1 of 2

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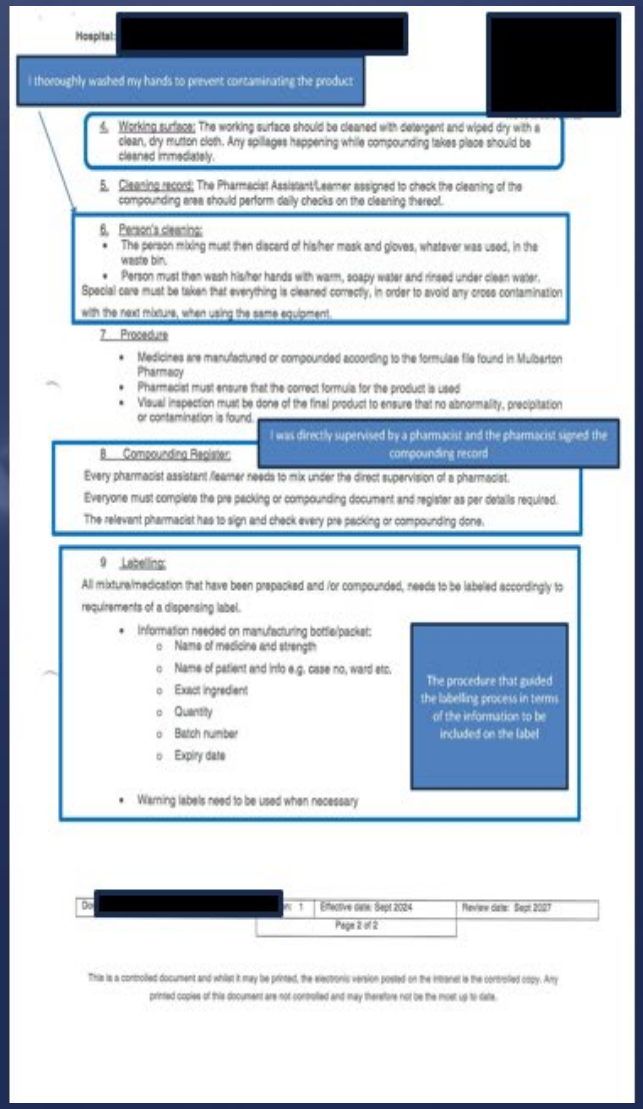

Hospital: [redacted]

[redacted]

I thoroughly washed my hands to prevent contaminating the product

4. Working surface: The working surface should be cleaned with detergent and wiped dry with a clean, dry mutton cloth. Any spillages happening while compounding takes place should be cleaned immediately.

5. Cleaning record: The Pharmacist Assistant/Learner assigned to check the cleaning of the compounding area should perform daily checks on the cleaning thereof.

6. Person's cleaning:
   - The person mixing must then discard of his/her mask and gloves, whatever was used, in the waste bin.
   - Person must then wash his/her hands with warm, soapy water and rinsed under clean water.

Special care must be taken that everything is cleaned correctly, in order to avoid any cross contamination with the next mixture, when using the same equipment.

7. Procedure
   - Medicines are manufactured or compounded according to the formulae file found in Mulbarton Pharmacy
   - Pharmacist must ensure that the correct formula for the product is used
   - Visual inspection must be done of the final product to ensure that no abnormality, precipitation or contamination is found.

I was directly supervised by a pharmacist and the pharmacist signed the compounding record

8. Compounding Register:
   Every pharmacist assistant /learner needs to mix under the direct supervision of a pharmacist.
   Everyone must complete the pre packing or compounding document and register as per details required.
   The relevant pharmacist has to sign and check every pre packing or compounding done.

9. Labelling:
   All mixture/medication that have been prepacked and /or compounded, needs to be labeled accordingly to requirements of a dispensing label.
   - Information needed on manufacturing bottle/packet:
     - o Name of medicine and strength
     - o Name of patient and info e.g. case no, ward etc.
     - o Exact ingredient
     - o Quantity
     - o Batch number
     - o Expiry date
   - Warning labels need to be used when necessary

The procedure that guided the labelling process in terms of the information to be included on the label

[redacted] | Version: 1 | Effective date: Sept 2024 | Review date: Sept 2027

Page 2 of 2

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Step 3: Implementation Evidence

Good Pharmacy Practice Manual

(r) All excess medicine, equipment and protective clothing used in the preparation must be disposed of and dealt with according to local procedures.

(s) Procedures for administration of cytotoxic medicines to patients must strike a balance between protecting the operator and alarming the patient. They must include details of action to be taken in the case of extravasation and for the disposal of excreta from patients receiving cytotoxic medicines.

(t) All procedures must be designed to ensure that all products achieve the required standard of quality.

(u) All personnel must receive special training in working with cytotoxic medicines and be monitored regularly to ensure compliance with all procedures.

(v) A permanent register must be maintained of all employees who routinely handle cytotoxic medicines. Acute exposure episodes must be documented and the employee must be referred for appropriate medical examination. Routine medical examination and blood tests must be performed on personnel handling cytotoxic medicine.

(w) Personnel working in a cytotoxic reconstitution service must be rotated regularly.

2.18 COMPOUNDING

(a) Compounding must be done under the direct supervision of a pharmacist, except in circumstances where specific exemption is granted in terms of the applicable legislation.

(b) All compounding processes must be in accordance with SOPs authorised by a pharmacist.

(c) All the necessary requirements must be provided, including:

(i) appropriately trained personnel;

(ii) adequate premises and space;

(iii) suitable equipment and services;

(iv) correct materials, containers and labels;

(v) approved procedures (including cleaning procedures); and

(vi) suitable storage and transport.

The compounding was done under the direct supervision of a pharmacist using a formula provided by Netcare Mulbarton and in line with the Local Operational Guidelines for compounding

A compounding record was produced for record keeping

(d) Procedures must be written in instructional form and be applicable to the facilities provided.

(e) Compounding may be done by pharmacy support personnel registered with Council who have the appropriate scope of practice and who are competent to perform the procedures concerned.

(f) Records must be kept during the process which demonstrate that all the steps required by the defined procedures were taken and that the quantity and quality produced were those expected.

(g) A system must be in place to recall any batch or product, should it be necessary.

(h) High standards of personal cleanliness must be observed by all those concerned with the compounding process.

(i) Hand-washing facilities must be conveniently available to the personnel involved.

Hand washing was done to ensure cleanliness and prevent contamination of the product during compounding

I made sure that the equipment used was clean.

(j) Storage areas must provide adequate space and must be arranged and equipped to allow dry, clean and orderly placement of store materials and products under controlled conditions of temperature and humidity.

(k) Equipment used for compounding must be designed and maintained in such a way as to:

(i) be suitable for its intended use;

(ii) facilitate thorough cleaning when necessary;

(iii) minimise any contamination of drugs and their containers; and

(iv) minimise the risk of confusion or the omission of a processing step such as filtration or sterilisation.

(l) Equipment and utensils must be thoroughly cleaned and, if necessary, sterilised and maintained in accordance with specific written directions.

(m) Before the commencement of any compounding, a check must be made to ensure that all apparatus and equipment to be used have been cleaned/sterilised.

2.19 PRE-PACKING

(a) Pre-packing entails the repacking of medicines from bulk packs into smaller packs suitable for patient use and must be performed in terms of the provisions of the Medicines Act and in accordance with Good Manufacturing and Distribution Practices as determined by the MCC as well as the standards provided below.

(b) Pre-packing may only be performed by a pharmacist or under the supervision of a pharmacist under strictly controlled conditions and according to a clearly designed system of quality assurance based on the standards provided in this document and the General Regulations published in terms of the Medicines Act.

(c) Where tablets are pre-packed they must be manually counted, weighed, or electronically counted. Measuring by volume is not permitted.

(d) Pre-packing must take place only under the required conditions of temperature and humidity.

(e) A batch numbering system must be used which gives ready access to all information required to ascertain the ingredient(s) and the procedure(s) used in preparing the finished product.

2.19.1 Minimum standards for pre-packing

To comply with the above requirements, the following minimum standards must be complied with in the packaging of medicines in patient-ready packs:

(a) All pre-packing operations must be confined to a separate area intended for such purposes and physically partitioned off from all other working areas, with limited access.

(b) The pre-packing area must be effectively lit and ventilated with temperature and humidity control facilities. Conditions must be such that there is no adverse effect on the product or equipment either directly or indirectly.

(c) All equipment must be kept clean and before each production run checked for efficiency and accuracy.

(d) Electronic tablet counters must preferably be fitted with dust covers and extractor fans.

[redacted]

Physician

Prescription for Medicine

Practicing	[redacted]	Address	[redacted]
Practice Number	[redacted]	Contact	-
Patient Name	[redacted]	Address	[redacted]
Age & Gender	88, M	Contact	[redacted]
Medical Aid	[redacted]	ID or Passport	[redacted]
Member Number	[redacted]	Dependant Code	00

The patient's personal information has been redacted to comply with the POPI Act which ensures the protection of the person's personal and sensitive information.

Prescription ID	[redacted]	Case	[redacted]
Date & Time	06-05-2025 13:10:38	ICD-10 Codes	

Item	Medication	Instructions
1	VANCOMYCIN ORAL SUSPENSION 25MG/ML	10 ML ORALLY STAT 10 ML ORALLY EVERY SIX HOURS

----END OF PRESCRIPTION----

A prescription was received into the hospital pharmacy for Vancomycin oral suspension 25mg/ml for an inpatient. I validated and interpreted the prescription. Because vancomycin oral suspension is not available, the 25mg/ml oral suspension had to be compounded extemporaneously using vancomycin powder intended for injection according to the master formula and instructions provided by the hospital.

The dosage form compounded was a syrup, but it is being referred to as a suspension in the documentation since it is saved and charged as vancomycin suspension on the Netcare system for charging drugs.

[redacted]

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Step 3: Implementation Evidence

Oral vancomycin solutions, syrups and suspensions are not commercially available but are required to treat *Clostridium difficile* infection in the colon, particularly for patients who are unable to swallow capsules. Oral Vancomycin can therefore be compounded extemporaneously using vancomycin powder intended for injection.

Netcare Mulbarton Master Formula

VANCOMYCIN ORAL SUSPENSION 25mg/mL (prescribed as syrup and bulk mixed up)

Ingredients and directions:

Vancomycin 1g vial	X 2 vials
Water for reconstitution (20mL per vial)	40mL
Reconstitute each 1000 mg vancomycin vial with 20 mL SWFI using an IV syringe and needle. Withdraw contents of both 1000 mg vials (40 mL) in an IV syringe and transfer into a graduate.	
Syrup Simplex	20mL
Sterile water	20mL
Mix syrup simplex and water together. Mix with reconstituted Vancomycin. Stir well. Transfer to an amber bottle. Label.	

Due to the absence of 1g vials in the pharmacy, four 500mg vials were used for compounding. Each 500mg vial was to be reconstituted using 10mg sterile water

Working Formula

Ingredient		Quantity
Vancomycin 500mg vial	-	4 vials
Water for reconstitution (10ml per vial)	-	40 ml
Syrup Simplex	-	20 ml
Sterile Water	-	20 ml

Concentration Calculation

Total quantity of syrup made = 40ml + 20ml + 20ml

= 80 ml

Total amount of vancomycin = 500 mg × 4 vials

= 2000 mg

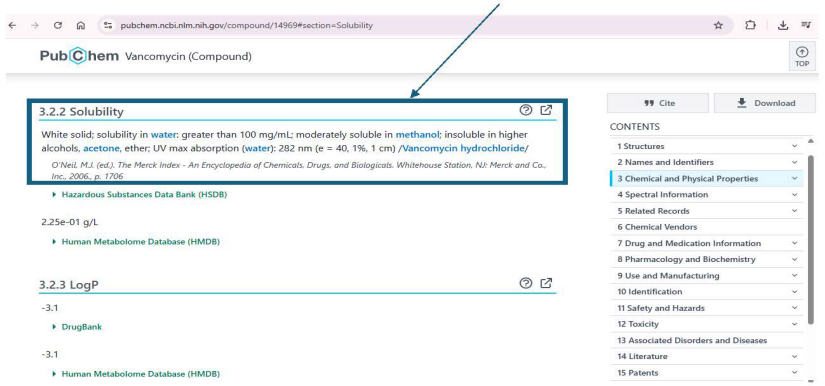
Therefore, there will be 2000 mg of vancomycin in 80 ml of syrup

X mg in 1 ml

$$X = \frac{1\ ml}{80\ ml} \times 2000 mg$$

= 25 mg/ml

I looked at the solubility of vancomycin on PubChem to ensure that the vancomycin was being dissolved in the right solvent and would fully dissolve in the amount of water that was going to be used.



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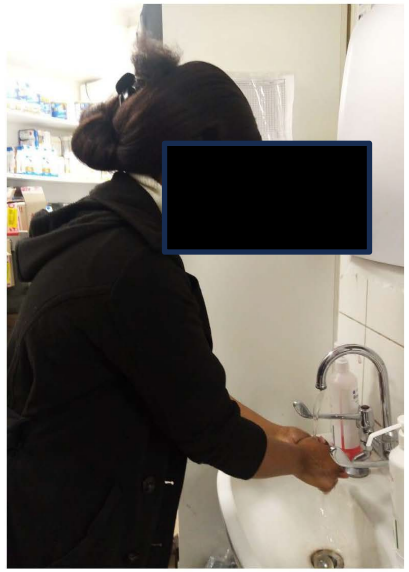
Step 3: Implementation Evidence

INFORMATION FOR DISPENSING PHARMACISTS:
Vancomycin capsules are licensed in Ireland and available under the GMS (Medical Card) or DPS (Drugs Payment Scheme) schemes. Vancomycin capsules should be dispensed first line where possible. In the event that vancomycin capsules are unavailable, or a person has swallowing difficulties or a nasogastric or PEG tube for enteral administration, vials of vancomycin powder for injection may be used to make an extemporaneous oral solution. Extemporaneous vancomycin oral solution has a bitter taste. Patients can be advised to mix the dose at the point of administration with a common flavouring syrup such as orange cordial to improve the taste.

Vancomycin solution has a bitter taste which can potentially lead to adherence problems. It is therefore essential to add a sweetener such as Syrup simplex to improve its palatability

Compounding Procedure

Step 1



Before compounding, I tied my hair up and washed my hands with soap and water as required by procedure 6 of the Netcare Mulbarton Local Operational Guidelines (LOGs) and in accordance with Section 2.18 (h) of the GPP, which emphasises the importance of high standards of personal cleanliness of the compounder.

I also ensured that the compounding area was clean and that the compounding surface and equipment were also clean.

Step 2

I gathered the equipment that I was going to use for the reconstitution of the Vancomycin 500 mg vials which included the four vials, 10 ml syringe and a needle

Step 3

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Step 3: Implementation Evidence

INFORMATION FOR DISPENSING PHARMACISTS:
Vancomycin capsules are licensed in Ireland and available under the GMS (Medical Card) or DPS (Drugs Payment Scheme) schemes. Vancomycin capsules should be dispensed first line where possible. In the event that vancomycin capsules are unavailable, or a person has swallowing difficulties or a nasogastric or PEG tube for enteral administration, vials of vancomycin powder for injection may be used to make an extemporaneous oral solution. Extemporaneous vancomycin oral solution has a bitter taste. Patients can be advised to mix the dose at the point of administration with a common flavouring syrup such as orange cordial to improve the taste.

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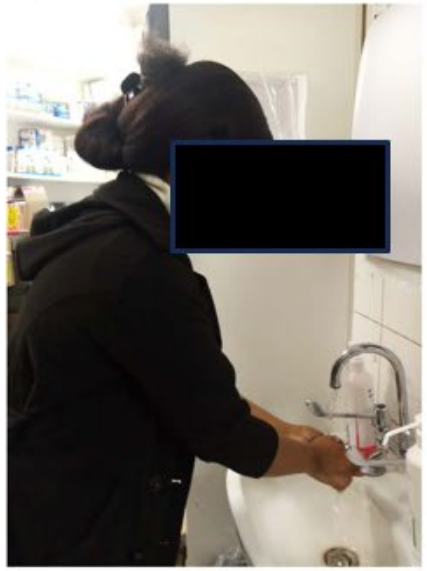

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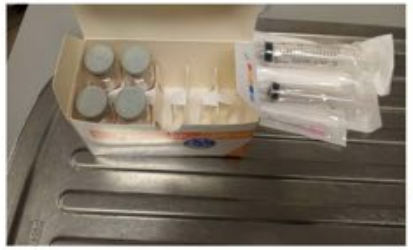
Step 2



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Step 3

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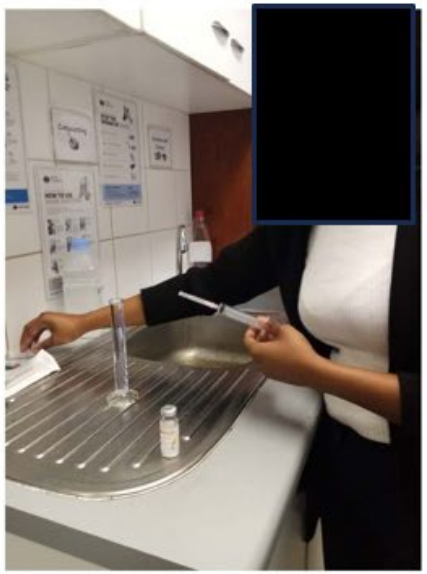
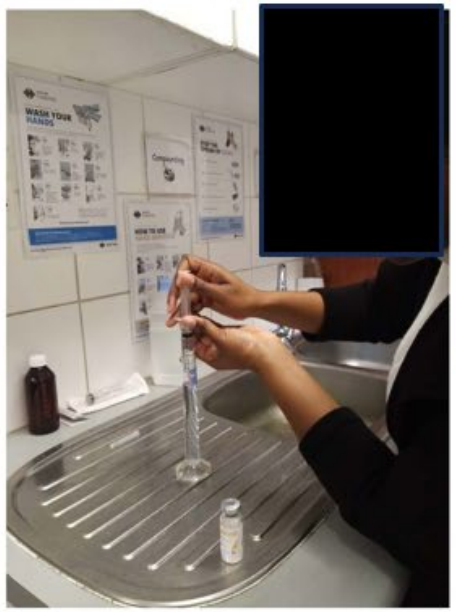
Step 3: Implementation Evidence



I connected the needle to the syringe with the cap of the needle still attached.

Step 4



Due to the absence of a beaker in the pharmacy, the sterile water was poured into a measuring cylinder which allowed adequate withdrawal of the water using a syringe and needle.

The needle was uncapped and used to withdraw 10 ml of water which would be used to reconstitute one 500mg vial

Step 5

10 ml of sterile water was withdrawn and the tapping method was used to remove air bubbles to ensure that the accurate amount of water was used

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Step 3: Implementation Evidence

Step 6

The rubber bung of the vial was punctured at a 45° angle and slightly moved to 90° to prevent coring of the rubber bung (the introduction of small rubber bung particles into the vial) as well as to maintain the integrity of the vial.

Images of the Journal article that were used as reference to learn more about the 45-90° technique to puncture a vial that reduces the chances of coring occurring

Fragmentation and coring of a vial - An avoidable threat

Dear Editor,

Coring is described as the impalement of the pieces of rubber stopper in the needle and its introduction in the vial with the impending risk of getting injected intravenously into the body, posing a constant threat to the patient's health. The incidence varies between 3.0% and 9.7%.[1] There is always a risk of wear and tear, abrasion and fragmentation of rubber particles, which can gain access to the vials and remain unnoticed due to their tiny size, masked by the medication's labels and its opacity.

We present a case of coring while loading Inj. propofol (Hyprovan 200 mg/20 ml; Celon Labs, Telangana, India) from the vial with the help of a 10-ml syringe (Romojet™, Romsons Juniors, India) with a 21G sharp needle for induction in a case of laparoscopic cholecystectomy in a 30-year-old lady weighing 58 kg. Before administering the drug, a black particulate contaminant was noticed in the vial [Figure 1a], so the entire drug in the syringe and the vial were discarded, and a fresh vial was selected.

The technique used to puncture the rubber bung on the vials

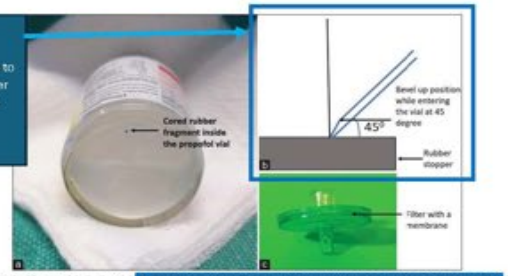

Figure 1: (a) Cored rubber particle in the vial, (b) Angle of entry at 45° for needle puncture with the bevel up while puncturing, (c) Use of interface-like spikes/filters during drug aspiration

Coring exposes the patient to an increased health risk, especially with multidose vials. Repeated puncture of these vials and size of the particulate larger than 6–8 μm in diameter can lead to phlebitis, pulmonary embolism, granulomas, latex allergy and mechanical blockade of the angiocath.[2,3] The factors which primarily affect coring include the rubber stopper's material, diaphragm's thickness, type of needle tip (blunt vs. sharp bevelled), penetration angle, needle bevel position and multidose vials.[3-5] The factors include the inferior elastomeric quality of the stopper, diminished resealability and reduced tensile strength.[2,3] Wani *et al.*[4] reported that fragmentation happened in 40.2% of the vials where a blunt cannula tip was used, in contrast to only 4.8% of vials being penetrated with sharp bevelled needles. Chotikawanich *et al.*[2] conducted an experimental study with a multidose vial of propofol. The authors punctured the rubber stopper with various needle sizes (18G, 20G, 21G) at different angles (45° and 90°). They concluded that coring increased with the larger size needle regardless of the angle. Rase *et al.*[5] tested the two-needle penetration method with varying sizes (18G, 20G, 22G). The first penetration method encompassed a 45° entry angle with the pressure applied along it, and the second method included the pressure applied in a direction perpendicular to the surface of the stopper. The authors observed increased incidence with a needle size of more than 22G with a bevel-down position; the fragmentation was maximum with the second penetration method regardless of the needle sizes. Heckar *et al.*[6] reported that the size of the cored particle varied in length between 29 and 244 μm and in width between 14 and 83 μm when using 18G and 23G needles, respectively.

To conclude, the mitigation strategy is suggested are meticulous inspection of the vial, changing the angle of entry to 45° [Figure 1b], sharp bevelled needles of not less than 22G, syringe attachments with interface-like spikes/filters [Figure 1c], single-use vials and promoting closed drug delivery system with prefilled syringes.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient consented to her images and other clinical information to be reported in the journal. The patient understands that her name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest
There are no conflicts of interest.

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A screenshot from an online textbook on coring and the use of the 45-90° techniques to prevent it.

library.kendallhunt.com/PES/PharmPractice/ILMA_book/pages/13_ch13-section04.html

FIGURE 13.7 Correct Needle Insertion into a Vial

Note the slight bend of the needle during the insertion.

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Step 3: Implementation Evidence

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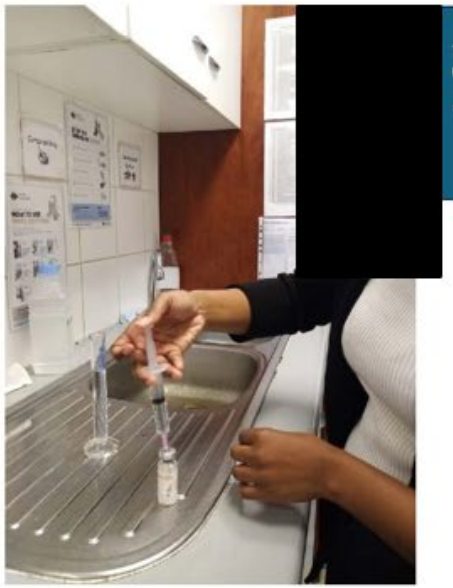
This technique prevents coring, or the inadvertent introduction of a small piece of the rubber top into the solution. If coring does occur, you must discard the contaminated vial and needle-and-syringe unit and repeat the process with new supplies. Because a vial is a closed-system container, the air cannot freely flow in or out, so you must use a milking technique. For milking, use a syringe to insert a small amount of air into the vial that is equal to, or slightly less than, the volume of liquid needing to be withdrawn. Then draw up some solution into the syringe. This insertion and withdrawal process is done a little at a time in alternating steps, easing sufficient fluid into the syringe. (If the vial contains powdered medications, a vented needle is used to add the diluent. The vented needle, with its hole in the lumen, allows the fluid to be injected into the powder while simultaneously venting the positive pressure that has built up within the vial without milking. Vented needles are used when inserting a solution into a vial containing a powdered medication for reconstitution.)

Once the fluid measurement seems to be reached, the sides will have to be tapped to make the bubbles rise and be released so that only fluid is in the syringe. More fluid may be needed. When the correct amount of fluid is precisely measured, it may be injected into an IV or IVPB bag, or into an IV port for an IV push, or into another vial with powder for reconstitution.

Step 7

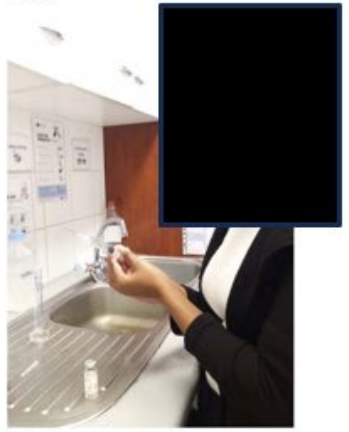


The sterile water (ml) was then gently injected into the 500 mg vial and the vial was gently swirled to allow the powder to dissolve whilst preventing foaming

Step 8

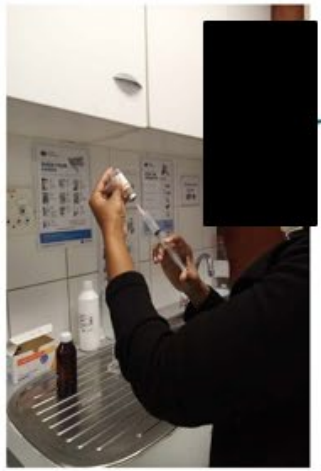
The solution was inspected to ensure that every particle had dissolved and to make sure there were no visible particles which may suggest contamination.

Step 9



An amount of air equal to 10ml was drawn into the syringe in preparation for the milking technique of drawing out the liquid from the vial.

Step 10



The vial was pierced using the 45-90° technique, The air (10 ml) from the syringe was injected into the vial whilst the needle tip was above the liquid surface to avoid bubbles and increase pressure inside the vial. The vial was then inverted, ensuring that the needle tip was in the fluid and the vancomycin solution flowed smoothly into the syringe. This technique was used to equalize the pressure in the vial, making the withdrawal of the liquid easier and safer

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This technique prevents coring, or the inadvertent introduction of a small piece of the rubber top into the solution. If coring does occur, you must discard the contaminated vial and needle-and-syringe unit and repeat the process with new supplies. Because a vial is a closed-system container, the air cannot freely flow in or out, so you must use a milking technique. For milking, use a syringe to insert a small amount of air into the vial that is equal to, or slightly less than, the volume of liquid needing to be withdrawn. Then draw up some solution into the syringe. This insertion and withdrawal process is done a little at a time in alternating steps, easing sufficient fluid into the syringe. (If the vial contains powdered medications, a vented needle is used to add the diluent. The vented needle, with its hole in the lumen, allows the fluid to be injected into the powder while simultaneously venting the positive pressure that has built up within the vial without milking. Vented needles are used when inserting a solution into a vial containing a powdered medication for reconstitution.)

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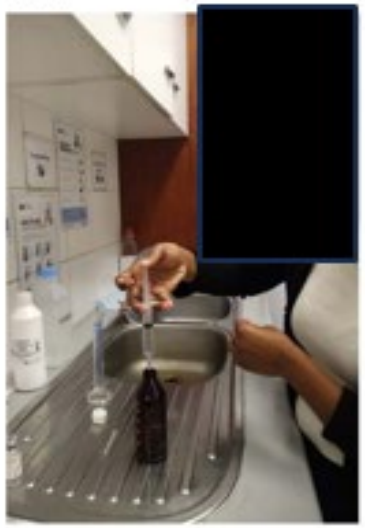
Step 3: Implementation Evidence

Step 11

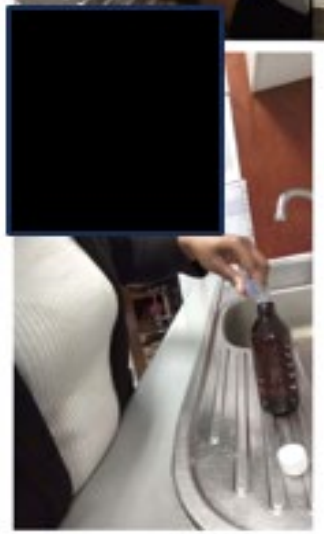


The solution was injected into a 200 ml bottle

Steps 4 to 11 were also performed for the remaining 3 vials to reconstitute them and finally obtain a final amount of 40ml of the vancomycin solution

The syringe and needle were discarded in the sharps container after use

Step 12



20 ml of the syrup simplex was measured using a 25 ml measuring cylinder and poured into the bottle containing the vancomycin solution

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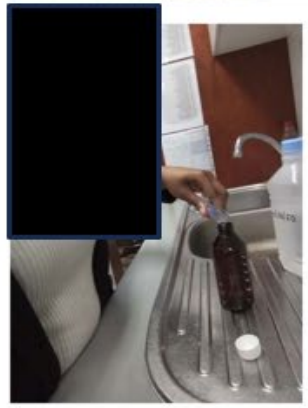
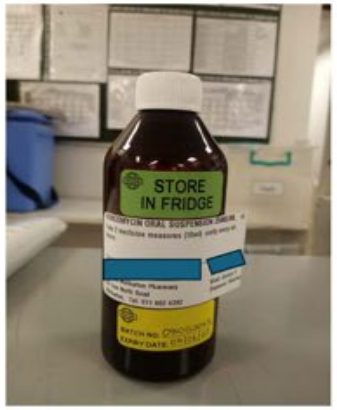
Step 3: Implementation Evidence

Step 13



20 ml of sterile water was measured using a 25 ml measuring cylinder and poured into the bottle containing the vancomycin solution and the mixture was gently mixed.

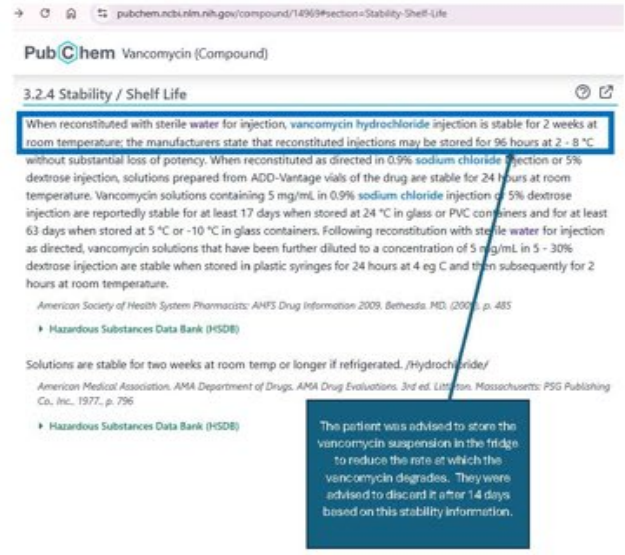
Step 14



The bottle containing the vancomycin 25mg/ml was labelled accordingly as required by the LOGs procedure 9. The name, strength, quantity, batch number and expiry date of the medicine were included in the label as well as the patient's name, case number and ward as required by the LOGs. The instructions on how to administer the medicine were also included in the label, as well as the storage instructions.

The patient's personal information on the label is covered to protect their personal information and sensitivity, in accordance with the POPI Act.

The compounded vancomycin oral suspension was then transported to the patient's ward in a cooler box with cold ice packs to maintain the temperature between 2 - 8°C, where it was then placed in the refrigerator.



The patient was advised to store the vancomycin suspension in the fridge to reduce the rate at which the vancomycin degrades. They were advised to discard it after 14 days based on this stability information.

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Step 3: Implementation Evidence

I made a manufacturing and compounding record for record-keeping as required by procedure 8 of the Netcare Mulbarton Local Operational Guidelines for compounding. The GPP Section 2.18 (f) also emphasised the need for a record to be kept to demonstrate that the quantity and quality produced were those expected.

[redacted]

Product Name and Strength: VANCOMYCIN SYRUP 25MG/ML
Preparation Date : 08/05/25 Pack Size : 80ml
Batch Number : 08052025
Exp date : 08/06/25
Patient Name : [redacted]
Hospital No : [redacted] or Rx No : [redacted]

Item	Qty	Manufacturer	Batch No	Exp Date
Vancocin CP 500mg Vials	4	Sandoz	NW6855	09/2025
Syrup Simplex	20ml	Medimlab	11730	03/2027
Distilled water	20ml	Adcock	25038162	03/2027

	Name	Signature
Prepared By:	[redacted]	
Checked By		

Document No:MUL-05-PH-LOG-79 Version 1 Effective Date Oct 2020 Review Date Oct 2025
This is a controlled document and whilst it may be printed, the electronic version posted on the intranet is the controlled copy
Any printed copies of this document are not controlled and therefore not be the most up to date

The pharmacist who supervised the compounding process signed the compounding record, as required by the LOGs procedure 8 and GPP Section 2.18 (a)

[redacted]

PRODUCT	DOSAGE FORM & STRENGTH	QTY	MANUFACTURER	MANUFACTURER BATCH NUMBER	MANUFACTURER EXPIRY DATE	PACKAGING DATE	ALLOCATED EXPIRY DATE	Pharmacist 1	Pharmacist 2
VANCOMYCIN ORAL SUSPENSION	25MG/ML SYRUP	80	[redacted]	08052025	08/06/25	08/05/25	08/06/25	[redacted]	

VANCOMYCIN ORAL SUSPENSION 25MG/ML
SHAKE YOUR WATER STERILE 1L
SYRUP SIMPLEX PER ML
[redacted]

[redacted] 18/05/25

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Assessor/Moderator comments

Step 3: Implementation

Requirement Partially met.

- The evidence is well-documented, specific to the competency standard, and demonstrates sound background research on stability, compatibility, solubility, palatability, shelf life, storage, correct withdrawal technique, accurate measurement, and a complete master batch document.
- To meet the description criteria fully, show how the information from each resource informed the steps you followed and link this to the annotated evidence.

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Assessor/Moderator comments

Step 3: Implementation

Requirement partially met.

- Cite the legislation used to validate and interpret the prescription; explain how you determined the quantity required, given that the treatment duration was not provided.
- Address the personal protective equipment appropriate to the preparation (e.g., gloves, mask); and endorse the expiry as “use within 14 days” in line with the stability data and the plastic final container.

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Step 4: Evaluation

I have gained a deeper understanding of the importance of applying the pharmaceutical knowledge of APIs, excipients and compounding techniques when compounding medicines in order to make stable dosage forms and to determine their storage conditions. I have learnt the different compounding techniques used in compounding, especially when adapting parenteral formulations for oral use. I have also learnt how to use credible online sources to get information on APIs and excipients. I now feel more confident when compounding, and I now ensure to research on every API, excipient and procedure to ensure I compound a stable, safe and patient-friendly dosage form. I was able to apply this knowledge in compounding a mixture of potassium chloride, where syrup simplex was also added to improve the palatability of the dosage form. I have, however, identified a future learning need in the different compounding techniques used in compounding other dosage forms, such as ointments and suppositories.

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Assessor/Moderator comments

Step 4: Evaluation

Requirement met.

A clear example of applying the learning (compounding a potassium chloride mixture with syrup simplex to improve palatability) and an appropriate future learning need are provided.

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Any questions?

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Way-forward

- Ensure that the entry is checked against the assessment criteria outlined in the Portfolio of Evidence guidelines (p.35 & 36 of the Intern and Tutor Manual).
- When making a resubmission, it is important to carefully review and address the feedback provided by assessors and moderators.

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Please complete the attendance register/survey

https://forms.cloud.microsoft/r/jMpmepHWGY

June 2026 Intern/Tutor CPD Post-Workshop Survey

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4th National Pharmacy Conference (NPC)

4TH NATIONAL PHARMACY CONFERENCE

4th National Pharmacy Conference will be held later this year

Date: 11 – 13 October 2026
Venue: Inkosi Albert Luthuli International Convention Centre Complex (commonly known as “Durban ICC”)

Theme: “A Glimpse into the Future: Advancing Pharmacy Towards 2050”

2026 SAPC National Pioneer Pharmacy Awards Nominations are open and close on 30 June 2026.

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Thank you!