Pharmacy Assessment System Action Plan Booklet

Use this booklet to record the actions you plan on taking to address the areas for improvements identified. Having completed the **Review** and **Compliance Assessment** for each section, you may have identified areas of non-compliance or areas where improvement is required.

The next step is to use this booklet to start developing your action plan to record the actions you plan on taking to address the areas for improvements identified.

In developing your action plan, ensure that the actions that you plan are (1) **Specific** (2) **Measurable** (3) **Achievable** (4) **Relevant** and (5) **Timely**.

Please note that further information and guidance is available in the Guide.

Pharmacy Name		
Pharmacy Address		
Registration Number		
Supervising Pharmacist	**Name**	**Reg. No**
Superintendent Pharmacist	**Name**	**Reg. No**
Pharmacy Owner(s)	**Name**	**Reg. No**

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Action Plan
Section 1: Management and Supervision

Have you identified area(s) for improvement in this Section? If No, you can proceed to the Approval of Action Plan for this section. If Yes, record these below:	Yes No

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ___________
				Yes No Date Completed: ___________
				Yes No Date Completed: ___________

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________

Approval of Action Plan by Supervising Pharmacist **Note:** This can be signed when the action plan has been developed		
Signature:	Date:	

Additional Comments by Supervising Pharmacist

Additional Comments provided by Members of the Pharmacy Team

Action Plan
Section 2: Sale and Supply of Non-Prescription Medicines

Have you identified area(s) for improvement in this Section? If No, you can proceed to the Approval of Action Plan for this section. If Yes, record these below:	Yes No

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ___________
				Yes No Date Completed: ___________

Approval of Action Plan by Supervising Pharmacist **Note:** This can be signed when the action plan has been developed		
Signature:	Date:	

Additional Comments by Supervising Pharmacist

Additional Comments provided by Members of the Pharmacy Team

Action Plan **Section 3: Sale and Supply of Prescription Medicines**	
Have you identified area(s) for improvement in this Section? If No, you can proceed to the Approval of Action Plan for this section. If Yes, record these below:	Yes No

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: __________
				Yes No Date Completed: __________

Approval of Action Plan by Supervising Pharmacist **Note:** This can be signed when the action plan has been developed		
Signature:	Date:	

Additional Comments by Supervising Pharmacist

Additional Comments provided by Members of the Pharmacy Team

Action Plan Section 4: Documentation and Record Keeping	
Have you identified area(s) for improvement in this Section? If No, you can proceed to the Approval of Action Plan for this section. If Yes, record these below:	Yes No

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: __________
				Yes No Date Completed: __________

Approval of Action Plan by Supervising Pharmacist **Note:** This can be signed when the action plan has been developed		
Signature:	Date:	

Additional Comments by Supervising Pharmacist

Additional Comments provided by Members of the Pharmacy Team

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Action Plan Section 5: Premises, Equipment and Storage	
Have you identified area(s) for improvement in this Section? If No, you can proceed to the Approval of Action Plan for this section. If Yes, record these below:	Yes No

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: __________
				Yes No Date Completed: __________
				Yes No Date Completed: __________

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: _______________
				Yes No Date Completed: _______________

Approval of Action Plan by Supervising Pharmacist **Note:** This can be signed when the action plan has been developed		
Signature:	Date:	

Additional Comments by Supervising Pharmacist

Additional Comments provided by Members of the Pharmacy Team

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Action Plan **Section 6: Supply of Medicines to Patients in Residential Care Settings**	
Have you identified area(s) for improvement in this Section? If No, you can proceed to the Approval of Action Plan for this section. If Yes, record these below:	Yes No

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: __________
				Yes No Date Completed: __________
				Yes No Date Completed: __________

Area(s) for Improvement	Action(s) to be taken to address the issues identified	Person responsible for ensuring each action is completed	Target date for completion	Action Completed
				Yes No Date Completed: ____________
				Yes No Date Completed: ____________

Approval of Action Plan by Supervising Pharmacist **Note:** This can be signed when the action plan has been developed		
Signature:	Date:	

Additional Comments by Supervising Pharmacist

Additional Comments provided by Members of the Pharmacy Team

ACTION PLAN BOOKLET

Approval of Action Plans by Superintendent Pharmacist

(if not also the supervising pharmacist)

Note: To be completed at the end of the annual cycle

Have you reviewed all sections of the completed Pharmacy Assessment System?	Yes No
What support was provided to assist the supervising pharmacist in **completing** the Pharmacy Assessment System:	
What support was provided to assist the supervising pharmacist in **implementing** the action plans:	
Have you identified any additional areas where improvement is needed to facilitate on going compliance at the pharmacy? Record details:	Yes No

Superintendent Pharmacist	Signature	Date

Additional Comments

Approval of Action Plans by Pharmacy Owner(s)

(if different from the supervising and superintendent pharmacist)

Note: To be completed at the end of the annual cycle

Have you reviewed all sections of the completed Pharmacy Assessment System?	Yes No
What support was provided to assist the supervising pharmacist in **completing** the Pharmacy Assessment System:	
What support was provided to assist the supervising pharmacist in **implementing** the action plans:	
Have you identified any additional areas where improvement is needed to facilitate on going compliance at the pharmacy? Record details:	Yes No

Pharmacy Owner(s)

Name	Position	Signature	Date

Additional Comments

Notes:

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