Community Pharmacy

Clinical Governance Multidisciplinary Audit 10/11

FP10HNC Audit

Please complete for every item

Pharmacy Stamp:

Name of person completing audit	
Audit period: From:	to:
Name of pharmacist	
Signature of pharmacist	

NHS Plymouth

	1	2	3	4	5	6	7	8	9	10	11	12	13					14									
													What colour is the drug in the Plymouth Area Joint Formulary?					Were there any problems with the prescription? Please give brief details if required									
																			Yes, there was a problem								
	Is the patient's name & address clear?	Are any of the patient's details missing? e.g. name, address, DOB if a child.	Is the name and strength of the drug clear?	Are there full and complete directions?	Is there sufficient information to allow you to dispense accurately ?	If "PRN" dosage, was quantity to be supplied included?	How many days' supply?	Date of dispensing?	Date prescription was written?	Has the prescriber printed his/her name clearly?	Has the prescriber included a bleep/ pager number?	Is the clinic address pre-printed or is it a stamp?	GREEN	BLUE	ORANGE	RED	Not in PAJF	No Problems (If no problems stop here)	Clarified Issues with the patient	Contacted the prescriber		Could not contact the prescriber patient had to return to hospital (or GP)		Issue could not be resolved over the telephone – patient had to return to hospital (or GP) e.g. CD prescription incorrectly written		What was the delay to the patient in receiving their medication	Did you have to return the prescription to the prescriber for alteration?
																			Yes/No (if Yes, stop here)	Patient waited	Patient had to call back	Patient returned later with new/revised prescription	Patient did not return	Patient returned later with new/revised prescription	Patient did not return	Specifiy time or DNR if did not return	Yes/No
	Yes or No	Yes or No Comment	Yes or No	Yes or No	Comment	Yes or No or N/A	Number or PRN	Date	Date	Yes or No	Yes or No	Pre-printed or Stamped	Please Tick					Please Tick	Yes or No	Please Tick	Please Tick	Please Tick	Please Tick	Please Tick	Please Tick	Time or DNR	Yes or No
Example	Yes	Yes, DOB for a child	Yes	Yes	Brand for M/R product	N/A	28	2-Jul-05	2-Jul-05	Yes	Yes	Pre-printed	✓					✓									
Item 1																											
Item 2																											
Item 3																											
Item 4																											
Item 5																											
Item 6																											
Item 7																											
Item 8																											
Item 9																											
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Item 14																											
Item 15																											
Item 16																											
Item 17																											
Item 18																											
Item 19																											
Item 20																											

At the end of the audit period please return to: Medicines Management Team, Building 1, Derriford Business Park, Brest Road, Plymouth PL6 5QZ

Forms must be received by Monday 22nd November

If you have any questions please contact: Emma Harrison 01752 315366