

Health + Pharmacy: Progress record and request for accreditation form

Name of pharmacy: _____ Contractor number: _____

Progress report for the month of: _____ Tel No: _____

Guidance on completing this document:

Please indicate beside each of the standards your progress towards achieving the standard in your pharmacy on a scale of 1 to 10, where 1 represents just starting work on this standard and 10 represents full achievement. Please refer to the H+P Quality Criteria for full descriptions of each standard.

- Also please indicate beside each standard the date by which you estimate that you will fully achieve this standard.
- At the end of the document, please indicate the date by which you estimate you will be ready for assessment and full accreditation as a Health + Pharmacy.
- **If you are not ready to be accredited yet retain the form in the pharmacy as your own record.**
- **When you are ready for accreditation (self-reporting '10s' under each standard) complete the declaration below and submit to HSCB**

Area	Standard		Progress towards achieving this standard (1 = just starting work, 10 = full achievement)	Estimated date for completion of this standard
Environment	1.1	Premises		
	1.2	Merchandise		
	1.3	Health promotion area		
	1.4	Private consultation area		
Staff development	2.1	Training		
	2.2	Public health needs		
	2.3	Communication skills		
	2.4	Behavioural change		
	2.5	Privacy & confidentiality		
	2.6	Protection of children and vulnerable adults		
	2.7	Service awareness		
	2.8	Staff		
	2.9	Pharmacist engagement		
Engagement with others in the local community	3.1	Engagement with primary care team, Trusts and C&V sector and statutory bodies		
	3.2	Signposting & referral		
	3.3	Engagement with local community		

Declaration: I request an assessment, for the pharmacy named above, to be accredited as a Health + Pharmacy. I consider that the pharmacy has fully achieved each of the standards outlined above. I confirm that the pharmacy complies with all the essential indicators in the [PSNI Standards for Registered Pharmacy Premises](#).

Signed _____ Print name: _____ Date: _____

The completed form should be returned by the last Friday of each month:

FAO Angela Neilly , HSCB Integrated Care, Tower Hill, Armagh, BT61 9DR

Alternatively by email: healthpluspharmacy@hscni.net

