CHAPTER 1

The Consultation

This chapter begins by considering consultations where a patient or their representative asks to purchase a named medicine and we go on to cover consultations where a request is being made for help with symptoms, or with a patient's self-diagnosis of a common condition. We discuss consultation frameworks and skills, and look at risk assessment and decision making. We then look at how making consultations more effective is an essential component of tackling antimicrobial resistance (AMR) and enabling antimicrobial stewardship (AMS).

REQUESTS FOR TREATMENT

Requests for a named medicine

The person making the request might already be an expert user or may be a novice. We define the expert user as someone who has used the medicine before for the same or a similar condition and is familiar with it. While pharmacists and their staff need to ensure that the requested medicine is appropriate, they also need to bear in mind the previous knowledge and experience of the purchaser.

Although most pharmacy customers do not mind being asked questions about their medicine purchase, many of those who wish to buy a medicine they have used before would prefer not to be subjected to the same questions each time. There are two key points here: firstly, it can be helpful to briefly explain why questions are needed; and secondly, fewer questions are normally needed when customers request a named

Symptoms in the Pharmacy: A Guide to the Management of Common Illnesses and Disease Prevention, Tenth Edition. Alison Blenkinsopp, Martin Duerden, and John Blenkinsopp.

Companion website: www.wiley.com/go/Blenkinsopp/Pharmacy/10e

medicine that they have used before. A suggested sequence in response to a request for a named medicine might be:

- Ask whether the person has used the medicine before; if the answer is yes, consider if any further information is needed.
- Quickly check on whether other medicines are being taken.
- If the person has not used the medicine before, more questions will be needed. One option is to follow the sequence for responding to requests for advice about symptoms (see the following text). It can be useful to ask how the person came to request this particular medicine. For example, have they seen an advertisement for it? Has it been recommended by a friend or family member?

Pharmacists use their professional judgement in dealing with regular customers whom they already know and where the individual's medication history is known, with the pharmacy Patient Medication Record (PMR) as a source of backup information. However, for new customers where such information is not known, more questions are likely to be needed.

With more patients being referred to the pharmacy from general practice and NHS 111, or from elsewhere, and the National Health Service (NHS) discouraging the prescribing of some over-the-counter (OTC) medicines, patients may ask for a named medicine that it has been recommended they buy. In some circumstances, it might be best or necessary that this is supplied on a general practitioner (GP) prescription (e.g. use is outwith the licence for pharmacy supply), and this needs to be handled carefully. Patients who have been referred to Pharmacy First (PF) may request an antibiotic and have one of the included conditions but may not meet the Gateway criteria or may fall outside the eligibility criteria in the relevant Patient Group Direction (PGD). This book suggests a framework for such consultations later in this chapter. The availability of antibiotics from pharmacies may also result in requests for them for conditions outside of PF and this too will need careful handling and an explanation of why the antibiotic cannot legally be supplied. Fortunately, pharmacists have extensive relevant experience of years of handling requests for medicines for an indication that falls outside its OTC licence.

Requests for help with symptoms or a specific condition

The request may be made in person by the patient or remotely by telephone or video call. The patient may have been referred to the pharmacy by NHS 111 or by a local healthcare professional and may be a PF referral. Requests may also be made by a customer on behalf of someone else. In this section, we set out the principles of responding using a simple framework:

(A) Information gathering: By developing rapport, listening and questioning to obtain information about symptoms, and eliciting the patient's ideas.
(B) Decision-making: Is referral for a medical opinion required?

(C) Treatment and advice: The selection of possible, appropriate and effective treatments (when needed), offering options to the patient and advising on use of treatment, and offering health advice.

(D) Outcome: Advising the patient what action to take if the symptoms do not improve.

A. Information gathering

Most information required to make a decision and recommend treatment can be gleaned from just listening to the patient. Some patients will have been referred for a recommended treatment, others may want to repeat a previous treatment and a few will have a new concern worrying them. In most cases, listening to the patient for a minute or two, rather than putting immediate questions, is usually the key to understanding their needs.

Patients with a new problem may have prepared a story to tell you and may be dissatisfied if the story is not heard; experience suggests that the story can give you much of the information you might need. Once the story has been told, additional, more focused information may be required. Start with open-type questions and perhaps an explanation of why it is necessary to ask personal questions. Some patients do not yet understand why the pharmacist needs to ask questions before recommending treatment. An example might be the following:

Patient	Can you give me something for my piles?
Pharmacist	I am sure I can. To help me give the best advice, though, I would like a bit more information from you, so I need to ask a few questions. Some of them will need to be a bit personal. Is that OK and would you like to come to a more private area?
Patient	That is fine.
Pharmacist	Could you start by telling me what sort of trouble you get with your piles?

Hopefully, this will lead to a description of most of the symptoms required for the pharmacist to make an assessment. Other forms of open questions could include the following: How does that affect you? What sort of problems does it cause you? By carefully listening and possibly reflecting on comments made by the patient, the pharmacist can obtain a more complete picture.

Patient	Well, I get spells of bleeding and soreness. It has been going on for years.
Pharmacist	You say years?
Patient	Yes, on and off for 20 years since my last pregnancy. I have seen my doctor several times and had them injected, but it keeps coming back. My doctor said that I would have to have an operation, but I do not want one; can you give me some suppositories to stop the bleeding?

Pharmacist Bleeding …?
Patient Yes, every time I go to the toilet, blood splashes around the bowl. It is bright red.

This form of listening can be helped by asking questions to clarify points: 'I am not sure I quite understand when you say …', or 'I am not quite clear what you meant by …'. Another useful technique is to summarise the information so far: 'I would just like to make sure I have got it right. You tell me you have had this problem since …'.

Once this form of information gathering has occurred, there will be some facts still missing. It is now appropriate to move onto some direct questions.

Pharmacist How are your bowels … Has there been any change? (This question is very important to exclude a more serious cause for the symptoms that would require referral.)
Patient No, they are fine, always regular.
Pharmacist Can you tell me what sort of treatments you have used in the past and how effective they were?

Other questions could include the following: What treatments have you tried so far this time? What sort of treatment were you hoping for today? What other medications are you taking at present? Do you have any allergies?

When the patient has been referred to the pharmacy by another healthcare professional or from a telephone triage service, such as NHS 111, they may already have been asked some or many questions as part of that process. However, the pharmacy may receive very little information and in some cases may have been provided with simply the presenting complaint, e.g. 'mouth ulcer'. The patient may think that all of the information they have already supplied has been sent to the pharmacy, so it is important to explain that it has not. Once the patient knows the reason why you seem to be asking questions that they have already been asked by someone else, they will understand why this is happening.

B. Decision-making

Triaging is the term given to assessing the level of seriousness of a presenting condition and thus the most appropriate action. It has come to be associated with both prioritisation (such as used in accident and emergency [A&E]) and clinical assessment. Most community pharmacists have developed procedures for information gathering to identify when the presenting problem can be managed within the pharmacy and when referral for medical advice is needed (so-called 'clinical pathways'). In making this clinical assessment, pharmacists incorporate management of certain conditions and make recommendations about them.

The use of protocols and algorithms in the triaging process is common in many countries, including the UK, with computerised decision-support systems increasingly used. Patients who are referred to you from NHS 111 (used across most of the UK) will already have been subject to questions based on a decision-support algorithm. It is

possible that in the future computerised decision support may play a greater part in face-to-face consultations, perhaps including community pharmacies.

If the consultation went like this, then a referral would be required:

Pharmacist	Could you tell me what sort of trouble you have had with your piles?
Patient	Well, I get spells of bleeding and soreness. It has been going on for years, although seems worse this time ….
Pharmacist	When you say worse, what does that mean?
Patient	Well … my bowels have been playing up and I have had some diarrhoea …. I have to go three or four times a day … and this has been going on for about 2 months.

For more information on when to refer, see *D – Danger/red flag symptoms* under the ASMETHOD pneumonic in the section Structuring the consultation, further on in the text.

C. Treatment and health advice

Next, we discuss selection of treatment, including assessing likely effectiveness and agreeing treatment choices with patients.

The pharmacist's background in pharmacology, therapeutics and pharmaceutics gives a sound base on which to make logical treatment choices based on the individual patient's need, together with the characteristics of the medicine concerned. In addition to the effectiveness of the active ingredients included in the product, the pharmacist will need to consider potential interactions, cautions, contraindications and the adverse reaction profile of each constituent. Evidence-based practice requires pharmacists to carefully think about the effectiveness of the treatments they recommend, combining this with their own and the patient's experience.

About one in two patients will have tried at least one remedy before seeking the pharmacist's advice. Treatment may have consisted of OTC medicines bought from the pharmacy or elsewhere, other medicines prescribed by the doctor on this or a previous occasion, or medicines borrowed from a friend or neighbour or found in the medicine cabinet. Homoeopathic or herbal remedies may have been used. The cultural traditions of people from different ethnic backgrounds include the use of various remedies that they may not consider medicines. The availability of more medicines from online pharmacies (including P medicines via an authorisation process), online supermarket ordering and online shops, such as Amazon, have increased access to medicines, herbal products and supplements.

The pharmacist will elicit the patient's preferences and discuss treatment options. Concordance is an agreement reached after negotiation between the patient and pharmacist (or other healthcare professional) that respects the beliefs and wishes of the patient in determining which, whether, when and how medicines are to be taken and is fundamentally important.

Some pharmacies have developed their own OTC formularies with preferred treatments that are recommended by their pharmacists and their staff. In some areas, these have been discussed with local GPs and practice nurses to cover the referral of patients

from the GP practice to the pharmacy. These may be area initiatives arranged by local healthcare organisations (such as primary care networks or health boards). The PF clinical pathways have effectively created a formulary for NHS-supplied treatments for each condition. Patients can choose a different treatment if they are willing and able to pay for it.

Pharmacy PMRs can provide helpful information about prescribed medicines if the patient is a regular customer at the pharmacy. Review of the record can identify potential drug interactions and adverse effects. Adding information to the PMR for certain patients, such as older people, can complete the medication profile.

Community pharmacies have access to parts of the NHS primary care medical record. In England, this is through the National Care Record Service (NCRS) and Local Health and Care Record, with similar systems in Wales and Scotland. With the patient's verbal consent, pharmacists can check medicine-related information when, in their clinical judgement, it is appropriate to do so. Using that record, the pharmacist can access information for patients who are not regular users of the pharmacy, thus overcoming the lack of PMR for these patients, especially if they are unsure about the names of any of their prescribed medicines, the reason why they were prescribed or the relevant medical condition. For certain NHS services (e.g. PF) the GP Connect system can be used to view the patient record. We cover this in more detail later in this chapter.

Health advice may be needed regardless of whether a treatment is recommended and symptom relief approaches, or simple reassurance and watchful waiting, can be appropriate in many conditions. Many guidelines include evidence-based health advice recommendations. An example of watchful waiting is seen with acute otitis media (AOM) in children for which antibiotics are often requested (and in the past have been provided routinely). Ear pain associated with viral respiratory infections usually gets better in a similar time period with or without antibiotics, so pain relief medicines with *paracetamol* or *ibuprofen* are usually the best option while waiting for symptoms to resolve. Conjunctivitis in children is similar as most cases resolve without treatment in a few days.

There is increasing interest in the role of pharmacy in social prescribing. Social prescribing is a concept based on the recognition that many of the problems that are presented to healthcare may be helped by a social solution, rather than by providing medical treatments (or selling OTC products). Social prescribing involves helping patients to improve their health, wellbeing and social welfare by helping them connect to a variety of community services run by voluntary groups, the council or a local charity. One example is encouraging a person who has depression symptoms related to social isolation and loneliness to join a local walking or litter picking group, which will give them the company of other people, with the added bonus of increasing physical activity. The NHS has a number of initiatives designed to improve access to social prescribing. Pharmacies can get involved in local programmes, develop ties with 'social prescribing link workers', and keep information packs enabling patients to be signposted to relevant services.

D. Outcome

Most minor illnesses will improve with treatment and advice. Each consultation should include 'safety-netting' by explaining the timescale for further assessment, and providing the advice needed if improvement has not occurred. This is set out for each condition in

this book as the 'Treatment timescale'. The treatment timescales outlined in this book naturally vary according to the symptom and sometimes according to the patient's age, but are usually less than 1 week.

Some sections of the book use the expression 'referral to doctor'. This is a commonly used expression within pharmacies and is generally well understood by patients. Increasingly in primary care, out-of-hour (OOH) services and A&E, patients may not see the doctor directly. Often trained nurses or suitably qualified clinical pharmacists may assess patients, and they may prescribe treatment as independent prescribers (IPs) or supply through PGDs. We have used this phrase for convenience, and this may need explaining to patients. Alternatively, to indicate that a doctor may not always be directly involved we have used the expression 'referral to the GP surgery'. Increasingly community pharmacists are training as IPs, and all newly qualifying pharmacists are expected to be IPs by 2026.

DEVELOPING CONSULTATION SKILLS

A framework for the consultation

Effective consultation skills are the key to finding out what the patient's needs are, and deciding whether you can manage the problem or whether they might need to be referred to another practitioner. All community pharmacists will have learned consultation skills during their undergraduate, pre-registration and post-registration education. This section therefore aims to provide a summary relevant to consultations when responding to symptoms. A useful framework for thinking about and improving consultation skills is provided by Roger Neighbour's five 'checkpoints' (see Table 1.1).

TABLE 1.1 Five checkpoints in the consultation

A	Connecting	'Have we got a rapport?'	Rapport-building skills
B	Summarising (clinical process)	'Can I demonstrate to the patient I have understood why she has come?'	Listening and eliciting skills (history taking and summarising to the patient)
C	Handing over	'Has the patient accepted the management plan we agreed?'	Concordance skills
D	Safety-netting	'Have I anticipated all likely outcomes?'	Contingency plans
E	Housekeeping*	'Am I in good condition for the next patient?'	Taking care of yourself

Source: After Roger Neighbour.

* *Housekeeping – This is a period of reflection where practitioners look at themselves and their response to the consultation. It may involve having a brief chat with a colleague, having a coffee break and thinking about it, or merely acknowledging to oneself whether a particular consultation has been effective or not.*

Challenges in pharmacy consultations

Face-to-face consultations will have comprised the majority of many community pharmacists' experience. Here, the pharmacist is likely to have minimal or no advance knowledge of what the patient wants to discuss. The pharmacist may or may not already know the patient and be aware of some of their medical and social situations. Pharmacists may therefore need to elicit more information from patients who are not regular users of their pharmacy, although research indicated there is often little or no difference in practice in the questions asked.

The COVID-19 pandemic impacted on pharmacy consultations, including the use of plastic screens and the wearing of masks. The barrier of the screen and the wearing of masks made it harder to hear and understand what was being said and picking up on non-verbal cues is more difficult when part of the face is covered. Some patients have continued to wear a mask in response to continued circulation of COVID-19.

Using the computer during the consultation

There is a wealth of experience from general practice about the effects of using the computer while consulting with a patient. Common complaints regarding the use of computers during the consultation is that the clinician appears disinterested, makes little eye contact with the patient and spends much of the consultation staring at their computer. It is important to avoid this and develop strategies to give the patient full attention for significant intervals of time.

The tips below make suggestions about ways of developing rapport with the patient during the process and avoiding misunderstandings and errors:

- If possible, face the patient when they first come in and maintain eye contact for the initial part of the consultation rather than already being positioned facing the computer.
- Explain to the patient why the computer is being used during the consultation. Patients will be familiar with staff at their GP practice making records but may not yet expect it at their pharmacy.
- Explain what you are doing and why. A patient is far less likely to feel disregarded if you make it clear why you are turning to use the computer.
- Tell the patient that you will need to type information into the computer periodically and that when you are doing this you will need to pause the conversation because you will not be able to fully take in information that the patient might give you.
- Make it clear to the patient when you are going to transfer your attention to the keyboard and screen, for example you might signpost by saying something like 'Hold on a minute, I just need to get that down on the computer' or 'I need to concentrate on the computer for a minute'.
- If you need to look at the screen to follow a clinical pathway and enter answers to questions, explain this to the patient.
- Sometimes you might want to look for an answer to a clinical question while the patient is present. Explain that you are doing this to ensure that the patient gets

the correct, most up to date treatment. To avoid misunderstandings make it clear that you're checking something from an accredited resource such as the *British National Formulary* or NICE guidelines, rather than the patient assuming you are using generic search engines to find out something you should know.

- You may need to consider sharing the screen with the patient and how best to do this. It is generally considered good practice. The consultation room may need to be configured to enable this. When showing patients information on the screen, check the patient can read it clearly and give them time to read it without interruption.
- Be aware of what your screen is displaying after each consultation. It does not necessarily have to display clinical notes to breach confidentiality; a clinic list with patient names or guidelines on a condition left on the computer are enough to do this. Clearing these data is often neglected and is a common error.

Remote consultations

Telephone and video consultations are now mainstream in primary care and in hospitals. Improvements in technology have enabled greater use of video consultations and the NHS has its own systems, such as *Attend Anywhere* for England and Wales, and *Near Me* for Scotland. Many patients will now have some experience of remote consultations for health reasons. These changes have brought both benefits and drawbacks. Benefits include improved efficiency and the possibility of increasing access to healthcare professional consultations, but there are also significant challenges; see Table 1.2.

TABLE 1.2 Summary of some of the challenges of remote consultations

	Telephone consultations	Video consultations
Access	Almost everyone has access to a telephone	Patient needs to own or have access to a smartphone, tablet, laptop or computer Computer literacy varies Risk of disadvantaging people who do not use the technology and those who are on low income
Appropriateness and risk management	Need to assess if face-to-face consultation required	Need to assess if examination needed to make diagnosis
Time management for both pharmacist and patient	Call tends to be 'unscheduled' – best if use appointment system	Use of appointment system important to make time, ensure availability of equipment, plus ensure privacy

(*Continued*)

TABLE 1.2 (Continued)

	Telephone consultations	Video consultations
Patient identification	Not seeing the patient means that you will need a robust method to check that you are speaking to the right person	If you know the patient, it is easy to know that you are speaking to the right person, but confirmation will still be required
Privacy and confidentiality	Other people in the patient's location might hear what is being discussed	Other people in the patient's location might see who the patient is talking to and hear what is being discussed Important to check that patient is able to consult in privacy
Technical issues	Signal strength for mobiles Mobile phone battery charge running out	Correct technology, equipment needed Wi-Fi connection strength and consistency – 'freezing', etc. Lighting
User issues	Has patient got 'capacity' and cognitive skills? Staff training required	Has patient got 'capacity' and required cognitive skills? Requires user familiarity with system User error Troubleshooting
Non-verbal communication	Non-verbal communication and cues are absent	Non-verbal communication and cues may be blunted
Interruptions and overlap	Strategies needed to enable patient to describe problems adequately	Speaking over one another because of lags between vision and sound
Hearing impairment	Telephone volume can be adjusted, or acoustic loop used	May allow lip reading by the patient
Shared decision-making	Ensure patient has access to necessary information for informed choices	Ensure patient has necessary information for informed choices. Can diagrams or illustrations assist?
Documentation	Record-keeping will be necessary. If recording, needs patient consent prior to recording	Record-keeping necessary. May be significant confidentiality issues if taking 'snapshots' or recording – consent needed in advance
Antimicrobial stewardship	Physical examination may be necessary for appropriate decision making	Physical examination may be necessary for appropriate decision making

Remote consultations can be used for PF in England, with the exception of acute otitis media. This means that 'distance selling' pharmacies can also participate in this scheme.

Face-to-face consultation remains the accepted norm in community pharmacy with use of remote consultations in specific circumstances, for example if the patient is:

- housebound
- too ill to go to the pharmacy, or may have a contagious illness
- resident in a care home
- unable to attend the pharmacy due to work, caring responsibilities or issues with transport.

For those pharmacists who are getting to grips with remote consultations, a summary of potential challenges is provided in Table 1.2. This is by no means exhaustive, but provides a framework for resolving some of the difficulties.

Several resources are available to assist in ensuring that the required equipment can be used most efficiently, and in adapting the consultation style to make the process more productive. Pharmacists should consider this learning as an essential part of their continuing professional development.

A useful set of articles and resources are indicated in the following text. These are not exhaustive and may be subject to change. Some are those used in UK general practice.

List of resources on remote consultations – websites accessed 9 September 2024

- Barnett, N. and Jubraj, B. (2020). Remote consultations: how pharmacy teams can practise them successfully. *Pharm. J.* https://pharmaceutical-journal.com/article/ld/remote-consultations-how-pharmacy-teams-can-practise-them-successfully
- Royal Pharmaceutical Society (2021). Remote consultations: conducting phone or video consultations. www.rpharms.com/resources/pharmacy-guides/coronavirus-covid-19/clinical-resources-during-covid-19/upskilling-during-covid-19/remote-consultations
- Royal College of General Practitioners (2023). Remote consultation and triaging, resource hub. https://elearning.rcgp.org.uk/mod/page/view.php?id=10551
- Royal College of General Practitioners (2020). Top 10 tips for successful GP video consultations. www.rcgp.org.uk/blog/video-consultations
- University of Oxford. Video consulting in the NHS: guidance and resources for NHS patients and clinicians to support online consultations. www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs

Structuring the consultation

Pharmacists need to develop a method of information seeking that works for them. There is no right and wrong here. It is very useful to adopt a framework to help structure the consultation.

The Calgary–Cambridge consultation model is widely taught in pharmacy, which includes:

- initiating the consultation
- gathering information
- explanation and planning
- closing the session.

Some pharmacists find that a mnemonic, such as ASMETHOD (developed by London community pharmacist Derek Balon), shown in the following text, can be a useful brief aide memoire, although care needs to be taken not to recite questions in rote fashion without considering their relevance to the individual patient. Good listening will glean much of the information required. Developing rapport is essential to obtain good information and reading out a list of questions can be off-putting and counterproductive.

- **A** – Age and appearance
- **S** – Self or someone else
- **M** – Medication
- **E** – Extra medicines
- **T** – Time persisting
- **H** – History
- **O** – Other symptoms
- **D** – Danger/red flag symptoms

A – Age and appearance

The appearance of the patient may indicate whether a minor or more serious condition is involved. If the patient looks pale, clammy, flushed or grey, referral to the doctor should be considered. For children, appearance is important, but asking the parent whether the child is generally well is also needed. A child who is cheerful and energetic is unlikely to have anything other than a minor problem, whereas one who is quiet and listless, or who is fractious, irritable and feverish, might require referral.

Age is important because some symptoms are potentially more serious according to age. For example, acute diarrhoea in an otherwise healthy adult could reasonably be treated by the pharmacist. However, such symptoms in a baby could produce dehydration more quickly; elderly patients are also at a higher risk of becoming dehydrated.

Age will also play a part in determining any treatment offered by the pharmacist. Some preparations are not recommended at all for children under 12 years, e.g. *loperamide*. Others must be given in a reduced dose or as a paediatric formulation. These are included in this book for each medicine.

Other OTC preparations have a minimum specified age, e.g. 12 years for nicotine replacement therapy and 16 years for treatments of vaginal thrush. Pharmacists are used to assessing patients' approximate age and would not routinely ask for proof of age here, unless there was a specific reason to do so.

S – Clarification as to who is the patient – self or someone else?

Establish the identity of the patient: the person in the pharmacy might be there on someone else's behalf. The exact nature of the symptoms should be established: patients often self-diagnose illnesses, and the pharmacist must not accept such a self-diagnosis at face value.

M – Medication regularly taken, on prescription or OTC

All medicines taken regularly by the patient need to be identified for two reasons: possible interactions and potential adverse reactions. Such medicines will usually be those prescribed by the doctor, but may also include OTC products and complementary or alternative remedies. The pharmacist needs to know about all medicines being taken because of the potential for interaction with any recommended treatment.

The community pharmacist has an important role in detecting adverse drug reactions, and once the list of medicines has been obtained, consideration should be given to the possibility that the patient's symptoms might be an adverse effect caused by medication. Sometimes, the patient will perceive that this might be the case and ask about it, for example whether a cough might be due to an angiotensin-converting enzyme inhibitor. When the pharmacist suspects an adverse drug reaction to a prescription-only medicine (POM), a discussion with the prescriber about what actions should be taken may be needed (perhaps including a Yellow Card report to the Medicines and Healthcare products Regulatory Agency by the pharmacist or patient) and the prescriber may wish the patient to be referred back to them.

E – Extra medication tried to treat the current symptoms

Any action taken by the patient should be established, including the use of any medication to treat the symptoms. If the patient has used one or more apparently appropriate treatments without improvement, referral to the family doctor may be the best course of action.

T – Time, i.e. duration of symptoms

Duration of symptoms can be an important indicator of whether referral to the doctor might be required. In general, the longer the duration, the more likely the possibility of a serious, rather than a minor, case. Most minor conditions are self-limiting and should clear up within a few days.

H – History

There are three aspects to the term 'history' in relation to responding to symptoms:

- the history of the symptom being presented
- previous medical history, for example does the patient have diabetes, hypertension or asthma? PMRs should be used to record relevant existing conditions, and

- social history, for example the pharmacist might know that the patient had a recent bereavement and is now living alone, or that they lost their job and had to move to a flat without a garden.

Questioning about the history of a condition may be useful; how and when the problem began, how it has progressed and so on. Any previous episodes should be asked about to determine the action taken by the patient and its degree of success. For example, in recurrent mouth ulcers: Do the current ulcers resemble the previous ones? Was the doctor, nurse or dentist seen on previous occasions? Was any treatment prescribed or OTC medicine purchased, and, if so, did it work?

In asking about the history, the timing of particular symptoms can give valuable clues as to possible causes. The attacks of heartburn that occur after going to bed or on stooping or bending down are indeed likely to be due to reflux, whereas those that happen during exertion, such as exercise or heavy work, may not be (these may signify angina).

History taking is particularly important when assessing skin disease. Recognition of the appearance of skin conditions is not the most important factor and many dermatologists would argue that history taking is more important because some skin conditions resemble each other in appearance. Furthermore, the appearance may be altered during the course of the condition. For example, the use of a topical corticosteroid inappropriately on infected skin may substantially change the appearance; allergy to ingredients, such as local anaesthetics, may produce a problem in addition to the original complaint. Knowing which creams, ointments or lotions have been applied is essential.

O – Other symptoms

Patients generally tend to complain about the symptoms that concern them most. The pharmacist should always ask whether the patient has noticed any other symptoms or anything different from usual because, for various reasons, patients may not volunteer all the important information. Embarrassment may be one such reason, so patients experiencing altered bowel habit for a period of time may only mention that they are constipated or that their stools are loose.

The significance of symptoms may not be recognised by patients, for example those who have constipation as a side effect from a tricyclic antidepressant will probably not mention their dry mouth because they can see no link or connection between the two problems.

D – Danger/red flag symptoms

These are the symptoms or combinations of symptoms that should ring warning bells for pharmacists that immediate referral to the doctor is required. They are often called ‘red flag’ symptoms and we refer to them as such throughout the rest of this book. Blood in the sputum, vomit, urine or faeces would be examples, as would unexplained weight loss. Red flag symptoms are included and discussed in each section of this book so that their significance can be understood by the pharmacist.

The ASMETHOD structure can be supplemented with questions to explore the patient perspective, for example by using LICEF (Lifestyle, Ideas, Concerns, Expectations and Feelings). This helps to identify relevant aspects of a patient's social circumstances, for example do they live alone and are lonely? Are they expecting to leave your pharmacy with a supply of antibiotic?

DECISION MAKING AND RISK ASSESSMENT

Most presenting symptoms will be of a minor and self-limiting nature and should resolve within a few days. We have already discussed safety-netting under D. Outcome earlier in this section.

In making decisions, the pharmacist assesses the possible risk to the patient of different decision paths. The possible reasons for referral for further advice include the following:

- red flag signs or symptoms
- unknown cause for symptoms
- incomplete information (e.g. an ear condition where the ear has not been examined)
- duration or recurrence of symptoms
- potential need for a POM.

As a general rule, the following indicate a higher risk of a serious condition and should make the pharmacist consider referring the patient to the doctor:

- long duration of symptoms
- recurring or worsening problems
- severe pain
- failed medication (one or more appropriate medicines used already, without improvement)
- suspected adverse drug reactions (to prescription or OTC medicine)
- red flag symptoms.

Each section of this book includes a suggested list of 'When to refer'. At the end of the book, in the Appendix, we provide a summary of these with a set of pointers for direct referral; this mainly relates to physical illnesses.

The clinical pathways for the seven PF conditions provide an excellent concise guide to decision making and referral for each condition. Discussions with local GPs can assist the development of protocols and guidelines for referral for other conditions. Often this process can be facilitated by the local healthcare organisation (clinical commissioning group or health board). Joint discussions of this sort can lead to effective two-way referral systems and local agreements about preferred treatments.

RECORD KEEPING AND COMMUNICATION

Recording the consultation

Making a concise clinical record of a consultation about a minor illness or suspected infection is now a necessary skill for community pharmacists. In supplying treatments via PGDs or making decisions for conditions such as those covered by PF, pharmacists are required to keep a record of their consultations with patients. The intention is to incorporate this into the NHS patient care record through systems such as GP Connect in England and Choose Pharmacy in Wales. The data that pharmacists are required to enter includes an explanation of the basis for the clinical decisions.

Most GP computer systems provide a structure for systematically recording the clinical findings and decisions made during the consultation. Pharmacists may not yet have access to such a structure and may instead have a single free text box to fill in. It is worth following a structured system to ensure that important information has been captured, in a way that fits with other entries in the primary care clinical record. The GP, when looking at the record, needs to be able to rapidly glean the key information. A further reason is that in the case of any challenge to your decision making it can help justify your actions – see Pitfalls in record keeping, later in this section. One system commonly used for recording is SOAP.

SOAP is a structure based on subjective, objective, assessment and plan. It might sound rather simplistic, but it has been in use for many years and has stood the test of time. It is a recording structure built into many GP computer systems and is as follows:

- *Subjective*. The subjective section of your documentation should include how the patient is currently feeling in their own words. You should document the patient's responses accurately and use quotation marks if you are directly quoting something the patient has said.
- *Objective*. The objective section needs to include your objective observations, which are things you can measure, see, hear, feel or smell. This includes appearance of the patient (pale, or sweaty, for example), clinical observations and investigation results (such as temperature, pulse rate, or blood pressure), where relevant.
- *Assessment*. This is where you document your thoughts on the important issues and the diagnosis (or differential diagnosis) based on the information collected. This may be your impression of the likely cause of the problem. If the diagnosis is fairly clear you can record the severity of the problem, and whether it is improving or deteriorating.
- *Plan*. The final section is the plan, which is where you document how you are going to address or further investigate any issues. This would include the need for investigations or referral, or the treatment that has been provided (such as antibiotics via PGD). You should record when you wish to review the patient, and any advice given. This may include information given to the patient, including things like patient information leaflets. Most importantly you should record any safety netting advice provided – see Pitfalls in record keeping, later in this section.

PF and the Patient Care Record

Integration of community pharmacy with other primary care professionals through technology has been a goal of pharmacists and the NHS for many years.

PF has brought together and updated the technology available to community pharmacies in England to enable greater integration into primary care. It has speeded up the adoption of electronic communication with both patients and GP practices. Similar systems are in use or are being introduced elsewhere in the UK.

With the patient's consent, their GP record via GP Connect, the NHS patient care record or an alternative clinical record for the patient must be checked by the pharmacist unless there is good reason not to do so. Access to the patient care record can also ascertain whether the patient may have a diagnosed condition listed in a PGD as excluding the patient from PF treatment. This overcomes the problem of a patient not knowing or not remembering specific diagnoses.

Pharmacists must adhere to defined standards of record keeping ensuring that the consultation record is made on the same day that it occurs unless exceptional circumstances apply. The details and the outcome of each consultation should be recorded. For PF purposes this record should be made on the Pharmacy First IT system (PFIT). Where PFIT is unavailable due to exceptional circumstances, then the consultation record must be added to the system as soon as possible after it becomes available again.

A notification of the provision of the PF service must be sent to the patient's general practice on the day of provision or on the following working day. Where possible, this should be sent as a structured message in real-time using PFIT. In the absence of an automated digital solution, or if there is a temporary problem with the system, this should be sent via NHS mail or hard copy.

GP Connect provides the functionality to automatically update a patient's GP medical record, but is not used to send any clinically urgent, safeguarding or time-sensitive information. Where an action is required by the general practice team, such as booking the patient in for a follow up or appointment, an 'action message' or 'urgent action communication' must be sent to the practice.

Tips for completing the record:

- Record directly onto the software system and do not use paper/pen unless it is unavoidable. The more you do this, the easier it will get.
- Consider what you are writing from the point of view of another health professional or patient who might read it.
- Include relevant social history.
- It is important to record negative as well as positive findings to show that you have considered key aspects.
- For fields that are not applicable, say N/A rather than leave blank. This shows that the item has been considered and not missed.

Pitfalls in record keeping

All patients have a right to access their clinical records. They are also entitled to challenge the validity of records and to have factual errors corrected. An important point regarding recording consultations is never to record something that you would not

want the patient to see; a common complaint in hospitals and in general practice is where judgmental or rude remarks about the patient have been made in the clinical record.

Some decisions may be subject to scrutiny or there may be medico-legal concerns if things have gone wrong. A general 'rule of thumb' is that in the eyes of the law, if a detail is not recorded, it cannot be proven to have happened. This includes negative findings (e.g. 'not pyrexial', 'no vomiting'), therefore records have to be thorough, with particular reference to safety netting guidance provided and advice on when further help might be required. In the absence of such a record, the patient's account of the consultation, even if you are not in agreement with it, is taken at face value and may be hard to disprove.

Many GPs and hospital doctors now provide the patient with a copy of the consultation record. This enables the patient to check what has been recorded at the time of the clinical encounter and to allow any corrections in interpretation. It also facilitates a common understanding in terms that the patient would use, rather than medical jargon. This is something the pharmacist may wish to consider.

If you need to add something to the record or make a correction, make sure you enter the date of the amendment and include your name. This is important as it enables the correct time of a change to be on the record and you cannot be accused of altering or tampering with the information.

Use of patient messaging software

An increasing number of pharmacies (and general practices) are using patient messaging software on NHS assured platforms such as AccuRx®, and the associated Accumail®. For pharmacists these can be used, for example, to:

- message patients before or after a PF consultation
- conduct a secure video consultation with a patient
- allow patients to send photographs of rashes and other dermatological conditions
- ask patients to complete a questionnaire prior to the consultation to inform consideration of whether they meet PF clinical gateway criteria; the pharmacist can then speak to the patient and decide next steps
- send the patient useful clinical information after the consultation: pharmacists can create templates for safety-netting/signposting information (see Figure 1.1) and leaflets to give to patients treated under one of the seven clinical pathways
- remind the patient of the timescale for returning to the pharmacy if necessary (safety netting) after consultations where antibiotic supply has been considered.

ANTIMICROBIAL STEWARDSHIP AND CONSULTATION SKILLS

Much of the research into consultation skills in general practice has taken place in the context of antimicrobial prescribing for respiratory tract infections. This is a therapeutic area where over 50% of all antibiotic prescribing in primary care occurs. It has long been

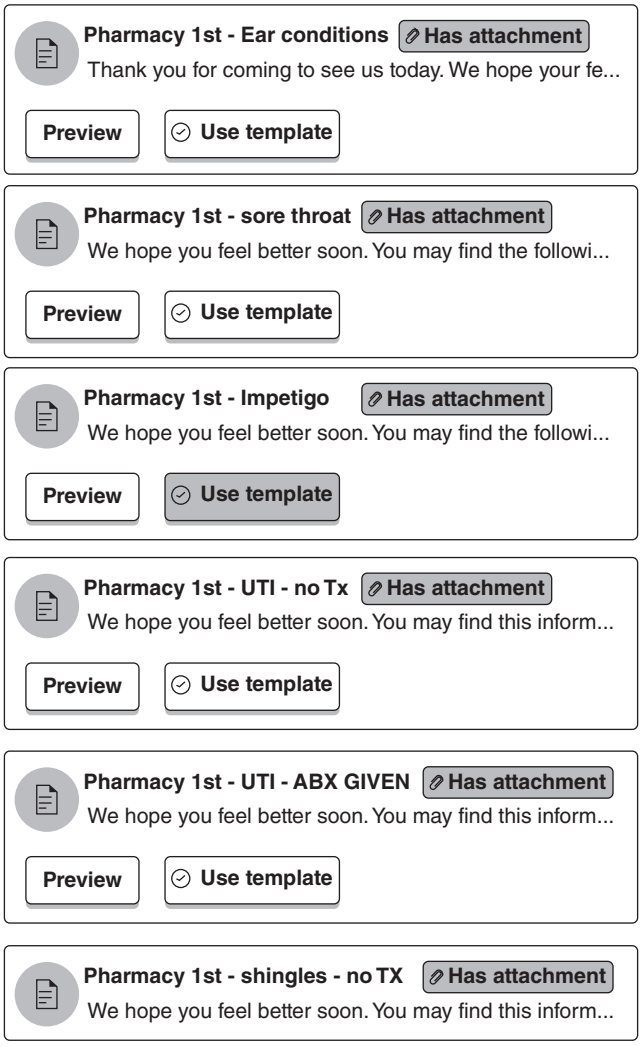

FIGURE 1.1 Example of template messages for safety netting and information.
Source: Reena Barai.

recognised that the use of antibiotics for these infections rarely reflects clinical need but is strongly related to historical and societal beliefs and expectations. Improving the dialogue and interaction between healthcare workers and patients is key to tackling inappropriate antibiotic use and addressing the needs of antimicrobial stewardship (AMS).

What is AMS?

The option to be able to supply an antibiotic to treat specific common conditions is relatively new for many pharmacists. PF services have extended this and with it the need for effective AMS by pharmacy teams. The term AMS is defined by the National

Institute for Health and Care Excellence (NICE) as 'an organisational or healthcare systemwide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. Inappropriate prescribing and overuse of antibiotics contributes to the growing problem of drug-resistant organisms known as AMR.

AMR is the loss of antimicrobial effectiveness, and although it evolves naturally, this process is accelerated by the inappropriate or incorrect use of antimicrobials (antibiotics, antifungals, antivirals and antiparasitics). Very few truly new antibiotics have been developed in the last few decades and we are running out of effective antibiotics for use when they really matter. Direct consequences of infection with resistant microorganisms can be severe and affect all areas of health, such as prolonged illnesses, longer hospital stays, increased costs and mortality, and reduced protection for patients undergoing operations or procedures. Things we take for granted like hip replacements, and neonatal care become much more hazardous.

The need for good consultation skills as part of AMS

Most patients now recognise that antibiotics should not be taken for coughs and colds, but far fewer know that acute sinusitis, ear infections or sore throats are self-limiting and will get better on their own without antibiotics. Telling patients the typical length of the infection they have helps to create a realistic expectation of likely duration of symptoms. There is good evidence that the way health professionals discuss whether antibiotics might or might not help influences how patients accept their recommendations and this is often determined by good consultation skills.

With community pharmacists across the UK now authorised to supply antibiotics, the importance of consistency of patient experience is clear. Drivers of antibiotic use by GPs include diagnostic uncertainty, the fear of unforeseen complications and belief (often misplaced) that patients are demanding them and not wishing to cause upset; these same drivers are likely to also potentially affect community pharmacists. Furthermore, delayed access to GP appointments could apply undue pressure on pharmacists to provide antibiotics.

Key principles for pharmacists seeking to minimise antibiotic use are:

- using clinical support tools such as scoring systems and presence/absence of key signs and symptoms to assess the likelihood of bacterial infection
- ensuring that symptom relief treatments are used effectively, and in preference to antibiotics, wherever appropriate
- discussing 'return for reassessment' with patients who do not meet clinical pathway criteria for considering an antibiotic at their initial pharmacy visit
- having a shared plan with local GP practices to ensure consistency of approach to the supply of antibiotics.

Tools to support AMS

Excellent resources are available to support AMS in pharmacies. The Treat Antibiotics Responsibly, Guidance, Education and Tools (TARGET) toolkit was developed by UK Health Security Agency (HSA) and the UK Royal College of General Practitioners (RCGP)

alongside a range of collaborators and is designed to support primary care clinicians to champion and implement AMS activities. The ultimate objective is to minimise the effects of antibiotic resistance. The contents are supported and hosted by the RCGP. There are some materials specifically for community pharmacists and their teams.

Explaining the natural course of common infections

Prescribing antibiotics in primary care for respiratory tract infections such as sore throat and coughs has become commonplace and is often expected by patients, but most of these prescriptions are unnecessary. Many patients and parents believe that infections should clear up more quickly than evidence shows is the expected duration. Telling patients the typical length of the infection they have helps to create a realistic expectation of likely duration of symptoms. This is an important part of the consultation.

Misperceptions about the natural course of infections can lead to unwarranted concern that an antibiotic must be needed. The TARGET 'most get better by …' list is shown in Table 1.3 and can be used to inform and reassure patients. This is discussed further in Chapter 2: Respiratory Problems.

A barrier to self-care and a driver of primary care consultations for common infections may be the labelling of OTC medicines which specifies a maximum number of days' use after which a health professional must be consulted. This may contribute to patient beliefs that the condition should be better by then, and if it is not, then medical intervention must be needed. Pharmacists can reassure patients that by consulting them the label requirement is met and use of the OTC medicine can continue, if appropriate so long as safety-netting has been clearly explained.

Could it be a bacterial infection?

Consultations that potentially involve antibiotics present specific challenges for pharmacists. Assessing clinical need, the presence of diagnostic uncertainty and patient expectations all play a part. Clinical support tools such as scoring systems and the presence or absence of key signs and symptoms will help pharmacists to assess the likelihood of bacterial infection (see Table 1.4).

Community pharmacy teams are used to questioning patients as part of decision making and risk assessment when a patient presents with symptoms and signs of an

TABLE 1.3 TARGET most get better by … list

'Ear infection' – acute otitis media	8 days
Sore throat	7–8 days
Acute sinusitis	14–21 days
Common cold	14 days
Acute cough or acute bronchitis	21 days
Uncomplicated urinary tract infection*	3–5 days

** Not on the TARGET list but worth noting.*

TABLE 1.4 Diagnostic features and diagnostic tools

Condition	Diagnostic symptoms/signs
Acute otitis media	Earache, or upset in young children, with abnormal ear drum
Acute sinusitis	Nasal blockage or nasal discharge with facial pain/pressure (or headache) ± reduction (or loss) of the sense of smell
Sore throat	FeverPAIN score – based on Fever, Purulence, Attends rapidly, severely Inflamed tonsils, No cough or coryza
Uncomplicated urinary tract infection in women	Three key diagnostic signs/symptoms: dysuria, new nocturia and cloudy urine

infection. For the most part this has involved referring the patient to the GP practice when the pharmacist believes antibiotics might be needed. Community pharmacists in some parts of the UK have been able to supply antibiotics through condition-specific PGDs for several years. Narrowing down and pinpointing likely bacterial infections is a skill that many community pharmacists have developed, and the PF clinical pathways include key diagnostic symptoms/signs and sometimes scoring systems to support this process.

Resources to use with patients

Two particularly useful leaflets are the TARGET *Treating Your Infection – RTI* and *Treating Your Infection – UTI* which are for use jointly with the patient during the consultation. These combine checklists of key symptoms together with points for treatment. These two *Treating Your Infection* leaflets are designed to be discussed by primary care health practitioners with patients rather than only being given out at the end of a consultation as a takeaway information source. The leaflets have been tested in primary care, including community pharmacies, and the results showed that they can address patient concerns, empower patients to self-manage, improve patient recall and patient satisfaction. Importantly, they standardise the advice given by different prescribers (GPs, nurses and pharmacists) and patients will become used to seeing them in different primary care settings. The respiratory tract infection leaflet covers acute otitis media, sore throat and sinusitis as well as coughs and colds.

An important concept to encourage is that antibiotics are not intended for acute symptom relief, but many patients may expect this. Whether they are given antibiotics or not, all patients should be provided with advice about how to best use OTC products to reduce their discomfort or pain.

- The *When Should I Worry?* booklet (discussed further, later) includes information on giving fluids, avoiding a smoky atmosphere, and the use of *paracetamol* and

ibuprofen: https://target-webinars.com/wp-content/uploads/2016/08/When-should-I-worry-Booklet.pdf.

- Another very useful source of patient information is NHS Health A–Z: www.nhs.uk/conditions. This gives guidance on the use of symptomatic therapy for all the common infections and is a valuable resource to which patients can be directed.
- Similar information is available in Wales – Choose Well: https://thepracticeofhealth.nhs.wales/clinics-services/self-help-care/minor-common-ailments
- And Scotland – NHS Inform: www.nhsinform.scot/symptoms-and-self-help/a-to-z.

Patients' health literacy

Patients' health literacy: their knowledge and understanding about infections and antibiotics varies considerably. A regular national survey in England tracks public understanding and attitudes and has consistently found that participants from social grades D/E, black, Asian and minority ethnic (BAME) participants, those with less education and younger groups had significantly less understanding about antibiotics and antibiotic resistance. UK rates of antibiotic use are higher in areas of deprivation and the survey findings have important implications for pharmacy teams in less advantaged areas.

The most recent (2020) survey found most people had a positive attitude to avoiding antibiotic use with over four-fifths agreeing they would be pleased if the GP said they or their child did not need an antibiotic. Those from social grades D/E, BAME participants and younger groups were significantly less likely to agree. Trust in health professionals about the need for antibiotics remained high but one in five said they would challenge a GP's decision not to prescribe antibiotics and those significantly more likely to challenge were BAME participants and those with lower income. These findings suggest that pharmacists working in disadvantaged areas may be more likely to encounter resistance when they do not recommend an antibiotic.

Talking with patients about infections

Experience from general practice shows that a viral illness diagnosis or a non-antibiotic treatment recommendation may initially be questioned by some patients. Alongside this there is good evidence that many patients are satisfied if listened to carefully, are examined thoroughly where this is needed and are provided with a reasoned explanation as to why an antibiotic may not be required with alternatives recommended for relieving symptoms. Studies in general practice show there is often a mismatch between what the GP thinks the patient is demanding and what the patient really wants. This mismatch may also occur with pharmacist consultations and is an issue that should be explored.

A useful way of thinking about the conversation with a patient is the 3Es: Empathise, Evaluate, Educate. UKHSA and the Royal College of General Practitioners developed a consultation structure with the acronym CHESTSSS as part of the

TARGET toolkit dealing with 'Finding the right words', drawing on the evidence base for communication strategies that work. CHESTSSS can help you to remember specific phrases which: reassure patients, increase patient understanding and satisfaction with a prescribing decision, avoid re-consultations and may be particularly helpful for patients who are expecting antibiotics. In Table 1.5 we suggest some phrases that might be useful and we have tailored this in Chapter 2: Respiratory Problems in the sections on Sore Throat and Sinusitis. Similarly, we have tailored this to show how this communication framework can be used for acute otitis media (see the section in Chapter 11: Childhood Conditions).

Worried parents

Understandably, parents are often more worried about an infection in a child than if they themselves had the infection. A useful resource here is *When Should I Worry?*. This booklet has been used in research in a GP setting and resulted in a two-thirds reduction in antibiotic prescribing, a reduced intention to consult in future and did not impact on parental satisfaction (see `https://target-webinars.com/wp-content/uploads/2016/08/When-should-I-worry-Booklet.pdf`). The booklet can be used by parents and retained in case of further infections in their children (which are inevitable). It provides guidance on severe symptoms that may require urgent medical attention.

TABLE 1.5 Communicating with patients and parents about treatment decisions during the consultation

C Ask specifically about **concerns**	If concerns are not specifically asked about, the patient will sometimes not share their main worries for fear of being seen as 'overly anxious'. ***'What are the things you are most worried about?'*** Show empathy here: **'You sound miserable, how are you holding up?'**
H Discuss **history and examination**	While responding to the patient's answers to your questions or examining them provide a 'no problem' commentary: ***'Fever is a sign that your body is fighting the infection whether it's viral or bacterial'*** ***'Green phlegm or snot can be caused by viruses as well as bacteria'*** ***'There isn't any spreading of redness or swelling around your insect bite so it's unlikely to be infected'*** ***'You don't have a fever and your symptoms haven't got worse. Although it seems a long time, it's usual for sinusitis to last for 2–3 weeks'*** You can explain that the diagnostic criteria or scoring system you are using are recommended across the UK, are used by local GPs and that they help to determine if antibiotics are likely to make a difference.

TABLE 1.5 (Continued)

E Ask specifically about prior knowledge and **expectations**	The only way of actually knowing what patients want or expect is to ask them. ***'How do you think I could most help you today?' or 'How do you feel about antibiotics?'***
S Provide non-serious explanation for **symptoms**	'Your body reacts to viruses or bacteria *by fighting the infection and this reaction* ***causes inflammation*** *– this is normal*.' Patients often consult for reassurance rather than with an expectation of being given an antibiotic. Making a clear statement combining a negative and a positive. ***'an antibiotic won't help but I can give you something else that will help'***
T Be specific about illness **timeline**/usual course	Give an accurate prognosis. ***'A typical ear infection can take 7–8 days to settle.'*** ***'A typical cough can take 3–4 weeks to clear completely.'***
S Explain **shortcomings of antibiotics**	Antibiotics ***don't help with pain*** but ***side effects***, such as diarrhoea, nausea and rash, can be ***experienced by up to 1 in 10 people***.
Back-up or delayed antibiotic prescriptions	For patients where your clinical assessment does not warrant antibiotics it is appropriate to advise returning if they do not feel better after a specified time or if they are feeling worse. The patient can then be re-evaluated.
S **Self-care advice**	For most people symptom relief is more effective than antibiotics. *'Pain in the throat is due to the inflammation,* ***you can take medicated lozenges, paracetamol, and/or ibuprofen, which will help the pain and soothe the inflammation***.'
S **Safety-netting** advice	Provide patients with specific ***information on red-flag symptoms*** and when they should seek further help. *'If your child is still poorly in a week, or if he develops a fever, call or come back and see me.'*
Check understanding	Summarise what has been found, and your advice. Check that the patient is reassured and satisfied.

When Should I Worry? concludes with this summary:

- Most common infections do not get better quicker with antibiotics.
- Most children with a cold, cough, sore throat or earache who see their GP will still be ill 4 days later. This does not mean that they need treatment or need to be seen again.

- One-third of children who have seen their GP with a cough will still be coughing 2 weeks later. This does not mean that they need treatment.
- Only children with signs of more serious illness generally need to be seen by a doctor or nurse. These signs include:
  - Excessive drowsiness
  - Difficulty breathing or rapid breathing
  - Cold or discoloured hands and/or feet with warm body
  - Abnormal pains in arms and/or legs
  - Abnormal colour (pale or blue).

The packaging for *paracetamol* and *ibuprofen* products often tells parents not to use them for more than a couple of days without seeing a doctor. If the child does not have any of the features above, and the parent is not overly worried about them, they can continue to use these products for longer, given your approval, so long as safety-netting has been clearly explained.

A similar resource is provided online by the Royal College of Paediatrics and Child Health. (see: `https://www.what0-18.nhs.uk/parentscarers/worried-your-child-unwell/cough-and-cold`).

The TARGET Antibiotic Counselling Sheet provides a summary for each antibiotic of common side effects, major drug interactions and use in pregnancy/breastfeeding (see `www.rcgp.org.uk/TARGETantibiotics`).

Remote consultations and antibiotics

Remote consultations are permitted for all conditions except acute otitis media in the Pharmacy First England scheme. This is controversial as some hold a view that prescribing antibiotics in a remote consultation should only occur in extreme circumstances, particularly given the need for AMS. Although remote consultations can be useful in many conditions, there are a number of limitations when dealing with infections. The patient's temperature cannot be taken (unless they have a thermometer and can do it themselves), examination may not be satisfactory (e.g. looking at the throat either by the patient/carer, or by using video or photograph). It is also difficult to holistically assess the patient and fully understand how unwell they may be. The reason for a request for remote consultation is also important; in general, if the patient is not sufficiently well enough to attend the pharmacy in person this may suggest that they might need a medical assessment.

RESOURCES AND REFERENCES

All websites accessed 9 September 2024

- NICE guideline [NG15], 2015. Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. www.nice.org.uk/guidance/ng15
- TARGET antibiotics toolkit hub, hosted by RCGP. This is a toolkit designed to support primary care clinicians to champion and implement antimicrobial stewardship activities. It has a section on discussing antibiotics with patients and a section on resources for Community Pharmacy. www.rcgp.org.uk/TARGETantibiotics
- Antibiotic Awareness: key messages on antibiotic use.
  www.gov.uk/government/publications/european-antibiotic-awareness-day-key-messages-on-antibiotic-use
- Antibiotic Guardian. This encourages healthcare organisations, GP practices, hospitals, community pharmacies, farmers, patients and the public to pledge towards responsible use of antibiotics. Includes useful information, resources and links to toolkits for healthcare professionals and the public:
  https://antibioticguardian.com
- McNulty, C., Read, B., Quigley, A., *et al.* (2022). What the public in England know about antibiotic use and resistance in 2020: a face-to-face questionnaire survey. *BMJ Open* 12: e055464.
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