Pharmacy First – Top Tips!

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# General

## Screening for Pathway Eligibility

* Screen FIRST
	+ Do NOT take full history or use open questioning to assess if patient meets Gateway Criteria
	+ Use targeted screening tools (many available including paper and electronic options – consider texting questionnaires through AccuRx)
* TOO UNWELL OR OUT OF COHORT? For patients with red flags or who fall out of the eligible cohort at screening (i.e. on age/pregnant etc FROM SCREENING Qs ONLY)
	+ Develop local procedures to determine whether your team can signpost appropriately or whether they are escalated to the pharmacist and under which circumstances.
		- Consider using the screening tools and history for the staff to come and check with you but for the team to signpost the patient under your direction
	+ Provide written/texted safety-netting information and only give top 2 or 3 self help and safetynetting points to speed up consultation and ensure biggest impact of points you consider to be most imporant
		- Develop template texts in AccuRx (can attach leaflets or link to websites)
		- Can order “Think Sepsis” credit card sized cards for adult and child warning signs and give these at the counter. <https://sepsistrust.org/shop/>
		- Use CPE QR codes sheet for in person consultations
* NOT UNWELL ENOUGH? For patients without red flag symptoms but who do not meet the clinical criteria to get through the Gateway:
	+ Have resources ready for team to use with patients and train team on using them to counselling patients
		- i.e. Leaflets pre-printed; Template text via AccuRx; QR codes printed for online resources
		- Highlight 2-3 most important self help pointers and 2-3 most important safety-netting points. Patients will often not remember more than that and the message will become lost or jumbled
			* Draw attention to written/electronic info and encourage patients to read for full info
	+ Develop a stocklist of product options that you’d like your team to recommend (within each individual’s competence) to ensure consistency of messaging and targeted re-stocking (especially for weekends!)
		- Ensure only recommending within evidence base
		- Can stock items outside of evidence base where commonly requested but should not be routinely recommending these
		- Try to have a range which includes low cost products to ensure that no patient is priced out of self help
		- Be creative! Depending on your space and customer base this could include: isotonic sports drinks; drinks bottles which track volume consumed; reusable cool packs; range of boiled sugar free sweets in addition to the usual pharmacy products
	+ Be prepared to empower your team to expect and deal with resistance from a minority of patients who will not accept that they are not eligible
		- Ensure your team know that they can check with you and you can ask further questions through them or provide further information through them without talking to the patient themselves
		- The only patients who have a right to expect to see a pharmacist are those with a referral or who pass the Gateway Criteria
		- It’s OK to signpost patients who do not make the Gateway Criteria back to the GP even where the GP has already signposted to the pharmacy (if patients are referred, though, the pharmacist should see them regardless)
		- Remember that, by not seeing patients who do not meet the gateway criteria or who do not have a referral you are:
			* Encouraging the GPs to refer rather than signpost
			* Creating capacity for those who DO NEED to see a pharmacist/DO have a referral
			* Creating capacity for additional services which, in turn, helps patients and helps to ensure your pharmacy remains viable
* REMEMBER THAT AN EXCLUSION UNDER THE PGD DOES ***NOT*** MEAN THAT THE PATIENT DOES NOT MEET THE GATEWAY CRITERIA
	+ Screen for gateway criteria FIRST, even where you know a patient will be excluded under the PGD
	+ This:
		- enables you to escalate the patient yourself rather than signposting the patient onwards
		- means that the consultation will be entered into the patient notes which maybe important for them in the future
		- means that you receive payment for your assessment and your consultation counts towards your target (which increases to 30 per month by the autumn!)

## Taking Temperatures

* Do NOT take a patient’s temperature routinely
	+ Score for fever if patient reports measured fever OR fever symptoms within previous 24hrs (i.e. rigors/feeling hot to touch but experiencing the sensation of coldness)
	+ Most patients will have taken painkillers that are also anti-pyretics within 2-4hrs of attending and so any fever could be masked, leading to low scoring when the patient is clinically unwell
	+ DO check temperature if you judge it to be clinically necessary and relevant. This may include where the patient has taken anti-pyretics but still appears to be clinically unwell or where you are concerned about the patient’s clinical condition and a temperature would help to inform your escalation urgency decision
* IF taking temperatures, remember:
	+ Forehead thermometers are easy BUT often inaccurate. Patients who have been out in the sun, had a brisk walk to get to the pharmacy, have a fringe, have been wearing a hat etc will all measure high. Patients who have been out in the cold will measure cold. If using, take this into consideration and allow time for an uncovered forehead to settle before taking temp (manufacturers recommend 15mins).
	+ Use an in-ear thermometer for better readings.
	+ LOW temperatures are a red flag. Ensure you are familiar with expected and red flag readings

# Sore Throat

* MOST will meet the gateway as MOST will score at least 2 on FeverPAIN:
	+ Very red/sore/swollen tonsils – MOST report this
	+ Attending within 3 days of onset – MOST report this
	+ Absence of cough – MANY report this
	+ Purelent tonsils – OFTEN reported
	+ Fever in last 24hrs – OFTEN reported
* Most patients will report having Red Flags at screening. Train team members to clarify symptoms with the patient to separate genuine red flags:
	+ Most will report difficulty swallowing – if painful to swallow but is managing sips of fluids, this is NOT a red flag team members should consider whether the patient may be dehydrated.
	+ Most patients report feeling “very unwell” – train staff in recognising signs of sepsis (can use eLfH, Virtual Outcomes training and Think Sepsis resources)
	+ Most patients report a change in their voice – if this is straining because of a painful sore throat, this is NOT a red flag. If they are experiencing a muffled (aka “hot potato voice”), this is a red flag.
* Clinical examination is NOT a requirement and you can assess from patient reported symptoms in a video consultation
	+ Remember that a pharmacist examination/assessment is NOT required to assess before the Gateway Point is reached and the FeverPAIN score is required to be calculated BEFORE the gateway point
	+ Remember that online pharmacies are permitted to provide this clinical pathway via video link and will, therefore, not be performing any physical examinations
* Those who DO make the gateway criteria (and so SHOULD have a Clinical Pathway consultation) but who canNOT be given treatment include:
	+ Those with previous tonsillectomy
	+ Those with failed antibiotic course for this infection
	+ Those with any other exclusion within the PGD
	+ Those who are not clinically unwell enough for, or who decline antibiotic treatment and who are advised to come back in 2-3 days if no better or worsen
* A re-presentation IS ANOTHER, separate consultation, providing that the Gateway Criteria are met
	+ If a patient is assessed as not needing antibiotics and told to come back if no improvement/worse, complete another separate consultation. Do NOT update the original consultation
	+ If a patient is given antibiotics but returns as they have not seen an improvement or their condition is worsening despite completing the course, this is another, separate, consultation
* Potential linked sales/services:
	+ Sore throat sprays (be aware of evidence base but that many patients report finding useful)
	+ Sore throat lozenges (medicated/non-medicated)
	+ Paracetamol/ibuprofen
	+ Water bottles
	+ Rehydration items
	+ Decongestant nasal sprays/tablets or cough suppressants etc (where likely viral with cold symptoms to help with post nasal drip/other symptom control)

# UTI

* Many patients self present
	+ Consider marketing/advertising for patients to encourage this
	+ Ensure team know that they can suggest this to patients asking about Cystitis relief or buying cystitis products
* Use clinical judgement when assessing if exclusions to the pathway apply before concluding that the Gateway Criteria are not met i.e.:
	+ If sexually active does not exclude UTI.
		- Post coital urethritis is less likely if the patient already practices good sexual hygiene (voiding before and after intercourse) and less likely if symptoms persist after 2-3 days of drinking plenty
		- Even if sexually active or peri-menopausal, assess likelihood of UTI vs. post coital urethritis/STI/menopausal vulvovaginal changes by considering:
			* New sexual partners
			* Potential for dehydration: i.e. on holiday; hot weather; cramming for exams; high care burden; very busy or stressful lifestyle; already known and controlled symptoms of vulvovaginal changes, PMH (i.e. if experiencing an increase in frequency of UTI symptoms) etc.
			* Remember that the PGD covers women of peri-menopausal and menopausal age so age is not an automatic exclusion
	+ If consider UTI likely and can be treated under PGD consider, as appropriate:
		- Counselling regarding STIs and ensure patient knows where they can access testing services and more information
		- Counselling on the increased risk of UTIs where vulvovaginal changes associated with the menopause is possible and that the patient would be advised to discuss this with their GP if they consider that that could be possible
			* Treatment is topical and can include topical hormonal products and topical hormone free products
			* Systemic hormones are not necessary to treat this and so, if a woman is reluctant to explore HRT, this might be reassuring (but should also re-assure that the preferred HRT used now does NOT increase cancer risks as the older HRT options did)
		- If supply nitrofurantoin:
			* Counsel to avoid cystitis relief sachets as they decrease the efficacy of nitrofurantoin (they change the pH of the urine to one that is less favourable for nitrofurantoin to act)
	+ Potential linked sales/services:
		- * Private STD testing
			* EHC
			* Pharmacy Contraception Service
			* Gina
			* Non-hormonal vaginal lubricants
			* Rehydration drinks/sachets
			* Cranberry products/Probiotics
			* Cystitis relief products (but NOT where nitrofurantoin is supplied)
			* \*\*beware to ensure only recommend products within evidence base but can sell where patients request as appropriate\*\*
			* IP services:
				+ UTI (for fit and generally well patients over 65yrs, those preferring/requiring trimethoprim, UUTI and others within competence of prescriber)
				+ HRT
				+ STDs
				+ Foreign tourists who would otherwise meet the gateway criteria

# Otitis Media

* If meet age criteria then automatically meet the gateway:
	+ Empower staff members to book patients in before you speak to them (ensuring that they are confident in recognising a very unwell child/red flags)
	+ Grommets or if the child is deaf are NOT exclusions to the pathway (but may be exclusions to PGDs). Put them through to the pathway.
* Generally, for child consultations, talk to the child, even if very young, as this gains their trust.
	+ Ask them to confirm their name and birthday
	+ Ask them about their symptoms
	+ Tell them what you would like to do, step by step (I am going to use this otoscope, it’s really just a magnifying glass with a torch but it helps me look inside your ear where it’s quite dark otherwise. I can’t see very far inside your head but I’m going to try to see your ear drum, which is just a little way inside. It shouldn’t hurt but, if at any time it does, or you would like me to stop, just say so and I’ll stop straight away and give you a break. It will only take a few seconds. I’ll look into your good ear first because everyone’s ears are a little bit different and this helps me to see what your ears look like when they’re healthy, then into your painful ear.)
	+ Ask if they have an questions of concerns
	+ Gain their consent if possible (even if they are young as this builds trust). Gain the parent’s consent if they are under 12 (or 16 without Gillick competence)
* BEFORE examination: Tell the parent that the service only covers treatment for middle ear infections and that, if there is an outer ear infection, you can sell them a treatment or escalate back to the GP for consideration of treatment
* Potential linked services/sales:
	+ Ear Calm for outer ear infections identified
	+ Ear wax treatments
	+ Ear wax removal service
	+ Otitis Media PGD/prescribing for adults

# Infected Insect Bite/Impetigo/Shingles

* Consider using pictures in staff training/resources to help to identify who meets the gateway criteria
* Consider an electronic screening tool where patients can submit photographs (i.e. AccuRx)
	+ Send out electronic screening + ask for pictures to be sent BEFORE calling the patient. This will help the consultation to be quicker
	+ If set up pharmacy as an “organisation” in AccuRx, any team member with an NHSmail address can send out the screening/photo request for you
* Empower staff to deal independently with histamine mediated reactions to insect bites
* Where flucloxicillin is provided, be honest about how awful it tastes and be prepared to offer advice on taking if/giving it to children.
	+ This leaflet from Great Ormand St may be helpful: <https://www.gosh.nhs.uk/medical-information-0/giving-your-child-medicines/>
* Potential linked services/sales:
	+ Antihistamine cream
	+ PoxClin Shingles Mousse
	+ Hydrocortisone cream 1%
	+ Chlorphenamine (remember Allevia is NOT licensed for skin reactions where the other oral antihistamines are)
	+ Paracetamol/ibuprofen