GGC CPIP Notebook
Winter 2024

First RPS credentialed Community Pharmacist is our very own…… Maxine McCabe!

We are delighted to congratulate Maxine on her recent RPS credentialing. Whilst we are sure that CPS and NES will be sharing her story, as our one of our Teach and Treat Hub Leads and member of the GGC Common Clinical Conditions Advisory Group, we took the opportunity to pick her brains for some top tips and pin her down to leading a session on her portfolio for GGC CPIPs in 2025 to help those who may be interested in completing their portfolio in community pharmacy can get started.

'I was keen to show that Community Pharmacists can demonstrate their provision of advanced practice to achieve RPS credentialing. The portfolio can be tricky to navigate at first, trying to work out what form works best for different evidence types and how to evidence the work you have undertaken. My advice is open it up and start exploring the form types. Use the RPS guidance on their website and the advanced practice resources on TURAS. I had great support from some peers at NES who had undertaken the portfolio in Primary Care as well as mentor support across all four learning pillars from experienced colleagues. Thinking about the four pillar can be daunting, I had a think about work and projects that I had been involved with over the years to see what might fit where, I was particularly concerned about the research arm but then realised a quality improvement project with benzodiazepine prescribing would be applicable for this domain. Similarly the education and leadership domains, I had to think about them from a different angle to others. I used a lot of testimonials from IPs and trainees that I had supported, I had been a DPP and a pre-registration tutor and had also supported several pharmacy technicians through their relevant courses. All of these activities, which I felt were part and parcel of my role, provided rich evidence for my portfolio'.

'When you think advanced practice, you often think of 'traditionally complex' cases. I was worried that my cases may not reflect a caseload that a practice pharmacist may be able to provide. However, I soon realised that whilst providing a busy Pharmacy First and First Plus service, I had a vast range of undifferentiated and undiagnosed patients presenting themselves and examples of onward referrals and collaborative working with other healthcare professionals. The ACAT tool was particularly useful in demonstrating the 'mix' of presentations that can arrive in a community pharmacy in one sitting and demonstrated the complex issues that CP often have to deal with: Co-morbidities, neurodiversity, cultural sensitivities and translators being required, family translators, all ages from babies to the frail elderly including pregnant and breastfeeding, deprivation, child and adult concern issues and dealing with patient expectations. Many of which do not have easy paths to deal with from a community pharmacy'.

'I am proud that I have managed to be credentialed as an advanced community pharmacist, I hope that it will inspire others to do the same to show what our sector of the profession does. It was hard work, with blood, sweat and tears to do it on top of the very busy day job. I know this may seem be prohibitive to some at present, but never say never – open the portfolio, start adding little bits of evidence when you can, as Lorna (who loves a running analogy) says "it is a marathon not a sprint". Keep notes on what you do, grab some SLEs when you get the time and start chipping away at compiling your evidence. You will be surprised at how quickly it comes together. If you are struggling for an idea for research or education pillars, get in touch with myself, Pamela or Lorna. It only takes a few clicks to open your portfolio'.

MORE INFO

For more information on GGC CPIP resources click here or scan the QR code.

Sign up to the NES mailchimp here and follow @NHSGGCPharmacy on X

Consultation Conundrum:

Male(84) known to pharmacy as son collects dosette box (on warfarin – metal heart valve), comes in with son on a Saturday at lunchtime as carers called to advise son that 'his face looked a bit funny and he did not seem himself'. Face as per picture. Son has checked that he can swallow, is able to move arms as had to get jacket on to come here, used his Zimmer and speech is similar to usual. He had heard about **FAST** check at a first aid course in work. Pt has vascular dementia, not complaining of any pain, lives alone with carers and family support. Has Falls alarm, no noticeable bruising (on warfarin and bruises easily) that would indicate a fall but cannot be 100% sure as not a reliable historian.

Son looking for advice on what to do.

CPIP 1: I know I would certainly be reluctant given his history, age, warfarin and the fact he lives alone to be diagnosing or treating this patient as he is very high risk, but that does not mean that I can't play a supporting role here. My initial thought was A&E but then I remembered about the Flow Navigation Centre (FNC). I had used it before for a wound, after our pharmacy champion highlighted it to us. I would check any baseline information I could temp/BP, from personal experience elderly patients can 'go off' very quickly and by doing this I am describing how they are at that point in time to help identify any further deterioration. Although, I would not be prescribing or formally diagnosing, by signposting patients, even at the weekend I am improving the patient journey which will hopefully reduce unnecessary stress for families with vulnerable adults just presenting at A&E with no real certainty that they should be there in the first place!

ANP: This is definitely a tricky one - Is the injury due to a fall? or is the skin damage something else? As the patient is on warfarin, and the statement "his face looked a bit funny" my over-riding concern is a stroke assessment. I would be doing some general visual observations on arrival of his movement (with Zimmer) to try and roughly assess if any MSK injury such as limping, which might suggest a fall. I would crudely assessing cerebellar function, assessing gait, any obvious one-sided weakness, loss of balance when moving as a crude stroke assessment. I would speak to the patient and try and assess if any speech disturbance.

I would want to try and quickly assess if there was any stroke involvement by taking Hx - any vomiting, headache, visual disturbance NB his son has done the FAST test, but I would probably ask the patient to raise his eyebrows, squeeze my hands to try and detect any unilateral weakness in arms. It's not clear from the picture if there is a facial droop here and I want to rule out stroke. If within your skill set, you may want to do a number of cranial nerve tests to be thorough. If a stroke is a strong differential then I wouldn't be doing any further exam and would be calling 999.

If stroke has been ruled out, I would take a thorough Hx and do some general observations - temp, sp02, pulse, BP, RR to get a sense of "unwellness" and do a NEWS score. If no concerns would then be looking more specifically at the skin lesion. Take a good history using SOCRATES model - it's hard to tell form the picture but at first glance it looked like it might be shingles so would be checking if it was blistered, painful. If it was shingles in this area would be making an urgent referral as it is close to the eye area. Similarly, it could be infected or a dermatitis. Depending on when this presented a "watchful wait" with worsening statement could be given. If on examination it was clearly an infection then Abx could be offered (using formulary choice) excluding any allergies or drug interactions. Overall though, if there is any chance there has been a fall with a facial/head injury in a warfarin patient, I might err on the side of caution and refer to A+E for a scan.

What actually happened – CPIP: My initial thoughts were that there was probably nothing I could do but advise to contact OOH, but in order to help the patient's son, who seemed quite overwhelmed, I took them into the consultation room and undertook some basic observations, so that if myself, or the son were contacting OOH they could be passed on as a baseline for the patient. I printed them on an SBAR and gave copy to son. I checked temperature (normal), automated BP (130/75), HR 50 - both normal for him as per son, I could not find my pulse oximeter to check O2 saturation, the patient seemed to be talking normally and was not breathless. I did not check respiratory rate, on reflection if he had seemed more poorly, I should have done and calculated a NEWS score. His top right cheek looked a little red, no overt bruising (warfarin) and was warm (not hot) to touch, no itchiness or blisters that might suggest shingles, I used the torch on my phone and with assistance from son, we checked inside mouth in case there was a lesion inside, there was nothing of note. With the son's permission I called the Flow Navigation Centre for advice.

What happened next? The son came into pharmacy to update that the FNC called him back at home, asked some more questions and advised to take his dad up to A&E, they wanted to rule out a fall and any complications due to being on warfarin. At A&E he had bloods taken, a CT scan of head, chest x-ray and ECG. He was there for observation for a few hours and discharged home late evening with a 7 day course of antibiotics for cellulitis.

What is the Flow Navigation Centre? There is a short video that you can watch here (for patients)

All Community Pharmacies in GGC can now directly refer appropriate patients to the Flow Navigation Centre (FNC) The FNC is a virtual service provided by ANPs that can deal with a range of conditions such as minor injuries, acute eye problems or cellulitis/infected bites stings. If a patient then needs to be seen they will organise a scheduled arrival time at A&E, Minor Injuries Unit or possibly a specialist clinic.

NB they do not deal with minor illnesses (such as chest infections/UTIs etc) that would normally be dealt with by GPs/GP OOH. FNC operates 10am to 10pm every day – including weekends.

NHS GGC Admin Hub on 0800-141-2312 and give the following details:

***Name * Date of Birth (CHI if available) *Home Address *Contact Telephone Number (where patient can be contacted now) *Email Address (will be used to send a link to any virtual consultation) *GP Practice Details *Short basic presenting complaint**

*** Advise patient that NHSGGC Admin Hub will be in contact within the next 4 hours to arrange the next step * Give the patient the Information Leaflet (Appendix 1)**

Click on the links to access the Referral Process or the Flow Chart

Who do they see?

Minor Injuries & / or Immunisation Any patient who has walked into the community pharmacy seeking help with managing an acute injury to their head, torso, limbs, wounds, burns. (Acute back pain e.g. mechanical injury could be included but not chronic pain).

Any patient for whom the Pharmacist suspects may require urgent immunisation for tetanus or hepatitis B, or administration of immunoglobulin for either disease.

Acute Eye Conditions • Post-operative problems • Loss of vision / altered vision • Severe pain • Possible cellulitis around eye • Acute injury including foreign body

Stroke: Signs and Symptoms

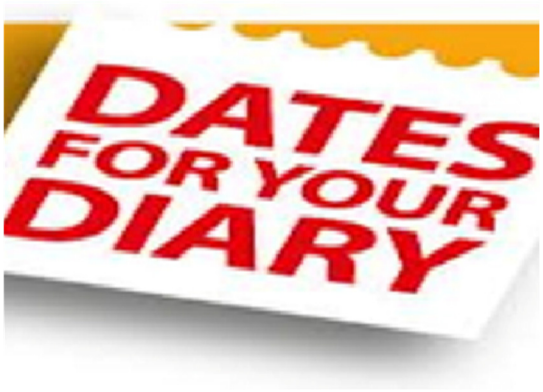
The FAST acronym (Face, Arms, Speech, Time) is a test to quickly identify the three most common signs of stroke:

- **Face weakness:** Can the person smile? Has their mouth of eye drooped?
- **Arm weakness:** Can the person raise both arms fully and keep them there?
- **Speech problems:** Can the person speak clearly and understand what you say? Is their speech slurred?
- **Time to call 999:** if you see **any one** of these signs

NICE Guidance on acute management of Cellulitis does suggest referring to hospital or seeking specialist advice if:

- Patient is severely unwell, **frail**, immunocompromised, **elderly** or very young
- Have **facial** cellulitis (unless very mild)
- Have infection **near the eyes or nose** (including periorbital cellulitis)

If you have any ideas for clinical conundrums, please send them to lorna.brown8@nhs.scot



- **How can the 'NEWS' help you?** An introduction to the NEWS score and how it can help support your consultations and onward referrals/SBARs. **Re-organised for Jan 2024**
- **Lifestyle Medicine –** how to incorporate a holistic approach into community pharmacy consultations (TBC)
- **Common Foot Condition management in pharmacy– IP Podiatrist (March 25)**
- **The role of district nurse prescribers in patient care (TBC)**
- **Peer Review session (April 25)**
- **Thinking about doing your RPS advanced practice portfolio?**

If you have any ideas for webinar topics, then please contact lorna.brown8@nhs.scot – we need your help to make the sessions relevant for you and your needs.

Alternatively, get in touch if you would like to get involved with a GGC Journal/Case Presentation Club as part of advanced practice journey.

Are you taking the plunge and undertaking the Designated Prescribing Practitioner (DPP) role?

If like me, you are taking the plunge and becoming a DPP in the next few months, get in touch - we can discuss how we can support each other in unchartered waters. NES are continuing to offer support and drop-in sessions for current or potential DPPs that can be booked on Turas. I used the DPP resources to help me complete my application, they available on TURAS.

Have you recently been a DPP? Send in your top tips and share the secrets to success. Many will be happy to hear them. If we can arrange some support, perhaps via the new Teams channel. Please let the Community Pharmacy Development team know what we can do to help.