Confident Consultations: Shared Decision-Making & Record-Keeping in Community Pharmacy

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Objectives

By the end of this session, you will be able to:

- Apply a structured consultation approach (5-step model)
- Use shared decision-making tools (Ask–Tell–Ask, Option Grids)
- Recognize and address barriers to effective consultations
- Understand NHS and GPhC requirements for record-keeping
- Document consultations safely, audibly, and defensibly

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Part 1 - Consultation Skills

Why Consultation Skills Matter

Patient safety: identifying red flags, preventing harm

Professional identity: pharmacists as clinicians, not just dispensers

Trust & adherence: patients more likely to follow advice if they feel heard

Regulatory expectation: GPhC standards demand structured consultation

Examples from Practice

Contraception consultation

- History-taking: smoking, migraines, BP
- Shared decision: implant vs pill

NMS

- Explore barriers to adherence
- Tailor education to patient understanding

Pharmacy First

- Assess sore throat
- Rule out red flags (stridor, drooling, systemic illness)

Private service

- Dermatology: acne assessment & escalation
- Vaccination: screening, suitability, consent

Protecting patients, preventing harm, and supporting informed choices

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Building Confidence in Consultations

Know your stuff – be familiar with PGDs, NICE guidance, local pathways

Structure = security – use 5-Step Model or SOAP to guide you

Project confidence – open posture, steady tone, good eye contact

Use confident language
"What I recommend…" (instead of "maybe you could…")
"Based on your symptoms…" (instead of "I think…")

Normalise uncertainty – it's safe to say: "I don't know, let me check"

Pause with purpose – a short pause = thoughtfulness, not weakness

Practise & role-play – builds muscle memory and fluency

Feedback is fuel – ask colleagues for constructive reflections

Reframe nerves – adrenaline = readiness, not weakness

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5-Step Structured Consultation (Overview)

1. **Opening & rapport** – greet, introduce, set agenda
2. **Information gathering** – patient's ideas, concerns, expectations + history
3. **Clinical assessment** – evaluate findings, exclude red flags, apply guidelines
4. **Shared plan** – discuss options, agree next steps
5. **Close & safety net** – summarise, confirm understanding, provide safety-net advice

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Step 1: Opening & Rapport

Warm greeting & introduction

Smile, eye contact, open posture
"Hello, my name is [Name], I'm one of the pharmacists here."

Clarify role & purpose

"I'd like to understand your symptoms and work out the best plan together."

Confirm patient details

Name, DOB, preferred way to be addressed

Make patient comfortable

Sit at eye level, offer privacy, avoid rushing

Build trust

Reassure confidentiality and a safe space
"Everything we discuss stays between us unless I need to share for your safety."

Use rapport-builders

Empathy: "It sounds like this has been troubling you."
Partnership: "We'll look at this together."

Set the agenda early

"What's the most important thing you'd like me to help with today?"

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Step 2: Information Gathering (ICE & History)

Patient's ICE:

Ideas – "What do you think is going on?"
Concerns – "Is there anything worrying you?"
Expectations – "What were you hoping I could do today?"

Full Medical History:

Presenting complaint – onset, duration, severity, progression
Past medical history – conditions, hospitalisations, surgeries
Medication history – prescribed, OTC, herbal, adherence
Allergies – drugs, food, reactions
Family history – relevant conditions (CVD, clotting, diabetes, cancers)
Social history – smoking, alcohol, occupation, living situation, travel, sexual history if relevant
Systems enquiry – key symptoms not yet covered (cardiac, respiratory, neuro, GI, GU, skin)

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Step 3: Clinical Assessment

Analyse presenting complaint (onset, duration, severity, progression)

Actively check for **red flags**:

- Dysphagia
- Drooling
- Stridor
- Severe unilateral pain
- Systemic illness (fever, rigors, malaise)

Consider differential diagnoses (viral, bacterial, quinsy, others)

Apply guidelines (NICE, Pharmacy First protocols)

Decide: treat, refer, or reassure

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Step 4: Shared Plan

Present all the safe options clearly - Self-care, referral, treatment, monitoring.

Explain the pros and cons honestly — Effectiveness, side effects, convenience, risk

Use plain, accessible language — avoid jargon, check understanding

Bring the patient in — ask what matters most to them - Explore values, lifestyle, preferences

Balance autonomy with our professional responsibility: patients have choice, but only within what's safe and evidence-based

Ground everything in NICE, NHS, and GPhC guidance

Contraception choice:
COCP (effective, but ↑ clot risk).
POP (safe with migraines, breastfeeding).
IUS (highly effective, long-term)

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Step 5: Close & Safety Net

Summarise key points – repeat back agreed plan in plain language

Confirm patient understanding – use teach-back ("Just to check I explained clearly…")

Provide written support – leaflet, self-care card, digital resources

Reinforce next steps – what the patient should *do now*

Safety-netting – when and how to seek help if: (Specific/Measurable)

- Symptoms worsen
- No improvement in expected timeframe
- Red flags develop

End positively – reassurance, encouragement, "You're doing the right thing"

PEARLS Active Listening

P – Partnership
- Work *with* the patient, not over them
- Tip: use phrases like "We'll look at this together"

E – Empathy
- Show you understand their feelings
- Tip: "I can see this has been difficult for you"

A – Apology
- Acknowledge frustrations or system issues
- Tip: "I'm sorry you've had to wait so long to be seen"

R – Respect
- Affirm their efforts, choices, or resilience
- Tip: "You've done well managing this until now"

L – Legitimation
- Validate their feelings as normal/understandable
- Tip: "It's completely understandable you're worried about this"

S – Support
- Reassure them of your ongoing help
- Tip: "I'll be here if things change, and you can come back anytime"

PEARLS = Behaviours that build trust & strengthen rapport

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Managing Difficult Conversations

Common challenges:

- Patient insists on antibiotics or inappropriate treatment
- Limited time & workload pressure (queues, phone ringing, multiple demands)
- Clinical uncertainty (grey areas, atypical presentations, borderline cases)

Strategies:

- **Acknowledge concerns first** – empathy before evidence
- **Be transparent about evidence** – NICE guidance, red flags, self-limiting illness
- **Provide alternatives & reassurance** – self-care, written advice, follow-up safety-netting
- **Use PEARLS phrases** – empathy, partnership, support

Time management tips:

- Use structured frameworks (5-Step, SOAP) to stay focused
- Summarise & signpost to written resources to save time
- Book follow-up or arrange callback if needed

Handling uncertainty:

- Share your reasoning: "Here's what I've considered and why this plan is safest"
- Normalise not having all the answers: "I want to be thorough, so I'll check the latest guidance / refer on"
- Safety-net robustly: explain when to return or escalate

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Part 2 – Shared Decision-Making

What Shared Decision-Making Is (and Isn't)

What it IS:

- Collaborative process between clinician and patient
- Balances clinical evidence with patient preferences
- Respects autonomy while ensuring safe care
- Empowers patients to take ownership of health decisions

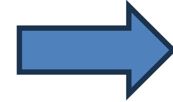
What it ISN'T:

- Telling patients what to do
- Leaving patients unsupported to make decisions alone
- "Doctor/pharmacist knows best" paternalism

Ask–Tell–Ask & Option Grids

Ask–Tell–Ask model

- **Ask** what the patient already knows or believes
- **Tell** them information in clear, structured language
- **Ask** for their thoughts, questions, or preferences



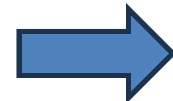
Step 1: Ask *“What have you heard about this medicine so far?”*
“How do you feel about starting it?”
“What are you hoping it will do for you?”

Step 2: Tell
Example (Ramipril for hypertension):
“This medicine helps lower your blood pressure and protect your heart and kidneys. Some people notice a dry cough — if that happens, let us know as we can switch to a different option.”

Step 3: Ask again
“How does that sound to you?”
“Do you feel confident starting this?”
“What concerns do you still have?”

Option Grids

- Visual tools comparing treatment options
- List pros, cons, side effects, effectiveness
- Helps patient weigh choices side-by-side



For example, contraception:

Combined pill – regular cycle, but risk of clotting in some women
Mini-pill – safer for migraines or smokers, but strict timing needed
Implant – highly effective, low maintenance, but requires insertion procedure

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Case Study: Contraception Choice - Subjective (History & Patient’s View)

28-year-old woman requests “the pill”

Non-smoker

BMI: 27

Migraines **only around menstruation**, no aura

Takes lamotrigine for epilepsy

Wants reliable contraception but also concerned about acne and cycle control

Says: *“I just want something simple that won’t mess with my skin or my epilepsy meds.”*

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Case Study: Objective (Assessment & Options)

Considerations:

- Migraines without aura → CHC could be used cautiously, but cycle-related migraines may worsen
- Lamotrigine → reduced effectiveness of COCP, and COCP can lower lamotrigine levels
- Acne → COCP may help, POP/implant may worsen
- Needs high reliability → long-acting options could be better

Option	Pros	Cons	Suitability
Combined pill	Cycle control, helps acne	Interaction with lamotrigine; may worsen migraines	⚠ Caution
Progestogen-only pill	No oestrogen risk, safe with lamotrigine	Irregular bleeding, no acne benefit	✅ Safe
Implant	Long-acting, reliable, no daily pill	May worsen acne, irregular bleeding	✅ Safe
IUS (LNG)	Very reliable, reduces bleeding, no systemic drug interaction	Invasive fitting, initial cramps/spotting	✅ Strong option

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Case Study: Plan & Safety Netting

Explained risks of COCP with lamotrigine interaction and migraine concerns

Discussed POP, implant, and IUS — pros and cons given patient priorities

Patient valued reliability and safety over acne benefit → chose IUS referral

Agreed short-term POP trial until fitting

Safety-netting: return if worsening migraines, bleeding changes, or AED adjustments

SOAP note:

- **S:** 35yo, requests COCP, wants cycle control & period relief. Smokes occasionally. Hx UC in remission.
- **O:** BMI 29, no other contraindications. COCP ↑ VTE risk with IBD + smoking.
- **A:** COCP higher risk. Safer alternatives: POP, implant, LNG-IUS.
- **P:** Discussed options; patient opted for IUS referral. Started POP as bridging. Safety-netting given.

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Respecting Patient Autonomy vs Professional Authority

Patient Autonomy

- Patients have the right to make informed choices
- Must consider values, preferences, lifestyle
- *Prompt: "What matters most to you?"*

Professional Authority

- Pharmacist's duty to practise safely within evidence & guidance
- Legal, ethical, and regulatory accountability
- Must refuse unsafe/inappropriate treatment
- *Prompt: "My responsibility is to keep you safe."*

Finding the Balance

- **Acknowledge** wishes → *"I understand this is what you'd prefer"*
- **Explain** risks & reasons clearly → "Because of X, this option isn't safe"
- **Offer** safe, evidence-based alternatives (use option grids/leaflets)
- **Document** fully to protect both patient & pharmacist

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Part 3 – Record-Keeping

NHS, GPhC & Indemnity Requirements

NHS Requirements

- Consultations must be **auditable, complete, and timely**
- Documentation is part of service delivery (e.g. Pharmacy First, NMS)
- Must record **clinical rationale, advice given, safety-netting, referrals**
- Records may be reviewed during claims validation or audits

GPhC Standards

- **Person-centred care** – document what mattered to the patient
- **Clear, accurate, contemporaneous records**
- Records must be **legible, secure, and retrievable**
- Support professional accountability – "If it's not written down, it didn't happen

Indemnity (Professional Liability)

- Defence organisations require thorough records for legal protection
- Poor or absent documentation can invalidate indemnity support
- Notes should show:
  – Clinical reasoning (why decision was made)
  – Alternatives discussed
  – Risks explained
  – Patient's decision and consent

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SOAP vs SBAR Frameworks

SOAP (good for Pharmacy First & clinical notes):

- **S – Subjective:** what the patient tells you
- **O – Objective:** what you observe or measure
- **A – Assessment:** your clinical impression
- **P – Plan:** agreed actions, advice, safety-netting

SBAR (useful for referrals):

- **S – Situation:** what is happening now
- **B – Background:** relevant history and context
- **A – Assessment:** your evaluation of the issue
- **R – Recommendation:** what you suggest or request

SOAP vs SBAR Frameworks (Example: UTI)

SOAP

- **Subjective (S):** Patient reports dysuria, frequency, urgency for 2 days. Concerned about needing antibiotics.
- **Objective (O):** Afebrile, no flank pain, urine dip positive for nitrites and leucocytes.
- **Assessment (A):** Likely uncomplicated lower UTI.
- **Plan (P):** Start nitrofurantoin 3-day course, advise on hydration, provide safety-netting for worsening symptoms (fever, flank pain, vomiting).
- 👉 Use SOAP for **your own consultation notes** — detailed, structured, legally defensible.

SBAR

- **Situation (S):** Patient with UTI, worsening after 5 days on antibiotics.
- **Background (B):** 46-year-old woman, now with fever, flank pain, vomiting. Past history of asthma.
- **Assessment (A):** Concern for pyelonephritis.
- **Recommendation (R):** Needs urgent referral to GP or A&E for review and possible IV antibiotics.
- 👉 Use SBAR for **referrals and handovers** — concise, clear, safe communication under time pressure

Common Pitfalls in Consultations & Record Keeping

Incomplete notes

- Pitfall: Only writing "supplied antibiotics" or "advice given."
- Solution: Use SOAP/SBAR to ensure full record — include reasoning, alternatives, safety-netting.

No documentation of safety-netting

- Pitfall: Failing to record when to return/escalate.
- Solution: Always note *"return if no improvement in X days or if red flags (list) appear."*

Copy–paste or templated notes

- Pitfall: Identical records for multiple patients — looks careless in audits/complaints.
- Solution: Use templates as a guide but personalise with patient-specific details.

Forgetting patient perspective

Pitfall: Documenting only your clinical impression, not the patient's ideas/concerns.
Solution: Write 1–2 lines on patient's expectations, e.g. *"Patient expected antibiotics but accepted self-care plan."*

Rushing due to workload pressure

Pitfall: Skipping steps in history-taking or cutting corners in notes.
Solution: Use structured frameworks (5-Step Consultation, SOAP) as "shortcuts to thoroughness." Even brief notes can be safe if structured.

Lack of clarity in referrals/handovers

Pitfall: Vague notes like *"Referred to GP."*
Solution: Use SBAR to document exactly what you told the GP and why.

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Part 4 – Remote Consultations

Good Practice in Remote Consultations

Before the consultation

- Confirm patient identity (name, DOB, address)
- Check **consent** for remote consultation (phone/video)
- Ensure privacy for both patient and pharmacist

During the consultation

- Use the same **structured framework** (5-Step / SOAP) as face-to-face
- Speak clearly, avoid jargon, check understanding frequently
- Ask safety questions you cannot observe (e.g. breathing difficulty, visible swelling)
- In video calls: check connection, ensure visibility, maintain eye contact

After the consultation

- Document clearly: method (phone/video), consent, limitations
- Provide written support (leaflets, text/email links, follow-up plan)
- Safety-net more explicitly (patient may be less observed than in person)

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Case Studies

Case 1: NMS (Apixaban Uncertainty)

Case:
67yo man, newly prescribed **apixaban** for AF.
Anxious after reading about bleeding risk online. Taking daily ibuprofen. Lives alone.

Discussion prompts:

- How would you explore his fears?
- How would you address the ibuprofen risk?
- What must you document?

Frameworks to use:

- **Ask–Tell–Ask** → *Ask what the patient knows, Tell new info clearly, Ask again to confirm understanding.*
- **SOAP** → *Subjective (patient story), Objective (findings), Assessment (your impression), Plan (agreed next steps).*

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Case 1: NMS (Apixaban Uncertainty)

Ask–Tell–Ask:

- Ask: “What worries you most about this medicine?” → Patient: “I’m scared of bleeding.”
- Tell: “Bleeding is possible, but the risk of stroke without this medicine is much higher. We also need to stop your ibuprofen, which increases bleeding.”
- Ask: “How does that sound to you?”

SOAP note:

- **S**: Patient anxious, taking daily ibuprofen, fears bleeding.
- **O**: On apixaban, lives alone, no contraindications.
- **A**: High bleed risk with NSAID. Needs reassurance and med review.
- **P**: Advised to stop ibuprofen, discussed stroke vs bleed risk, referred to GP for pain management, safety-netting given

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Case 2: Pharmacy First (Sore Throat & Work Pressure)

Case

35yo teacher, sore throat for 5 days.
FeverPAIN score = 2 (fever in last 24h, purulence present, but no severe tonsil inflammation, no rapid onset, no absence of cough).
History: recurrent tonsillitis (3x antibiotics last year).
Says: *"I can't miss work, I need antibiotics."*

Discussion prompts:

- Would you supply antibiotics? Why/why not?
- How would you manage her expectations?
- What should you document?

Frameworks to use:

- **PEARLS** → Partnership, Empathy, Acknowledge, Respect, Legitimisation, Support.
- **5-Step Consultation** → Rapport, Info gathering, Assessment, Shared plan, Safety-net.
- **SOAP** → *S = Subjective (patient's story), O = Objective (findings), A = Assessment, P = Plan.*

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Case 2: Pharmacy First (Sore Throat & Work Pressure)

PEARLS phrases:

– Empathy: “I can see how stressful this is with your teaching job.”

– Partnership: “Let’s look at this together and make a safe plan.”

5-Step Consultation:

– Rapport: explore patient’s concern about work absence.

– Info: recurrent tonsillitis history, symptom duration.

– Assessment: **FeverPAIN 2 → low likelihood of bacterial infection → antibiotics not indicated.**

– Shared plan: self-care (analgesia, fluids, lozenges), work advice.

– Safety-net: seek review if worsening, red flags (dysphagia, peritonsillar swelling, stridor, fever >38°C).

SOAP note:

– **S**: 35yo teacher with sore throat 5 days, requesting antibiotics, worried about missing work.

– **O**: FeverPAIN 2, no red flags, afebrile.

– **A**: Likely viral sore throat. Antibiotics not indicated.

– **P**: Self-care advice, safety-netting given, documented patient expectation and discussion.

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Case 3: Emergency Contraception (Language & Consent)

Case: 20yo woman requests EC. Limited English. Male partner insists on translating. Patient appears anxious and gives minimal responses.

Discussion prompts:

- What safeguarding concerns does this raise?
- How do you ensure **valid consent**?
- What must be documented in your notes?

Frameworks to use:

5-Step Consultation →

- **Opening & Rapport** – confidentiality, privacy, safe space.
- **Information Gathering** – sexual history, last UPSI, menstrual cycle.
- **Assessment** – eligibility for EC, safeguarding review.
- **Shared Plan** – discuss EC options.
- **Close & Safety-net** – reinforce confidentiality, written advice.

SOAP →

- **S** = Subjective: patient's request, concerns, language barrier.
- **O** = Objective: observations, behaviour, translator present.
- **A** = Assessment: safeguarding + EC suitability.
- **P** = Plan: what was agreed, safety-net, next steps.

PEARLS → empathy ("I can see this is difficult"), support ("I want to make sure this is safe for you").

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Case 3: Emergency Contraception (Language & Consent)

5-Step Consultation

- **Opening**: Politely but firmly ask to speak with patient alone → "Thank you for helping, but I need to speak privately with her to ensure this is safe."
- **Info Gathering**: Clarify when UPSI occurred, menstrual history, risk factors. Use professional telephone interpreter if available.
- **Assessment**: Safeguarding concern raised due to partner's insistence + patient anxiety. Patient competent, able to consent once private. Eligible for LNG EC.
- **Shared Plan**: Discussed options (LNG, ulipristal, IUD). Patient chose LNG tablet.
- **Close**: Provided written advice in patient's language (leaflet), reinforced confidentiality, safety-net (return if vomits within 3h, pregnancy test if period >7d late).

SOAP note example:

- **S**: 20yo requesting EC. Limited English. Male partner attempted to translate. Patient anxious.
- **O**: Patient withdrawn in partner's presence, more comfortable when alone.
- **A**: Safeguarding considered. Patient competent, valid consent obtained. EC suitable.
- **P**: Used telephone interpreter, LNG EC supplied, confidentiality reinforced, written advice given, safeguarding logged.

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Part 5 – Closing

Reflection

Think of a recent consultation you carried out…

- Did you structure it using a clear model?
- Did you involve the patient in decision-making?
- Did you document your findings, decision, and safety-netting?
- If another clinician read your notes, would they fully understand what happened?

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Summary & Key Takeaways

- Use the **5-Step Consultation Model** to structure discussions
- **PEARLS** Active Listening
- Apply **shared decision-making** tools to empower patients
- Document using **SOAP or SBAR** for clarity and defensibility
- Avoid common pitfalls: vagueness, missing safety-netting, no rationale
- Remember: **“If it isn’t written down, it didn’t happen”**

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