Pharmacy First: Clinical Documentation

NHS England Pharmacy First Service Spec 2024 | PGD Requirements

REQUIRED: Every Consultation

- ☐ Patient name, date of birth, NHS number (where available)
- ☐ Verbal consent obtained and recorded
- ☐ Presenting complaint and duration in days
- ☐ Eligibility confirmed: inclusion criteria met, exclusions checked
- ☐ Clinical score: record all individual scoring components where a validated scoring tool is used (e.g. FeverPAIN for sore throat)
- ☐ Supply decision and rationale linked to PGD criteria
- ☐ Consultation outcome documented (supply, delayed supply, self-care or referral)
- ☐ GP notification completed via the approved Pharmacy First IT system (PharmOutcomes)

Required for EVERY consultation: including self-care only and referral outcomes.

RECORD: For Any Antibiotic Supply

- ☐ Allergy status confirmed (especially penicillin allergy)
- ☐ Supply made under current authorised PGD: confirm version applies
- ☐ Antibiotic: name, strength, dose, frequency, duration, quantity
- ☐ Batch number and expiry date must be recorded for medicines supplied under a PGD
- ☐ Counselling: complete the course, common side effects, allergy advice, and when to seek further help explained

Additional Fields by Consultation Outcome

Outcome	Extra fields required	Notes
Self-care only	Self-care advice + safety netting	Specific symptoms and action required
Delayed supply	Antibiotic details + when/how to use + review timeframe + trigger symptoms	Stewardship: document when not to start antibiotics
Immediate supply	All antibiotic fields + safety netting	Batch number and expiry are mandatory
Referral	Reason, destination, urgency, interim advice, escalation, acceptance/refusal of referral advice	Record even when no medicine is supplied

SAFETY NET: Must Be Specific

- ☐ Name the exact symptoms the patient should watch for
- ☐ State the timeframe (e.g. if not improving within 3 days)
- ☐ "Seek help if needed" does NOT meet the audit standard
- ☐ State the exact action: return to pharmacy / 111 / A&E / 999

Timing and compliance:	Start the PharmOutcomes record at the beginning of the consultation. Complete records contemporaneously and submit claims promptly. Retrospective records are an audit risk. Retain records in accordance with current NHS records management requirements.
Consultation skills:	Documentation should support, not replace, patient-centred consultation skills. Maintain eye contact, actively listen, and use the record as a prompt while engaging with the patient.
Safeguarding and capacity (where applicable):	Document safeguarding concerns, mental capacity concerns, or best-interest decisions where applicable. Record whether referral advice was accepted or declined by the patient.

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