Below are the objectives and outline agenda

Learning Objectives

- Demonstrates key clinical assessment skills in the investigation of commonly presenting acute conditions.
- Demonstrates a holistic, patient-centred approach to the use of clinical assessment skills, including the application of principles relating to hygiene and infection control, safeguarding, and confidentiality.
- Demonstrates an ability to take an appropriate clinical history, including recognition of red flags and appropriate referral.
- Records the history and clinical findings in an appropriate format, taking into account data protection and confidentiality.
- For each clinical assessment skill, demonstrates an understanding of why the assessment is being undertaken; what the normal or expected results are; how to interpret the results in the context of the clinical history; what action to take; and the appropriate urgency of action required.
- Demonstrates ability to decide immediate treatment options, including referral, and negotiate with the patient regarding treatment decisions.
- Demonstrates ability to promote antimicrobial stewardship and negotiate patient expectations in order to avoid inappropriate treatment, investigation or referral.
- Demonstrates an understanding of own role in clinical assessment skills within the wider healthcare team, including how to communicate within and outside of the team, to include referral to other services and signposting to other local health services, with appropriate safety-netting.
- Demonstrates an awareness of the limits of own competence and ability to undertake appropriate action, including asking for advice from a colleague.
Indicative Course Content

DAY ONE

Introduction

- Setting the scene for acute illness consultations - the roles of community pharmacy, general practice, urgent care and A&E
- Awareness of other primary care services – e.g. walk-in centres, out of hours services, rapid response nurses, district nurses, dentists, physios, osteopaths, counsellors, health visitors...
- Principles of clinical history taking, record keeping, safeguarding, confidentiality
- Extending the role of the pharmacist to include clinical examination
- How to request relevant investigations
- Red flags and safety netting
- The importance of immunosuppression in acute illness
- Practicalities of working in general practice. Getting prescriptions signed, Quality and Outcomes framework (QOF), referral within the team, notification of infectious diseases, fit notes and absence from school

Children

- General principles of assessing children
- The feverish child and NICE CG160
- Examination of the capillary refill time and oxygen saturation

Throat, ear and eye conditions

- Relevant history taking for acute throat, ear and eye conditions
- Examination of the throat, ear (using an otoscope), neck lymph nodes, external eye and visual acuity
- When to send a swab for bacterial culture
- Assessment and management (including self care) of: sore throat, quinsy, glandular fever, scarlet fever, oral thrush, hand foot and mouth disease, ear wax, otitis media and externa, sinusitis, colds, flu, hay fever, conjunctivitis and blepharitis
- Identification and appropriate referral of red flags relating to throat, ear and eye
DAY TWO

Respiratory

- Relevant history taking for acute respiratory conditions
- Examination of oxygen saturations, cyanosis, respiratory rate, accessory muscle use and recession, chest inspection, percussion and auscultation (using a stethoscope)
- When to send sputum samples and refer for chest x-ray
- Assessment and management (including self care) of acute bronchitis, laryngitis, croup, exacerbations of asthma and COPD
- Identification and appropriate referral of red flags relating to the respiratory system

Gastroenterology

- Relevant history taking for acute gastrointestinal conditions
- Examination of the patient with a GI problem, including assessing for dehydration and basic abdominal examination
- When to send a stool sample and test for *Helicobacter pylori*
- Assessment and management (including self care) of indigestion, diarrhoea and vomiting, constipation and abdominal pain
- Identification and appropriate referral of red flags relating to gastroenterology

Genitourinary (GU) System

- Relevant history taking for UTI and vaginal discharge
- Abdominal and loin examination to exclude a distended bladder and check for renal tenderness
- When to dipstick the urine and send a midstream specimen to the laboratory. When to refer for vaginal and speculum examination
- Assessment and management (including self care) of urinary tract infection and vaginal discharge
- Identification and appropriate referral of red flags relating to the GU system
Neurology
- Relevant history taking for headache and dizziness
- Examination of the temporal arteries, sitting and standing blood pressure
- Assessment and management (including self care) of migraine, tension headache, medication overuse headache, vertigo and fainting
- Identification and appropriate referral of red flags relating to headache and dizziness

Musculoskeletal
- Relevant history taking for neck and back pain
- Basic examination of the neck and back
- Assessment and management (including self care) of neck and back pain
- Identification and appropriate referral of red flags relating to musculoskeletal pain

Infection
- Global and historical perspectives
- Resistance to infection, transmission and prevention
- Infection control
- Commensals and the microbiome
- Common bacteria that cause acute illness
- Sepsis and meningitis
- Fever management, fever phobia, febrile convulsions
- Antibiotic stewardship – local antimicrobial guidance, patients’ expectations regarding antibiotics, antibiotic resistance and superbugs. Matching the antibiotic to the condition
DAY THREE

Dermatology

- Relevant history taking for acute dermatological conditions
- Examination of the patient with a skin condition
- When to send samples for fungal and bacterial culture
- Assessment and management (including self care) of rashes, including viral illnesses/shingles/impetigo/cellulitis/bites and stings/fungal infection/nappy rash/urticaria/scabies/eczema/infected eczema/changing moles and skin lesions
- Identification and appropriate referral of red flags relating to the skin

Concluding session

- Consultation skills for acute illness – the diagnostic consultation
- Maintaining a patient-focused and holistic approach
- Risk management: recognition of the limits of your own competence
- Limitations of the evidence base. Appropriate use of guidelines
- Minor illness resources and opportunities for further learning and development