

Supply of Fluconazole 150mg capsule by Community Pharmacists working in Forth Valley Pharmacies under NHS Minor Ailment Service.

Protocol Number 125 Version 2

Date protocol prepared: September 2008

Date protocol due for review: September 2010

This patient group direction must be signed by all health care professionals involved in its use. NHS Forth Valley should hold the original signed copy

Organisation	NHS Forth Valley
---------------------	------------------

Job Title	Name	Signature	Date
Director of Nursing	Angela Wallace	Signed Angela Wallace	24/09/2008
Medical Director	Gareth Davies	Signed Gareth Davies	03/10/2008
Director of Pharmacy	Gail Caldwell	Signed Gail Caldwell	05/11/2008

This document authorises the supply of Fluconazole by appropriate practitioners to patients who meet the criteria for inclusion under the terms of the document.

The practitioner seeking to supply of Fluconazole must ensure that they assess all clients to make sure they meet the criteria before supplying the product.

The purpose of this Patient Group Direction is to help patients by ensuring that they have ready access to a quality assured service which provides a timely, consistent and appropriate supply of Fluconazole.

Signatures of those developing the Patient Group Direction

Job Title	Name	Signature	Date
Doctor	Leslie Cruickshank	Signed Leslie Cruickshank	07/10/2008
Pharmacist	Matthew Barclay	Signed Matthew Barclay	22/10/2008
Nurse			
Microbiologist (if appropriate)			
Paediatrician (if appropriate)			

Approval from Relevant* Advisory Committee/Group

Committee/Group	Chair	Signed on behalf of committee	Date
Patient Group Directions Group	Fiona Stewart	Signed Fiona Stewart	28/10/2008
Primary Care D&T Committee			
Primary Care Prescribing Group	Leslie Cruickshank	Signed Leslie Cruickshank	07/10/2008
Primary Care Out of Hours Clinical Governance Committee			
Wound Management Group			
Acute Services D&T Committee			
Antimicrobial Management Team			

***Patient Group Directions Group** and **Primary Care Prescribing Group** for services relating to the Primary Care setting

Primary Care D&T Committee for services relating to the Care Groups

Primary Care Out Of Hours Clinical Governance Committee for services relating to the Primary Care Out Of Hours service

Wound Management Group for PGDs relating to wound management

Acute Services Drug and Therapeutics Committee for services relating to the Acute Services

Signature of **one** GP on behalf of Practice **OR** Head of Service **OR** Employer to indicate that other professionals may undertake the work within the confines of the Patient Group Direction

Name	Signature	Date

The following Patient Group Direction for the supply of Fluconazole 150mg capsules may be used from the following business/practice:

Name:

Address:

YOU MUST BE AUTHORISED BY NAME, UNDER THE CURRENT VERSION OF THIS PGD BEFORE YOU ATTEMPT TO WORK ACCORDING TO IT

CLINICAL CONDITION

Indication	To allow community pharmacists working in Forth Valley Pharmacies under NHS Minor Ailments Service to Supply Fluconazole 150mg capsule for the treatment of Vaginal Candidiasis
Inclusion Criteria	Woman with previous history of vaginal candidiasis presenting in a Community Pharmacy with a need for treatment of symptoms of vaginal candidiasis, and registered for the Minor Ailment Service (MAS).
Exclusion Criteria	<ul style="list-style-type: none"> ▪ Under 16 and over 60 years of age ▪ Women who are experiencing the symptoms for the first time ▪ Liver and kidney disease ▪ Risk of sexually transmitted disease (STD) or other cause for vaginal discharge. ▪ Irregular or abnormal vaginal bleeding ▪ Genital ulceration ▪ Known hypersensitivity to fluconazole ▪ More than two infections of thrush within the last six months ▪ Pregnancy or suspected pregnancy ▪ Breastfeeding ▪ Lower abdominal pain ▪ Dysuria ▪ A known diabetic with recurrent infection
Caution/ Need for further advice	If treatment fails, see GP
Action if Patient declines or is excluded	Refer to GP.

DRUG DETAILS

Name, form & strength of medicine	Fluconazole 150mg capsule
Legal Status	POM

Route/ Method	Oral
Dosage	Vaginal candidiasis – a single dose of 150mg by mouth
Frequency	One capsule completes the course
Duration of treatment	One capsule completes the course
Maximum or minimum treatment period	One course of a single capsule
Quantity to Supply/ administer	One capsule
Side Effects	<p>Occasional : nausea, abdominal discomfort, diarrhoea, flatulence, headache, rash</p> <p>Rare: dyspepsia, vomiting, taste disturbance, hepatic disorders, hypersensitivity reactions, anaphylaxis, dizziness, seizures, alopecia, pruritus, toxic epidermal necrolysis, Stevens-Johnston syndrome, hyperlipidaemia, leucopaenia, thrombocytopenia, hypokalaemia, urticaria,</p> <p>For a full list of side effects please refer to the Summary of Product Characteristics (SPC). A copy of the relevant SPC must be available to the health professional administering medication under this Patient Group Direction.</p> <p>See BNF for further details. Patients should be informed who to contact should they experience an adverse drug reaction</p> <p>All adverse reactions should be reported to the MHRA through the Yellow Card Scheme</p>
Advice to patient/carer	<ul style="list-style-type: none"> ▪ Provide Patient Information Leaflet ▪ Treat at any time of menstrual cycle, including during periods. ▪ Discuss any possible side effects with the patient. ▪ Advise regarding re-infection and that partner may need treatment if symptomatic ▪ Wash the vaginal area with water only, avoiding the use of perfumed soaps, vaginal deodorants or douches. ▪ Avoid using latex condoms, spermicidal creams and lubricants if they cause irritation. • Wear cotton underwear and loose-fitting clothes if possible.
Follow up	None

STAFF CHARACTERISTICS

Qualifications	Pharmacist whose name is currently on the practising section of the pharmaceutical register held by The Royal Pharmaceutical Society of Great Britain
Specialist competencies or Qualifications	MRPharmS
Continuing Training & Education	Up to date knowledge in therapeutic area

REFERRAL ARRANGEMENTS & AUDIT TRAIL

Referral arrangements	Urgent referral : Not applicable Routine referral : <ul style="list-style-type: none">▪ If symptoms not clearing within 5 days▪ Pregnant▪ Breast feeding▪ Renal impairment▪ Known diabetic and recurring candidiasis▪ Third request within 6 months▪ Vaginal pain, bleeding or blistering
Records/audit trail	Following to be noted in the computerised patient information record and on the CP 2 form : <ul style="list-style-type: none">• Dose, frequency and the quantity supplied• Date of supply to patient• Relevant information from consultation should also be included in the computerised patient information record.
Reference sources and comments	Electronic Medicines Compendium (www.medicines.org.uk)

PATIENT GROUP DIRECTION AUTHORISATION DOCUMENT

Patient Group Direction for Supply of Fluconazole 150mg by Community Pharmacists working in Forth Valley Pharmacies under NHS Minor Ailment Service Protocol 125 Version 2

Name of Premises _____

Address of Premises _____

PROFESSIONAL AGREEMENT

I have read and confirm that I have understood the above named protocol. I confirm that I have the necessary competency and training. A copy of the protocol is available in the clinical situation in which the supply or administration will occur.

Name of Professional	Job Title	Signature	Date

The above people have been authorised to use this protocol

Signature of CHP Nurse Advisor/ Clinical Nurse Manager/ GP (for Practice Nurses)
Professional Lead for PGDs pertaining to other professions

Name	Signature	Date

Patient Group Direction

Agreement by Practitioner

Supply of Fluconazole 150mg by Community Pharmacists working in Forth Valley Pharmacies under NHS Minor Ailment Service

I have read and fully understand the Patient Group Direction for the supply of Fluconazole 150mg Capsules and agree to provide this medicine only in accordance with this PGD in NHS Forth Valley Community Pharmacies.

Name of Pharmacist _____

RPSGB Registration Number _____

Normal Pharmacy Location _____

Signature _____

Date _____

Note :

A copy of this agreement must be signed by each pharmacist who wishes to be authorised to use the PGD for Supply of Fluconazole 150mg by Community Pharmacists working in Forth Valley Pharmacies under NHS Minor Ailment Service. Please return this form (page 7) to Pharmacy Services, Euro House, Wellgreen Place, Stirling. FK8 2DJ, Fax: 01786-431199.

Each pharmacist must also sign the PGD Authorisation sheet in the PGD document (page 6) in **each** pharmacy premises that they wish to provide the medicine from.

Each authorised pharmacy practitioner should be provided with an individual copy of the clinical content of the PGD and a photocopy of the document showing their authorisation.