

Patient Group Direction

Supply of Chloramphenicol Eye Drops 0.5% by Community Pharmacists working in Forth Valley Pharmacies under NHS Minor Ailment Service or Pharmacy First. Protocol Number: 124 Version 8

Date protocol prepared: February 2019

Date protocol due for review: February 2021

Expiry date: February 2022

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. The PGD must be easily accessible in the clinical setting.

Organisation	NHS Forth Valley
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Job Title	Name	Signature	Date
Director of Nursing	Angela Wallace	Signed by Angela Wallace	7/5/19
Medical Director	Andrew Murray	Signed by Andrew Murray	7/5/19
Director of Pharmacy	Scott Mitchell	Signed by Scott Mitchell	9/5/19

This document authorises the supply of **Chloramphenicol Eye Drops 0.5%** under the Minor Ailments Service or Pharmacy First by appropriate practitioners to patients, who meet the criteria for inclusion under the terms of the document.

The practitioner seeking to supply **Chloramphenicol Eye Drops 0.5%** under the Minor Ailments Service or Pharmacy First 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 **Chloramphenicol Eye Drops 0.5%** under the NHS Minor Ailments Service or Pharmacy First.

Signatures of those developing the Patient Group Direction

Job Title	Name	Signature	Date
Doctor	David Herron	Signed by David Herron	1/4/19
Pharmacist	Kirstin Cassells	Signed by Kirstin Cassells	29/3/19
Nurse			
Microbiologist (if appropriate)	Robbie Weir	Signed by Robbie Weir	26/3/19
Paediatrician (if appropriate)	David Watson	Signed by David Watson	6/5/19

Approval from Patient Group Directions Group

	Chair	Signed on behalf of group	Date
Patient Group Directions Group	Scott Mitchell	Signed by Scott Mitchell	9/5/19

The following Patient Group Direction for the supply of Chloramphenicol Eye Drops 0.5% 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 or Pharmacy First to supply Chloramphenicol 0.5% eye drops for the treatment of bacterial conjunctivitis.
Inclusion Criteria	<p>Presentation in a Community Pharmacy with a need for treatment of symptoms of bacterial conjunctivitis, and registered for the Minor Ailment Service (MAS). Patients not eligible for MAS can be treated under the Pharmacy First Service where the current service specification includes treatment of bacterial conjunctivitis. Those patients eligible for MAS must be treated via MAS rather than Pharmacy First.</p> <p>Conjunctivitis will give the sensation of a gritty or itchy eye or eyes, with possibly a purulent discharge or crusting of the eyelid margins. It will only have been present for a few days and is not associated with any reduction in vision. The affected eye(s) will often look <u>slightly</u> red/infected, but this is not usually very marked. Pain is not a feature of simple conjunctivitis.</p>
Exclusion Criteria	<ul style="list-style-type: none"> • Children under 1 year. • Pregnancy • Breast feeding • Known hypersensitivity to Chloramphenicol or to any other ingredient of the drops. • Persistent bacterial conjunctivitis lasting > 2weeks • Recent ophthalmic surgery • Contact lens use
Caution/ Need for further advice	<p>Urgent referral and/or advice from Optometrist, , or minor injuries/Emergency Department as appropriate:</p> <ul style="list-style-type: none"> - if painful, rather than itchy or gritty - if reduced visual acuity - if eye looks cloudy

	<ul style="list-style-type: none"> - if pus level visible in anterior chamber - if any history of trauma to eye, immediately prior to onset of symptoms - if possibility of foreign body on/in eye - if history of welding or grinding without eye protection immediately prior to onset of symptoms - if no improvement within 48 hours - Restricted eye movement - Patient has glaucoma - They have recently returned from abroad - If taking other medication likely to suppress bone marrow. - Symptoms persisting > 2 weeks <p>Urgent referral and/or advice from GP Practice if</p> <ul style="list-style-type: none"> - Photophobia is present - A skin rash, spots or blisters develop on skin next to the eye
Action if Patient declines or is excluded	Refer to Optometrist under most circumstances. Only refer to GP or OOH if there appears to be systemic illness or a health issue beyond the eye socket.

DRUG DETAILS

Name, form & strength of medicine	Chloramphenicol 0.5% eye drops
Legal Status	POM
Route/ Method	Ocular
Dosage	Adults and children 1 year and over: Instil one drop into the affected eye.
Frequency	Adults and children 1 year and over: Instil one drop into the affected eye every two hours for the first 48 hours, then four hourly thereafter. To be used during waking hours only
Duration of treatment	For a total of five days.
Maximum or minimum treatment period	Maximum duration of treatment is 5 days. If eye is not healed after 5 days of treatment- advise patient to seek advice from Optometrist
Quantity to Supply/ administer	10ml
Side Effects	<p>Occasional: Transient stinging on instillation.</p> <p>Rare : Allergic reaction (persistent burning, swelling of lids)</p> <p>For a full list of side effects please refer to the authorisation holder's Summary of Product Characteristics (SPC). A copy of the SPC must be available to the health professional supplying medication under this Patient Group Direction.</p> <p>Patients should be informed to contact the supplying pharmacy should they experience an adverse drug reaction. Under these circumstances, the pharmacy should inform the GP practice of the adverse event.</p>

	All adverse reactions that are serious or result in harm should be reported to the MHRA through the Yellow Card Scheme. Online reporting available from https://yellowcard.mhra.gov.uk/
Advice to patient/carers	Chloramphenicol eye drops should be administered for the duration of the infection and continued for 48 hours after healing. Chloramphenicol eye drops should be stored in the fridge. If the condition worsens, patient should be advised to seek advice from Optometrist or Out of Hours Service.
Follow up	None

STAFF CHARACTERISTICS

Qualifications	Pharmacist currently registered with the General Pharmaceutical Council.
Specialist competencies or Qualifications	Any pharmacist approved under local training
Continuing Training & Education	Up to date knowledge in therapeutic area

REFERRAL ARRANGEMENTS & AUDIT TRAIL

Referral arrangements	<p>Description of circumstances in which further advice should be sought from a doctor and arrangements for referral</p> <p>Urgent referral :</p> <ul style="list-style-type: none"> • if painful, rather than itchy or gritty • if reduced visual acuity • if eye looks cloudy • if pus level visible in anterior chamber • if any history of trauma to eye immediately prior to onset of symptoms • if possibility of foreign body on/in eye • if history of welding or grinding without eye protection immediately prior to onset of symptoms • if no improvement within 48 hours • restricted eye movement • patient has glaucoma • photophobia is present • a skin rash, spots or blisters develop on skin next to the eye • they have recently returned from abroad • if taking other medication likely to suppress bone marrow <p>Routine referral :</p> <ul style="list-style-type: none"> • pregnancy • breast feeding
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	<ul style="list-style-type: none"> • Contact lens wearer
Records/audit trail	<p>Following to be noted in the computerised patient information records and on the CP 4/3 form if supplied under Minor Ailments Service:</p> <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. <p>If supplied under Pharmacy First :</p> <p>A record of supply should be made on PMR which includes Name, strength, form and pack size of medicine supplied Dose and route of administration Date of supply and name of person making supply</p> <p>The medicine must be labelling in accordance with requirements detailed in the current version of Medicines, Ethics and Practice.</p> <p>For Pharmacy First, the GP must be notified that a supply has taken place using the GP notification form. The patient's GP must be informed if the patient experiences an adverse drug reaction.</p> <p>A computer or manual record of all individuals receiving a supply under this PGD should also be kept for audit purposes.</p> <p>Any adverse events/incidents should be reported to the PGD group in addition to any existing pharmacy processes</p> <p>Records of supply should be kept for 8 years.</p>
Reference sources and comments	<p>Electronic Medicines Compendium (www.medicines.org.uk)</p> <p>BNF 76</p> <p>NICE 2018</p>

PATIENT GROUP DIRECTION AUTHORISATION DOCUMENT

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Individual Authorisation

This PGD does not remove inherent professional obligations or accountability

I _____ (please print in capitals), confirm that I have read and understood the above Patient Group Direction. I confirm that I have the necessary professional registration, competence, and knowledge to apply the Patient Group Direction. I will ensure my competence is updated as necessary. I will have ready access to a copy of the Patient Group Direction in the clinical setting in which the supply of the medicine will take place and agree to provide this medicine only in accordance with this PGD.

I understand that it is the responsibility of the pharmacist to act in accordance with the Code of Ethics for Pharmacists and to keep an up to date record of training and competency. I understand it is also my responsibility to ensure that all consultations with patients occur within a private and confidential area of the pharmacy.

I have read and fully understand the Patient Group Direction for the supply of chloramphenicol eye drops 0.5% and agree to provide this medicine only in accordance with this PGD in NHS Forth Valley Community Pharmacies.

Name of Pharmacist (in block capitals) _____

GPhC Number _____ Employee ☐ Locum ☐ Relief Pharmacist ☐

If you are a locum please provide a contact email address:

Normal NHS Forth Valley Pharmacy Location
(Please state contractor code)

Signature

_____ Date _____

Note :

A copy of this agreement must be signed by each pharmacy practitioner who wishes to be authorised to use the PGD for Supply of Chloramphenicol eye drops 0.5% by Community Pharmacists working in Forth Valley Pharmacies under the NHS Minor Ailments Scheme or Pharmacy First.

Please return this page either by mail to Community Pharmacy Development Team, NHS Forth Valley Royal Hospital, Stirling Road, Larbert, FK5 4WR **OR** by email to FV-UHB.communitypharmacysupport@nhs.net

attaching a scanned / photographed image. A copy should be retained in each pharmacy premises you provide the service in.

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Name of Premises & Contractor

Code _____

Address of

Premises _____

PROFESSIONAL AGREEMENT

I have read and confirm that I have understood the above named patient group direction. **The people below have been authorised to use this protocol.** I confirm that I understand that it is my professional responsibility to ensure all those signed below are professionally registered and have undertaken all the mandatory training requirements to enable them to work under this PGD. A current version of the PGD is available in the above named premises.

Signature of **Lead Pharmacist** for the contractor code

Name (in block capitals)	Signature	Date

Name of Professional (IN BLOCK CAPITALS)	Registration Number	Signature	Date