Supply of Fluconazole 150mg capsule by Community Pharmacists working in Forth Valley Pharmacies under NHS Minor Ailment Service. Protocol Number 125 Version 7

Date protocol prepared: **August 2018**

Date protocol due for review: **August 2020**

Expiry Date: **August 2021**

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

Job Title	Name	Signature	Date
Deputy Director of Nursing	Rita Ciccu-Moore	Signed by Rita Ciccu-Moore	18/9/2018
Medical Director	Andrew Murray	Signed by Andrew Murray	17/9/2018
Director of Pharmacy	Scott Mitchell	Signed by Scott Mitchell	20/9/2018

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

Practitioners seeking to supply **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 for vaginal candadiasis**.

Signatures of those developing the Patient Group Direction

Job Title	Name	Signature	Date
Doctor	**David Herron**	**Signed by David Herron**	**6/9/2018**
Pharmacist	**Kirstin Cassells**	**Signed by Kirstin Cassells**	**6/9//2018**
Nurse			
Microbiologist (if appropriate)	**Robbie Weir**	**Signed by Robbie Weir**	**6/9/2018**
Paediatrician (if appropriate)			

Approval from the Patients Group Directions Group

	Chair	Signed on behalf of group	Date
Patient Group Directions Group	**Scott Mitchell**	**Signed by Scott Mitchell**	**20/9/2018**

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 recurrent 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	▪ Under 16 and over 60 years of age ▪ Women who are experiencing the symptoms for the first time ▪ Known 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 or related azole compounds or any exipient in the capsule. Consult Summary of Product Characteristics (SPC) or manufacturer's Patient Information Leaflet (PIL) ▪ 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 ▪ Women currently taking cisapride, terfenadine, amiodarone or erythromycin ▪ Consent to treatment refused
Caution/ Need for further advice	If treatment fails, contact GP practice Although fluconazole has the potential to interact significantly with a number of drugs, the BNF notes that in general fluconazole interactions relate to multiple dose treatments. Please check Appendix 1 in the current edition of the BNF for the latest information on fluconazole interactions and refer to a doctor if necessary.

Action if Patient declines or is excluded	Refer to GP Practice.

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 no more than twice in six months
Quantity to Supply/ administer	One capsule
Side Effects	Common side effects include headache, abdominal pain, diarrhoea, nausea and vomiting. 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. This can be accessed on www.medicines.org.uk All adverse reactions should be reported to the MHRA through the Yellow Card Scheme. https://yellowcard.mhra.gov.uk/
Advice to patient/carer	▪ 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	Advise patient to seek medical advice should symptoms worsen or not improve

STAFF CHARACTERISTICS

Qualifications	Pharmacist currently on the practising section of the pharmaceutical register held by The General Pharmaceutical Council
Specialist competencies or	Pharmacists must have the necessary competencies and training to

Qualifications	use the PGD and be authorised to use the PGD by their Lead Pharmacist.
Continuing Training & Education	Up to date knowledge in therapeutic area evidenced through ongoing CPD.

REFERRAL ARRANGEMENTS & AUDIT TRAIL

Referral arrangements	Urgent referral : Not applicable Routine referral : ▪ If symptoms not clearing within 5 days ▪ Pregnant ▪ Breast feeding ▪ Renal impairment ▪ Hepatic 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 4/3 form : • Strength, 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) Current edition of the British National Formulary (BNF)

PATIENT GROUP DIRECTION AUTHORISATION DOCUMENT

Supply of Fluconazole 150mg capsule by Community Pharmacists working in Forth Valley Community Pharmacies under NHS Minor Ailment Service Protocol number 125 version 7

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 Fluconazole 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 Fluconazole by Community Pharmacists working in Forth Valley Pharmacies.

Please return this form (page 6) to Community Pharmacy Services, Forth Valley Royal Hospital, Stirling Road, Larbert. FK5 4WR and retain a copy in each pharmacy premises you wish to provide the medicine from. Each authorised pharmacy practitioner should be provided with an individual copy of the authorised PGD and a photocopy of the document showing their authorisation.

PATIENT GROUP DIRECTION AUTHORISATION DOCUMENT

Patient Group Direction for Supply of Fluconazole 150mg capsule by Community Pharmacists working in Forth Valley Community Pharmacies under NHS Minor Ailment Service Protocol Number 125 version 7

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 it is my professional responsibility to ensure all those signed below have had their professional registration confirmed as per normal company processes and have signed the necessary PGD paperwork to enable them to work within the confines of this PGD.
*The professional signing the PGD paperwork accepts personal responsibility for having undertaken all the mandatory training requirements for the PGD.

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

Name (in block capitals)	Signature	Date

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