# Patient Group Direction for the treatment of bacterial skin infections in patients over 18 years, including infected insect bite, cellulitis (patient afebrile and healthy other than cellulitis), and acute paronychia (with signs of cellulitis)

# Patient assessment form

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:**  | Click or tap here to enter text. | **Date of Birth /CHI:** | Click or tap here to enter text. |
| **Sex** | M ☐ F ☐ |
| **Date of assessment:** | Click or tap to enter a date. | **Patient consents to GP being informed:** | Yes ☐ No ☐(Exclude if no consent) |

## Patient clinical picture and related appropriate actions

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical features/symptom assessment** | **Yes** | **No** | **Actions** |
| Is patient over 18 years of age?  | ☐ | ☐ | If NO, do not treat and refer  |
| **Is presenting condition any one of the following three?** |
| Infected insect bite | ☐ | ☐ | If NO, do not treat and refer |
| Cellulitis (patient afebrile and otherwise healthy) | ☐ | ☐ |
| Acute paronychia (nail infection) with signs of cellulitis | ☐ | ☐ |
| **Other exclusion criteria** |
| Known hypersensitivity to beta-lactam antibiotic (penicillins or cephalosporins) or any excipients? | ☐ | ☐ | If YES, do not treat and refer |
| Is patient febrile and/or unwell (i.e. features suggestive of systemic infection)? | ☐ | ☐ | If YES, do not treat and refer |
| Is cellulitis related to a human or animal bite, a surgical wound, chronic wound/ leg ulcer or burns? | ☐ | ☐ | If YES, do not treat and refer |
| Is peri-orbital (preseptal)/facial cellulitis present? | ☐ | ☐ | If YES, do not treat and refer |
| Is cellulitis present on arms or torso but **NOT** linked to an insect bite? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have recurrent cellulitis i.e. more than once within a year? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have paronychia which requires drainage of pus and/or severe pain? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have a diabetic foot infection? | ☐ | ☐ | If YES, do not treat and refer |
| Known hepatic impairment or flucloxacillin associated jaundice? | ☐ | ☐ | If YES, do not treat and refer  |
| Known severe renal impairment? | ☐ | ☐ | If YES do not treat and refer  |
| Is there any history of MRSA infection or colonisation? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have history of injecting drug use (e.g. illicit drugs, anabolic steroids)? | ☐ | ☐ | If YES, do not treat and refer |
| Concomitant use of interacting medication? e.g. probenecid, methotrexate, oral typhoid capsule, warfarin | ☐ | ☐ | If YES, do not treat and refer |
| History of porphyria?  | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have known immunosuppression or taking immunosuppressants? | ☐ | ☐ | If YES, do not treat and refer |
| Is the patient pregnant or breastfeeding? | ☐ | ☐ | If YES, do not treat and refer |
| Has informed consent to treatment been obtained? | ☐ | ☐ | If NO, do not treat and refer |

### **Preparation options and supply method**

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| --- | --- | --- |
| **Medicine and strength** | **Regimen - Health Board specific****(during waking hours)** | **Supply method** |
| Flucloxacillin 500 mg capsules  | 500 mg - One capsule FOUR times daily x 201g – Two capsules FOUR times daily x 40 | PGD via NHS Pharmacy First Scotland |
| Flucloxacillin 250 mg capsules  | 500 mg - Two capsules FOUR times daily x 401g – Four capsules FOUR times daily x 80 |
| Flucloxacillin 250mg/5ml oral solution | 500 mg - Two 5ml spoonful (10ml) FOUR times daily x 200ml1g - Four 5ml spoonful (20ml) FOUR times daily x 400ml |

**Patient advice checklist**

|  |  |
| --- | --- |
| **Advice** | **Provided** **(tick as appropriate)** |
| How to take medication – when stomach is empty – either ONE hour before food, or TWO hours after food | ☐ |
| Take regularly and complete the course | ☐ |
| Common side effects of medication e.g. nausea, vomiting and diarrhoea – speak to pharmacist or GP if troublesome | ☐ |
| If a rash or other signs of hypersensitivity occur, STOP taking medication and contact GP or NHS 24 for advice | ☐ |
| Expected duration of symptoms Seek medical assistance that day if symptoms worsen – becomes systemically unwell, or develops a raised temperature, racing heartbeat, rapid shallow breathing or confusion | ☐ |
| Seek medical advice from GP if symptoms do not resolve after 2 - 3 days treatment | ☐ |
| If taking oral contraceptives, no additional precautions are required unless diarrhoea and vomiting occur (absorption of contraception may be affected) | ☐ |
| Patient information leaflet relating to medication is given to patient | ☐ |

**Communication**

|  |  |
| --- | --- |
| **Contact made with** | **Details (include time and method of communication)** |
| Patient’s regular General Practice (details) | Click or tap here to enter text. |

## Details of medication supplied and pharmacist supplying under the PGD

|  |  |
| --- | --- |
| Medication supplied | Click or tap here to enter text. |
| Batch number and expiry | Click or tap here to enter text. |
| Print name of pharmacist | Click or tap here to enter text. |
| Signature of pharmacist | Click or tap here to enter text. |
| GPhC registration number | Click or tap here to enter text. |

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# Notification of supply from community pharmacy

**CONFIDENTIAL WHEN COMPLETED**

Data protection confidentiality note: this message is intended only for the use of the individual or entity to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.

|  |  |  |  |
| --- | --- | --- | --- |
| GP name | Click or tap here to enter text. |  | Pharmacy Stamp |
| GP practice address | Click or tap here to enter text. |  |  |
| Click or tap here to enter text. |  |
| The following patient has attended this pharmacy for assessment and potential treatment of skin infection: |  |
| Patient name | Click or tap here to enter text. |  |
| Date of birth/CHI | Click or tap here to enter text. |  | Pharmacist nameClick or tap here to enter text. |
| Patient address | Click or tap here to enter text. |  |
| Click or tap here to enter text. |  | GPhC number Click or tap here to enter text. |
| Postcode | Click or tap here to enter text. |  | DateClick or tap to enter a date. |

Following assessment (Tick as appropriate)

|  |
| --- |
| Presenting condition |
| Infected insect bite ☐ | Cellulitis ☐ | Paronychia ☐ |
| Your patient has been given a 5 day course of flucloxacillin 500 mg / 1g four times daily (delete as appropriate) | ☐ |
| Your patient has been given self-care advice only | ☐ |
| Your patient is unsuitable for treatment via PGD for the following reasons and has been referred:Click or tap here to enter text. | ☐ |

Your patient has been advised to contact the practice if symptoms fail to resolve following treatment.

You may wish to include this information in your patient records.

**Patient consent**: I can confirm that the information is a true reflection of my individual circumstances and I give my consent to allow a pharmacist working under the terms of NHS Pharmacy First Scotland to provide the most appropriate advice and/or treatment for me. I also give my permission to allow the pharmacist to pass, to my own GP, details of this consultation and any advice given or treatment provided. I have been advised that some of the information may be used to assess the uptake of the service but this will be totally anonymous and not be attributable to any individual patient.

|  |  |
| --- | --- |
| Patient signature | Date |
| Click or tap to enter a date. | Click or tap to enter a date. |

This form should now be sent to the patient’s GP and a copy retained in the pharmacy