**Patient Group Direction for the supply of Penicillin V (Phenoxymethylpenicillin) for the treatment of acute sore throats by community pharmacists in those aged 5 years and over**

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

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| --- | --- | --- | --- |
| **Clinical features/symptom assessment** | **Yes** | **No** | **Actions** |
| Is patient aged 5 years of age or over?  | ☐ | ☐ | If NO, do not treat and refer over  |
| **Does the patient score 4 or 5 on the Fever PAIN score?** |
| **F**ever in the last 24 hours | ☐ | ☐ | If patient does not score 4 or 5 then do not treat.  |
| **P**urulence | ☐ | ☐ |
| **A**ttending rapidly (under 3 days) | ☐ | ☐ |
| Severely **i**nflamed tonsils | ☐ | ☐ |
| **N**o cough or coryza | ☐ | ☐ |
| **Other exclusion criteria** |
| Known hypersensitivity to beta-lactam antibiotic (penicillins or cephalosporins) or any excipients? | ☐ | ☐ | If YES, do not treat and refer |
| Is there any signs of uvula deviation or severe suppurative complications (e.g peri-tonsillar abscess or cellulitis (Quinsy) parapharyngeal abscess, retropharyngeal abscess, or Lemierre syndrome) as there is a risk of airway compromise or rupture of the abscess- refer to secondary care immediately | ☐ | ☐ | If YES, do not treat and refer |
| Adult epiglottis present - suggested by severe and acute onset of sore throat and fever, muffled voice, drooling and stridor (do not examine the throat of anyone with possible epiglottitis and refer to secondary care immediately)? | ☐ | ☐ | If YES, do not treat and refer |
| Child epiglottitis – high fever, sore throat, noisy breathing and dribbling (do not examine the throat of anyone with possible epiglottitis and refer to secondary care immediately) | ☐ | ☐ | If YES, do not treat and refer |
| Is there stridor or respiratory difficulty or severe airway obstruction ? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have any signs of sepsis or meningitis? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient any signs of dehydration or reluctance to take fluids/fluid intake less than 50% of normal? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have signs of infection with Herpes virus? | ☐ | ☐ | If YES, do not treat and refer |
| Any risk of airway compromise or rupture of the abscess? | ☐ | ☐ | If YES, do not treat and refer  |
| Difficulty breathing or speaking? | ☐ | ☐ | If YES do not treat and refer  |
| Does the patient have signs of being profoundly and systemically unwell and/or risk of immunosuppression? | ☐ | ☐ | If YES, do not treat and refer |
| Penicillin-associated jaundice or hepatic dysfunction | ☐ | ☐ | If YES, do not treat and refer |
| Patients who are immuno-compromised (including treatment with methotrexate)  | ☐ | ☐ | If YES, do not treat and refer |
| Severe hepatic impairment?  | ☐ | ☐ | If YES, do not treat and refer |
| Has the patient had a previous course of antibiotics for the same episode? | ☐ | ☐ | If YES, do not treat and refer |
| Is the patient pregnant or breastfeeding? | ☐ | ☐ | If YES, do not treat and refer |
| Concomitant use of interacting medication? | ☐ | ☐ | If YES, do not treat and refer |
| Patients with atypical symptoms e.g. other rashes/lesions | ☐ | ☐ | 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****Penicillin**  | **Regimen - Health Board specific****(during waking hours)** | **Supply method** |
| Aged 5 years  | 125mg QDS for 5 days or 10 days if a recurrent sore throat (previous episode within past 12 months) | PGD  |
| Aged 6 – 11 years  | 250mg QDS for 5 days or 10 days if a recurrent sore throat (previous episode within past 12 months) |
| Aged 12 years and over  | 500mg QDS for 5 days or 10 days if a recurrent sore throat (previous episode within past 12 months) |

**Patient advice checklist**

|  |  |
| --- | --- |
| **Advice** | **Provided** **(tick as appropriate)** |
| How to take medication – when stomach is empty – either 30 minutes 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 acute sore throat: |  |
| 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

|  |
| --- |
| Presenting condition: Fever PAIN score of 4 or 5 |
| Your patient has been given a 5/10 day course (delete as appropriate) of Penicillin V125mg/250mg/500mg 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 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/Guardian 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