

6-4-18 →





J. YOUNG
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**CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST
AUTHORISATION AND RECORD OF AGREEMENT OF NAMED HEALTH
PROFESSIONALS TO SUPPLY OR ADMINISTER MEDICINES UNDER: M. DAVIES**

**PATIENT GROUP DIRECTION FOR THE ADMINISTRATION OF
INHALED/NEBULISED SALBUTAMOL
BY
REGISTERED HEALTHCARE PROFESSIONALS
IN
EMERGENCY DEPARTMENTS**

CAC ✓

1. PGD AUTHORISATION

Position	Name	Signature	Date
Acting Clinical Director of Pharmacy	Fiona Smith		28/3/18
Executive Director of Nursing	Brendan Brown		28/03/18
Medical Director	David Birkenhead		28/3/18
Chairman of Medicines Management Committee	Anu Rajgopal		29/3/18

Date of Patient Group Direction: March 2018

If revision please tick box

Valid Until: March 2020

Review Date: September 2019

Approved by the Trust Medicine Management Committee on: 24TH MAY 2018

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2. CLINICAL CONDITION

Indication	Adults and children 2 years and over, presenting with acute asthma.
Relevant National and Local Guidelines/Information sources	BTS/SIGN Guidance for Asthma 2014 CHFT Asthma Care Bundle
Description of Patients included in treatment	<p>Patients presenting with signs of moderate or severe asthma</p> <p>Adults Moderate – increasing symptoms, no features of severe asthma, PEFR > 50%-75% best or predicted Acute severe – unable to complete sentences in one breath, resp. rate ≥ 25/min, heart rate ≥ 110/min, PEFR 33-50% best or predicted Life-threatening asthma – cyanosis, silent chest, exhaustion, arrhythmias, hypotension, altered conscious level, coma, feeble respiratory effort, peak flow <33% best or predicted, SpO₂ <92%, PaO₂ <8kPa, normal PaCO₂ (4.6-6.0 kPa)</p> <p>Children Moderate – able to talk, HR - 2-5yrs ≤ 140/min, 5-12yrs ≤ 125/min, >12yrs <110, Resp. Rate – 2-5yrs ≤ 40/min, 5-12yrs ≤ 30/min, >12yrs <25/min, PEFR >5yrs >50% predicted/best Acute Severe – unable to complete sentence in one breath, or too breathless to speak or feed, Heart Rate – 2-5yrs >140/min, >5yrs >125/min. Resp. Rate – 2-5yrs >40/min, >5yrs >30/min PEFR 33-50% best or predicted. SpO₂ <92% Life-threatening asthma – cyanosis, silent chest, poor respiratory effort, fatigue/exhaustion, agitation, confusion, coma, hypotension, PEFR <33% predicted/best (older children). SpO₂ <92%</p> <p>Any Life-Threatening asthma should be immediately managed by a senior A&E doctor</p>
Description of Patients excluded from treatment under the terms of this PGD	Patients presenting with life threatening asthma Known hypersensitivity to Salbutamol
Action if excluded	Refer to ED doctor or Advanced Clinical Practitioner
Action if patient self excludes/declines	Refer to ED doctor or Advanced Clinical Practitioner

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3. TREATMENT

Name, form and strength of medicine	Salbutamol by inhalation either as: 2.5mg/2.5ml and 5mg/2.5ml solutions for inhalation via nebuliser OR 100mcg metered dose CFC-free (MDI) inhaler via spacer device
Legal Status <i>GSL, P, POM</i>	POM
Dose	Nebulised Salbutamol: Child >12yrs/Adult: 5mg Child 5-12yrs – 2.5 - 5mg Child 2-4yrs: 2.5mg Salbutamol MDI using spacer device: Child: 2-10puffs, given one at a time and inhaled via large volume spaced device up to max. 10puffs. If child <3yrs, use facemask rather than mouthpiece, on spacer
Frequency of administration	Single administration
Method and route of administration	Nebuliser solution: Inhale undiluted over 5-10mins via a well fitting facemask, or mouthpiece, by oxygen driven nebuliser in well-ventilated room. May be diluted with sodium chloride when giving over 10mins MDI/Spacer device: Preferred option for children. Inhalers delivered into spacer in individual puffs, and inhaled immediately
Supporting facilities required	
Quantity to supply/administer	Single administration only
Duration of treatment	Single administration only
Potential side effects	Tremor, headache, muscle cramp, palpitation, vasodilation, hypokalaemia, arrhythmias, hypersensitivity reactions
Advice to patient/carer	Explain why the drug is being administered and inform of possible side effects such as tremor, or increased heart rate, and ask patient to inform staff of any change in their condition

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Managing & Reporting Adverse Events	<ul style="list-style-type: none"> • All suspected adverse drug reactions occurring after treatment following this PGD must be reported to a senior medical practitioner responsible for the area in which the direction is in use • The healthcare professional administering/supplying from the PGD must also report the ADR using Trust incident reporting procedure • All serious adverse drug reactions should be reported to the MHRA / CSM using the Yellow Card System. Yellow cards and guidance on its use are available at the back of the BNF or at www.yellowcard.gov.uk
Follow up	Referral back to GP/Respiratory Nurse Specialist for Asthma management review
When to refer to doctor	All patients to be seen by a doctor or Advanced Clinical Practitioner
Treatment record Specify method of recording supply/administration sufficient for audit trail	<ul style="list-style-type: none"> • Document in Electronic Patient Records in ED • Prescription as PGD • Name, dose and frequency of drug • Advice given, verbal or written • Signed and dated

4. STAFF

Professional Qualifications	Registered Nurse or Paramedic Current NMC or HCPC registration
Any Exceptions to above	Bank & Agency Staff
Specialist competencies, qualifications and experience	Trust PGD training (ED)
Continuing training & education	Update in line with clinical guidelines

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5. MANAGEMENT AND MONITORING

Records to be kept for Audit Purposes	<p>STORAGE AND RETRIEVAL Pharmacy will retain the original signed version of the PGDs</p> <ul style="list-style-type: none"> • Adult – 8 years • Children (under 18 years) <i>As the requirement is until child is 25 years old or for eight years after child's death and PGDs are not child specific – this would be indefinitely (at least a minimum of 43 years)</i> <p>Division/Author is responsible for keeping the record/retrieval method of those authorised to work under a PGD/signature sheet to comply with the above</p>
Date of writing	March 2018
Name of manager holding record of names of those authorised to work under this PGD	Louise Croxall – Matron, ED

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<p>Names of all authors of PGD (to include a Dr or Dentist)</p>	<p>Print Name: Janet Youd</p> <p>Title: Emergency Nurse Consultant</p> <p>Signature: <i>Janet Youd</i> Date: 20/3/18</p> <p>Print Name: Dr Mark Davies</p> <p>Title: Emergency Medicine Consultant</p> <p>Signature: <i>[Signature]</i> Date: 21/3/18</p>
<p>Lead Pharmacist involved in preparation of PGD</p>	<p>Print Name: Lisa Hodgson</p> <p>Signature: <i>[Signature]</i></p> <p>Date: 23/3/18</p>
<p>Approval of Clinical Director</p>	<p>Print Name: Mark Davies</p> <p>Signature: <i>[Signature]</i></p> <p>Date: 21/3/18</p>

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This Patient Group Direction is to be read and agreed and this Authorisation and Record of Agreement signed by all Health Professionals who will administer and/or supply treatment using it. It is the responsibility of each professional to practice only within the bounds of their own competence

A copy of the Patient Group Direction and the original, signed Record of Agreement must be held together by the Ward/Departmental Manager/Community Team Leader.

'I confirm that I have read and understood the content of this Patient Group Direction and that I am willing to work under it within my Professional Code of Practice/Conduct.'

Name of Health Professional	Designation e.g. RGN	Signature of Health Professional	Signature of Ward/Departmental/Area Manager	Date

