




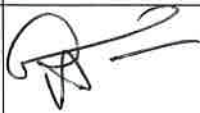
6-4-18 → J. YOOD  
A. KEASKIN  
M. DAVIES

**CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST**  
**AUTHORISATION AND RECORD OF AGREEMENT OF NAMED HEALTH**  
**PROFESSIONALS TO SUPPLY MEDICINES UNDER:**

**PATIENT GROUP DIRECTION FOR THE SUPPLY OF**  
**FLUCLOXACILLIN**  
**BY**  
**REGISTERED HEALTH PROFESSIONALS**  
**IN**  
**EMERGENCY DEPARTMENTS**

CAY ✓

**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**

<b>Indication</b>	Potential or established soft tissue infection Refer to Trust antibiotic policy.
<b>Relevant National and Local Guidelines/Information sources</b>	<ul style="list-style-type: none"> <li>• Licensed use</li> <li>• Recognised first line antibiotic</li> </ul>
<b>Description of Patients included in treatment</b>	<ul style="list-style-type: none"> <li>• Adults</li> <li>• Children 1yr and over</li> </ul>
<b>Description of Patients excluded from treatment under the terms of this PGD</b>	<ul style="list-style-type: none"> <li>• Allergy to Penicillin</li> <li>• Severe renal failure</li> <li>• Hepatic impairment</li> </ul>
<b>Action if excluded</b>	Refer to doctor, Advanced Clinical Practitioner or consider other antibiotics
<b>Action if patient self excludes/declines</b>	Refer to doctor, Advanced Clinical Practitioner or consider other antibiotics

**3. TREATMENT**

<b>Name, form and strength of medicine</b>	Flucloxacillin 500mg capsule Suspension 125mg/5ml, 250mg/5ml
<b>Legal Status <i>GSL, P, POM</i></b>	POM
<b>Dose</b>	Adult - 500mg Child 1-2 years – 125mg Child 2-10 years – 125-250mg Child 10-18 years – 250-500mg
<b>Frequency of administration</b>	QDS
<b>Method and route of administration</b>	Oral
<b>Supporting facilities required</b>	
<b>Quantity to supply/administer Duration of treatment</b>	Course length 7 days 500mg caps qds – 28 125mg/5ml qds – 200ml 250mg/5ml qds – 200ml
<b>Potential side effects</b>	Nausea/vomiting, diarrhoea, gastric upset, hypersensitivity reaction, hepatitis and cholestatic jaundice

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<b>Advice to patient/carer</b>	<ul style="list-style-type: none"> <li>• Complete prescribed course</li> <li>• Take before food</li> <li>• If rash/pruritis develops stop taking</li> <li>• If jaundice develops during or after course, stop taking &amp; consult doctor</li> <li>• Suspension – shake the bottle</li> </ul>
<b>Managing &amp; Reporting Adverse Events</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The healthcare professional administering/supplying from the PGD must also report the ADR using Trust incident reporting procedure</li> <li>• 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 <a href="http://www.yellowcard.gov.uk">www.yellowcard.gov.uk</a></li> </ul>
<b>Follow up</b>	As required by clinical condition
<b>When to refer to doctor</b>	Any reaction to medication or exacerbation of symptoms
<b>Treatment record Specify method of recording supply/administration sufficient for audit trail</b>	<ul style="list-style-type: none"> <li>• Electronic Patient Record in ED</li> <li>• Prescription</li> <li>• Name , dose, and frequency of drug,</li> <li>• Volume/ quantity supplied</li> <li>• Advice given, verbal or written</li> <li>• Signed and dated</li> </ul>

**4. STAFF**

<b>Professional Qualifications</b>	Registered Nurse or Registered Paramedic Current NMC or HCPC Registration
<b>Any Exceptions to above</b>	Bank and Agency Staff
<b>Specialist competencies, qualifications and experience</b>	Emergency Nurse Practitioner Programme (ED) or Advanced Clinical Practitioner Programme (inc. Trainees) Trust PGD training
<b>Continuing training &amp; education</b>	Update in line with clinical guidance

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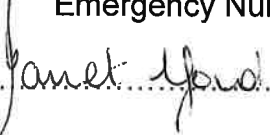



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**5. MANAGEMENT AND MONITORING**

<b>Records to be kept for Audit Purposes</b>	<b>STORAGE AND RETRIEVAL</b> Pharmacy will retain the original signed version of the PGDs <ul style="list-style-type: none"><li>• Adult – 8 years</li><li>• 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</i> (at least a minimum of 43 years)</li></ul> <b>Division/Author</b> is responsible for keeping the record/retrieval method of those authorised to work under a PGD/signature sheet to comply with the above
<b>Date of writing</b>	March 2018
<b>Name of manager holding record of names of those authorised to work under this PGD</b>	Louise Croxall – Matron, ED

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