# Patient Group Direction for the treatment of adults and children presenting with symptoms of impetigo

# Patient assessment form

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| --- | --- | --- | --- |
| **Patient Name:**  | Click or tap here to enter text. | **Date of Birth /CHI:** | Click or tap here to enter text. |
| **Date of assessment:** | Click or tap to enter a date. | **Patient consents to GP being informed:** | Yes [ ]  No [ ]  |

## Patient clinical picture and related appropriate actions

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| --- | --- | --- | --- |
| **Symptom assessment** | **Yes** | **No** | **Actions** |
| Rash typical of impetigo? (Initially presents as vesicles with erythematous base which easily rupture with exudate drying to form a yellow/gold or yellow/brown crust which gradually thickens).  |[ ] [ ]  If NO, consider alternative diagnosis and proceed appropriately.If YES, may be suitable to receive Fusidic acid cream under PGD. |
| **Clinical features** | **Yes** | **No** | **Actions** |
| Has already tried Hydrogen Peroxide (Crystacide) 1% cream to treat lesions? |[ ] [ ]  If NO, consider recommending this as first step of treatment.If YES, may be suitable to receive Fusidic acid under PGD. |
| Widespread skin infection?  |[ ] [ ]  If NO (minor/localised, uncomplicated area of infection only) may be suitable to receive Fusidic acid under PGD.If YES (widespread, extensive lesions), REFER to GP. |
| History of MRSA colonisation or infection? |[ ] [ ]  If YES, REFER to GP. |
| Had impetigo treated with any form of antibiotics within the last 3 months? |[ ] [ ]  If YES, REFER to GP. |
| Patient systemically unwell? |[ ] [ ]  If YES, REFER to GP or OOH if appropriate. |
| Known allergy to any component of the cream? |[ ] [ ]  If YES, REFER to GP. |
| Presenting with any underlying skin condition on the same area of the body as impetigo? |[ ] [ ]  If YES, REFER to GP. |

**Preparation options and supply method**

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| --- | --- | --- |
| **Medicine and strength** | **Regimen - Health Board specific** | **Supply method** |
| Fusidic acid 2% cream (1 x 15 g) | Apply gently to affected area THREE or FOUR times daily for 5 days | PGD via UCF |

**Patient advice checklist**

|  |  |
| --- | --- |
| **Advice** | **Provided** **(tick as appropriate)** |
| Wash hands before and after applying cream |[ ]
| Where possible, remove scabs by bathing with warm water before applying the cream |[ ]
| Impetigo is a very infectious condition. Important to prevent infection spreading by using own flannels and towels (hot wash after use) |[ ]
| Do not scratch or pick spots |[ ]
| Suggest applying creams THREE times daily on school days (before school, after school and evening) and FOUR times daily at other times |[ ]
| Inform school of condition – advise that child should be excluded from school until the lesions are crusted and healed or 48 hours after commencing antibiotic treatment |[ ]
| If infection spreads or there is no improvement after 5 days, seek medical advice from GP |[ ]
| If patient becomes systemically unwell or infection is rapidly spreading to large areas of body during OOH period, seek medical advice from NHS 24. |[ ]
| Do not share cream with anyone else |[ ]
| Do not apply to breast if patient is breastfeeding |[ ]
| Inform patient of possible side effects of medication and their management |[ ]
| Provide patient information leaflet |[ ]

**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 assessment and 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 impetigo: |  |
| 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)**

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| --- |
| **Presenting symptoms** |
| Rash typical of impetigo(Initially presents as vesicles with erythematous base which easily rupture with exudate drying to form a yellow/gold or yellow/brown crust which gradually thickens – minor/localised lesions) |[ ]
| **Treatment** |
| Your patient has been supplied with 1 x 15 g Fusidic acid cream (Apply gently to affected area THREE or FOUR times daily for 5 days) |[ ]
| 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.