NHS
Black Country
Integrated Care Board
NHS
Midlands and Lancashire
Commissioning Support Unit

Service Specification

This Service Specification defines the terms and standards required by:

The Integrated Care Board **known as the Commissioner** (Black Country Integrated Care Board (BC ICB)

and

The Community Pharmacy **known as the Provider**

For the provision of the

Pharmacy First Service

(in line with the requirements of this service specification) during the period

1st April 2023 – 31st March 2024

Service Context

Much of the UK population experiences symptoms of minor ailments every day. Most people take responsibility for dealing with their symptoms by self-care and self-medication. If these consultations were handled by a pharmacist, the NHS could, better allocate resources to higher priority areas that have a greater impact for patients. It is vital that the NHS achieves the greatest value from its finite resources.

1.1 Local Context

This ICS led service aims to bring a consistent and cohesive Pharmacy First Service across the Black Country ICS. This Pharmacy First Service existing from 2019/20, follows on from the Minor Ailment Scheme 2018/19, NHSE commissioned Pharmacy First scheme for Under 16s (2015-2018) and the Wolverhampton and Dudley CCG led Pharmacy First scheme for Over 16s (2017-2018).

1.2 National Context

Community Pharmacy services are increasingly being highlighted nationally as part of the NHS response to managing increasing demand and complexity.

- Community Pharmacy has been identified as having a potential role in managing winter pressures and establishing a network of community pharmacies could help manage surges in demand in both the summer (e.g. by provision of medicines for hay fever) and winter (e.g. by supporting self-care for winter ailments).
- Delivering the forward View: NHS Shared Planning Guidance 2016/17-2020/21 (December 2015)
- The NHS England 5 year forward view https://www.england.nhs.uk/five-year-forward-view/
- The NHS England Conditions for which over the counter items should not be routinely prescribed in primary care was published in March 2018 and the Pharmacy First Service has been updated in line with this.
- The Community Pharmacy Clinical Services Review [Murray; 2016] highlighted the potential for the clinical expertise within community pharmacy to be used to the benefit of patients and the NHS.
- The Murray review supported the provision of Minor Ailments Services as an important means of reducing pressure on other urgent care services.

Outcomes

1.3 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

1.4 Locally defined outcomes

- Helping people with specified minor ailments recover from episodes of ill health by providing access to a defined list of medicines and advice from community pharmacy premises.
- Improve primary care capacity by reducing medical practice workload related to minor ailments and to ease pressures on their local A&E department and primary care urgent services.
- Promote the role and greater contribution of community pharmacies in primary health care to build the public understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for GP appointment or emergency care visit.

Scope

1.5 Aims and objectives of service

The Pharmacy First Service is primarily designed as a “walk in” service so that patients exempt from prescription charges of all ages can access self-care advice for the treatment of minor ailments and, where appropriate, be supplied with over the counter medicines, without the requirement to attend their GP practice for an appointment and prescription.

This service is available to patients exempt from prescription charges who are **registered with a participating General Practice in the Black Country geography (Dudley, Sandwell, Walsall and Wolverhampton).**

This service is also available to people seeking asylum, who have not yet registered with a GP practice and who currently reside in ‘Contingency’ Initial Accommodation or ‘pre-dispersal’ accommodation (currently this includes hotels, repurposed MoD facilities, student, and other self-contained accommodation), within the Black Country geography.

People seeking asylum who have not yet registered with a GP practice can be provided with advice and/or treatment and signposted to a local GP practice for NHS registration.

Patients can access the scheme up to a maximum of **6 times** in a 12-month period.

**Access to the scheme is subject to change. Service Providers will be informed of any changes at the earliest opportunity.*

Pharmacy First Service consultations will be reimbursed to the provider at a rate of £5 per consultation and the cost of the medicine.

If a patient has been referred to the Pharmacy First service via the GP or 111 Community Pharmacy Consultation Service (CPCS), consultations will be reimbursed to the provider at a rate of £2 per consultation and the cost of the medicine.

The Pharmacy First Service aims to:

- Support patients to self-manage their condition and recover quickly from episodes of ill health, that are suitable for management in a community pharmacy setting.
- Ensure that patients have a positive experience of care in a community pharmacy setting.
- Enable more patients to access advice and medicines where appropriate from the NHS without requiring a GP appointment or A&E/urgent care visit to provide a prescription.
- Release capacity in other healthcare setting by providing convenient access to advice and treatment in community pharmacy.
- Divert patients with specified minor ailments from general practice and other urgent care settings into community pharmacy where the patient can be seen and treated in a single episode of care.

This service is only available for patients presenting with identified symptoms as per the minor ailment conditions and medicines included within appendix 3 and 4 of this specification.

Management of these conditions is set out in the treatment protocols in Appendix 4.

*The formulary and treatment protocols are subject to change, providers will be notified by means of an updated document on PharmOutcomes.

Service Provider Duties

1.6 Service Availability

The pharmacy must be located within one of the participating ICS place based areas and must comply with all the requirements of the NHS Community Pharmacy Contractual Framework. There must be suitable access to a confidential patient consultation room on site to undertake a private consultation (should this be requested by a patient). The service must be available at the pharmacy throughout the whole core and supplementary opening hours. An individual patient can access the scheme up to six times per calendar year.

1.7 Service Accreditation Criteria

Once Pharmacy service providers are signed up and are accredited, individual practitioners at the service provider pharmacy will need to enrol on the platform (at the first point of access only). The Pharmacy Service Provider must ensure that staff members delivering the service must have completed or are intending to complete the following (within the 3-month grace period):

- Common clinical conditions and minor ailments (distance learning)
- Minor ailments: a clinical approach – CPPE (2023) (e-assessment)

  **Assessments will need to be repeated every two years and if the course is updated.*

- Confirm they have read and understood the service specification between the commissioner and the provider and agree to offer this service in accordance with these requirements
- Confirm the pharmacy is registered with the information commissioner.

Pharmacy Service providers are responsible to ensure all staff delivering this service have met the service accreditation criteria above and the service provider has a Standard Operating Procedure (SOP) in place (within the 3-month grace period). The pharmacy service provider must ensure any staff member delivering the service complies with the SOP.

1.8 Standard Operating Procedure (SOP)

- The service provider will have developed a SOP which specifically details the operational delivery of the Pharmacy First Service in accordance with this specification.
- The service provider must ensure that all staff working in the pharmacy have relevant knowledge, are appropriately trained, and operate within the SOP, this includes understanding when to recommend the service to clients.
- The SOP should be reviewed at least every two years or before if circumstances dictate. Each review should be documented and the SOP subject to version control. Staff must read, date and sign the SOP after a review.
- The SOP must be available to the commissioner if requested.

1.9 Service Continuity

- It is the responsibility of the service provider to have a process in place that ensures that all new staff and locums are aware of the Pharmacy First Service and must maintain continuity of service during and after staff changes.
- Counter staff and support staff should have full knowledge of the operation of the service but should not make independent decisions regarding a patient's suitability for the service without referring to a pharmacist. For example, turning a patient away because the regular pharmacist is not on duty.
- The service provider has a responsibility to ensure that all staff members provide the service strictly in accordance with the service specification and Standard Operating Procedures.

1.10 Promotion and Advertising

- The service provider is required to display a service poster provided by the commissioner to support service delivery.
- The service provider is required to actively promote service uptake.
- The service provider must ensure that they keep their **NHS Choices** website accurately updated with their opening hours and provision of this locally commissioned Pharmacy First Service.
- The service provider should co-operate and liaise with local GPs to discuss the service and that patients can be signposted into it.
- Local practices should be aware of the service and the limitations of what can be referred into it.
- Agree together on how patients presenting at the pharmacy who need to be seen by a GP, are referred.
- Service providers should explain the provision, range of conditions covered and features of the service to the public and other appropriate professionals; encouraging patients to self-care in the future.
- Any adverse incident that has happened in relation to this scheme must be reported to MLCSU via the following email address within 72 hours of occurrence: mlcsu.pharmacyservicequeries@nhs.net

1.11 Complaints and Incidents

Complaints from service users should be handled by using existing complaints procedures within each pharmacy. The service user can also choose to send the complaint to the local commissioner of the service. https://psnc.org.uk/contract-it/psnc-briefings-pharmacy-contract-and-it/psnc-briefing-09113-nhs-complaints-procedure/

The Provider will co-operate with any Commissioner-led assessment of Service user experience.

The content of the log of **patient safety incidents** should be used to help identify trends, or to highlight weaknesses in pharmacy systems and procedures https://psnc.org.uk/contract-it/essential-service-clinical-governance/patient-safety-incident-reporting/

Service Funding

1.12 Service Funding

The service provider will enter details of the consultation on the online PharmOutcomes system which will in turn generate a monthly claim for the pharmacy. The service provider will be reimbursed based on:

- The formulary price of the medicine (+VAT) supplied to the patient
- The professional service fee for the consultation provided by the pharmacist.
    - Pharmacy First Service consultations will be reimbursed to the provider at a rate of £5 per consultation and the cost of the medicine.
    - If a patient has been referred to the Pharmacy First service via the GP or 111 Community Pharmacy Consultation Service (CPCS), consultations will be reimbursed to the provider at a rate of £2 per consultation and the cost of the medicine.

Consultations not leading to a supply of medicines will be reimbursed at the professional service fee only.

Medicines supplied as retail sale are not included in the calculation between the service provider and the commissioner.

1.13 Payments

Payments will be entered on to the NHS BSA Local Payments Application and will appear on pharmacy contractors' FP34 monthly statement from the NHS BSA under Local Scheme 1. Pharmacy contractors do not need to submit monthly claims as these are processed automatically.

Duties of Individuals Performing this Service

1.14 Patient Registration

When accessing the Pharmacy First Scheme for the first time, patients must be registered onto the PharmOutcomes Pharmacy First registration platform. Registration is not required for subsequent patient access to the service.

- Recording of patient NHS Numbers is mandatory.
- For people seeking asylum, select 'Not registered to GP surgery' from GP drop down list and add '0000000000' in NHS number field.

For patients registered within a participating GP Practice, the pharmacist will need to verify the patients GP practice registration by one of the following methods:

- Pharmacy's Patient Medication Record (PMR).
- Patient provided repeat prescription slip or actual prescription.
- Patient's NHS Medical card.
- Contacting the GP practice for confirmation.
- Where this information is not available, pharmacies should request appropriate identification to confirm the patients name and address. Where patients are unable to provide identification, pharmacies should use their professional discretion as to whether registration and consultation should be provided under the Pharmacy First Service.
- Where a consultation is provided the patient should be advised that they bring appropriate identification for future consultations and a note be made on their Data Management record.

For people seeking asylum, the following documentation can be used to verify their asylum seeker status:

- ARC (Asylum Registration Card) as well as Home Office letter to prove that they are an asylum seeker.
- Letter from Serco (accommodation) with National Asylum Support Number (NASS)
- Notification of Grant (Bail 201 form) with full name, photo, date of birth, and country of nationality
- HC2 Certificate (People seeking asylum – if supported by the National Asylum Support Service (NASS), NASS will automatically be sent a NHS Low Income Scheme HC2 certificate entitling them to help with health costs including free prescriptions. Patients can apply for support using the HC1 application form if needed.
- In addition to the above, they may have a Tenancy agreement to prove their accommodation allocation and please note sometimes paperwork can be delayed, and people seeking asylum are housed into accommodation before having this.

For those patients who consent to join the scheme, a consent form must be completed upon registration. The registration phase of the online platform has printable versions of the patient consent form. The consent form must be printed and completed in full, (signed by the parent or legal guardian for Under 16s). Patient consent must be sought in writing by the "registering" Pharmacy before any consultation can take place under the service. This record must be stored within the registering pharmacy for two years.

1.15 Patient Consultation

Pharmacists must ensure that consultations are only undertaken for patients that attend the pharmacy in person, non-face-to-face consultations are not permitted. Consultations will consist of:

- Patient assessment
- Provision of advice (as per Pharmacy First protocols included in this Service) and sign- post to self-care resources including www.selfcareforum.org
- Check that the maximum usage of the Pharmacy First Service has not been exceeded.

- Provision of a medication, only if necessary, from the agreed formulary appropriate to the patient's condition (as per Pharmacy First protocols included in this scheme).
- Rules of patient confidentiality apply.

Patients who have a) already attended a GP appointment or intend to take up a GP appointment for the same symptoms or b) accessed the maximum number of six interventions in a 12-month period are not eligible to access the service.

It is acknowledged that pharmacists will not have access to a patient's full medical record when conducting Pharmacy First Service consultations and will need to assure themselves that the patient can provide a reliable history of the presenting condition and other relevant elements of the patient history (e.g. long-term conditions, concomitant medication). Pharmacists can and should decline to provide medicines under the Pharmacy First Service where a reliable history cannot be obtained to protect patients from avoidable harm.

For people seeking asylum, there will be additional support, for example, point of contact, interpreter services and access to services off site.

Provision of medication from the formulary in Appendix 3 is appropriate if:

- Patient assessment is carried out by an accredited pharmacist following a face-to-face consultation with the patient (the patient parent/guardian/representative may be present where appropriate).
- Patients meet the inclusion criteria specified in the relevant treatment protocol.

Up to two formulary medicines can be supplied per consultation i.e. up to two symptoms can be treated under this service. The consultation phase of the online platform has printable versions of the patient declaration form. For every consultation, the declaration form must be printed and completed in full, (signed by the parent or legal guardian for under 16s).

The details of the consultation must be recorded on PharmOutcomes during or following the consultation (It is optional if service providers wish to record consultation details on the Pharmacy's PMR system), this also enables payment to the service provider. A record of the consultation should be entered onto PharmOutcomes ideally within 72 hours of the consultation or within 7 days.

Pharmacies will not be eligible for payment where the NHS number is not captured (add '0000000000' in NHS number field for people seeking asylum)

1.16 Rapid Referral

If the patient presents with symptoms indicating the need for a consultation with the GP, the pharmacist should (within surgery hours) contact the patient's GP by phone to arrange an appointment or if outside surgery hours to contact the on-call doctor or advise the patient to attend A & E immediately. People seeking asylum who are not yet registered to a GP practice, should be referred to NHS111/ Walk in Centres or A&E as appropriate. Any referrals made to the GP must be documented and the reason for the referral recorded on the online PharmOutcomes platform.

1.17 Record Management

Maintaining and retaining good quality records (including copies of signed patient consent forms and declaration forms) as per relevant professional and information governance standards.

Applicable Service Standards

1.18 General Pharmaceutical Council standards

- Standards of conduct, ethics and performance
- Standards for registered pharmacies
- Standards for continuing professional development (CPD)

1.19 Applicable National Standards

- Medicines supplied under the Pharmacy First Service should be in original packs and must contain a patient information leaflet.
- The service must be delivered in accordance with the most recent treatment protocols, and service specification.
- Records created during the delivery of the Pharmacy First Service should be managed according to the current NHS Code of Practice.
- The provider must satisfactorily comply with its obligation under Schedule 1 of the Pharmaceutical Services regulations to provide Essential Services and have an acceptable system of Clinical Governance.
- The Provider must ensure that this service is performed in accordance with current national standards and guidelines including the Misuse of Drugs Act 1971, Misuse of Drugs Regulations 1985

1.20 Health and Safety

The service provider shall comply with the requirements of the Health and Safety at Work Act 1974, the management of Health and Safety at Work Regulations 1999 and any other acts, regulation, orders or rules of law pertaining to health and safety.

1.21 Safeguarding

- Where there are safeguarding issues, appropriate action must be taken to address those concerns.
- Accredited staff providing consultations must be aware of national and local safeguarding guidelines and referral pathways.

Confidentiality and Data Protection

- Providers are expected to offer a professional service and the pharmacy must protect personal data in accordance with provisions and principles of the current Data Protection Act legislation.
- Any information and/or records relating to patients that may be available to the
- Provider or for providing the service required, shall be held in the strictest confidence, and shall not be divulged to any third party without the express permission of the patient.
- The pharmacy will provide a non-judgmental, patient centred, confidential service.
- The Pharmacy staff must not disclose to any person any information acquired by them in connection with the provision of the service which concerns; the identity of any service user and/or the medical condition or any treatment received by any service user.
- Pharmacists may need to share relevant information with other health care professionals and agencies, in line with locally determined confidentiality and data security arrangements, including, where appropriate, the need for the permission of the patient to share the information.

Period of Service and Termination

This Locally commissioned service will run from 1st April 2023 – 31st March 2024. No further notice period will be required unless the scheme is terminated before the 31st March 2024, in which case the notice period will be three months.

The exception to the above is where a Contractor fails to meet any of the obligations in this contract. In such circumstances they will be notified in writing of the nature of the breach. Where the breach is not remedied within appropriate time-frames or the commissioner deems it is not capable of remedy, the commissioner will be entitled to terminate this agreement with immediate effect.

Appendix One – Patient Consent Form

Violet Patch Pharmacy
678 A Street in a Town Narrow EF45 6GH 0789 123456

Patient Details	
Name	Mickey Mouse
Address	123 Alphabet Road Broad way AB12 3CD
Date of Birth	2003-02-01
Gender	Male
NHS Number	1111111111
Consent to share	Consent to share given

Provision Details	
Provision Date	22 May 2018
GP Practice	Selection of *GP Practice* (Healthcare Providers (was Surgeries) lookup list)

Scheme eligibility and consent	
Scheme eligibility	*Scheme eligibility*: One of: Medical card Prescription request sheet PMR records or other pharmacy records Confirmation of registration document Surgery confirmed registration
Consent form printed	*Consent form printed*: Yes

Declarations

Patient Signature: ..... Date: .....

Appendix Two – Patient Declaration Form

Violet Patch Pharmacy
678 A Street in a Town Narrow EF45 6GH
0789 123456

Patient Details	
Name	Mickey Mouse
Address	123 Alphabet Road Broad way AB12 3CD
Date of Birth	2003-02-01
Gender	Male
NHS Number	1111111111
Consent to share	Consent to share given

Provision Details	
Provision Date	22 May 2018
[Layout question 50760]	Condition result of layout question
GP Practice	Selection of *GP Practice* (Healthcare Providers (was Surgeries) lookup list)
NHS Number	Answer to *NHS Number* single line input
Consultation details	
Time of consultation	
Visit number	

Medicines supply - If no medicine supply leave these fields blank

Presenting symptom 1	
Medicine supply necessary	*Medicine supply necessary*:
Medicine 1 supplied	Selection of *Medicine 1 supplied*
Second symptom?	*Second symptom?* One of: Yes No
Presenting Symptom 2	
Medicine supplied	*Medicine supplied*:
Medicine 2 supplied	Selection of *Medicine 2 supplied*
if supply made	*No supply made - select N/A if supply made*: One of: Not Fourth visit within 6 months Inappropriate referral - condition not in service Patient referred to GP - e.g. Red flag symptom
Relevant notes	Answer to *Relevant notes* text box
Service Audit	
Without pharmacy service would you	*Without pharmacy service would you*: One of: Go to GP Go to Walk in Centre Go to A and E Go to Badger clinic Purchased medicine Gone without Other
Final Check-list	
Please ensure - Tick to indicate complete	*Please ensure - Tick to indicate complete*: Patient signs declaration before leaving pharmacy

Patient Signature:..... Date: .....

Appendix Three – Formulary

Formulary Medicine
Acute Cough U16
Simple Linctus BP s/f (200mls) For Acute Cough
Simple Linctus paediatric s/f (200ml pack) For Acute Cough
Acute Cough O16
Simple Linctus BP s/f (200mls) For Acute Cough
Acute Fever U16
Ibuprofen 100mg/5ml s/f suspension (100ml pack) For Acute Fever / Earache
Ibuprofen 200mg tabs (24 pack) For Acute Fever / Earache
Paracetamol 500mg tablets (32 pack) For Acute Fever / Cold and Flu
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething
Acute Bacterial Conjunctivitis U16
Chloramphenicol 0.5% Eye Drops (10ml pack) for Acute Bacterial Conjunctivitis
Acute Bacterial Conjunctivitis O16
Chloramphenicol 0.5% Eye Drops (10ml pack) for Acute Bacterial Conjunctivitis
Acute Pain/Earache/Headache/Temperature O16
Paracetamol 500mg tablets (32)
Ibuprofen 200mg tablets (24)
Athletes Foot U16
Clotrimazole 1% cream (20g)
Athletes Foot O16
Clotrimazole 1% cream (20g)
Bites and Stings and Allergies U16
Hydrocortisone 1% cream (15g pack) For Bites and Stings
Mepyramine maleate 2% cream 20g (Anthisan®)
Chlorphenamine syrup s/f 2mg/5ml (150ml) For Hay Fever
Chlorphenamine 4mg tabs (28 pack) for Hay fever
Bites and Stings and Allergies O16
Crotamiton 10% cream (30g)
Hydrocortisone 1% cream (15g)
Chlorphenamine 4mg tablets (30)
Cetirizine 10mg tablets (30)
Coldsores U16
Aciclovir 5% cream (2g)
Coldsores O16
Aciclovir 5% cream (2g)
Cold and Flu U16
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu Paracetamol 500mg 32 tablets
Pseudoephedrine linctus 30mg/5ml 100ml (Sudafed decongestant liquid)
Cold and Flu O16
Paracetamol 500mg tablets (32)
Ibuprofen 200mg tablets (24)
Menthol and Eucalyptus inhalation (100ml)
Xylometazoline 0.1% Nasal Spray (10ml)
Constipation U16
Lactulose Liquid (300ml pack) For Constipation
Constipation O16
Ispaghula 3.5g sachets (10)
Senna 7.5mg tablets (20)
Lactulose solution (300ml)
Glycerol suppositories (12)
Cystitis O16
Potassium Citrate sachets (6)
Sodium Citrate sachets (6)
Diarrhoea U16

Dioralyte sachets (6)
Diarrhoea O16
Dioralyte sachets (6)
Dry Skin (Simple Eczema) U16
ZeroAQS (500g pack) For Dry Skin / Simple Eczema
Zeroderm (125g pack) for Dry Skin / Simple Eczema
Zeroderm (500g pack) For Dry Skin / Simple Eczema
Dermatitis/Allergic type rashes U16
Zeroderm ointment (500g)
Hydrocortisone 1% Cream (15g)
Dermatitis/Allergic type rashes O16
Zeroderm ointment (500g)
Hydrocortisone 1% Cream (15g)
Earache U16
Ibuprofen 100mg/5ml s/f suspension (100ml pack) For Acute Fever / Earache
Ibuprofen 200mg tabs (24 pack) For Acute Fever / Earache
Paracetamol 500mg tablets (32 pack) For Acute Fever / Cold and Flu
Paracetamol 250mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu
Paracetamol 120mg/5ml s/f suspension (100ml pack) For Acute Fever/ Cold and Flu/ Teething
Earwax U16
Olive Oil Ear Drops (10ml pack) For Ear Wax
Earwax O16
Olive Oil Ear Drops (10ml pack) For Ear Wax
Sodium Bicarbonate Ear Drops (10ml) For Ear Wax
Hay Fever U16
Cetirizine liquid (70ml pack) For Hay Fever
Chlorphenamine syrup s/f 2mg/5ml (150ml) For Hay Fever
Cetirizine 10mg tabs (30 pack)
Chlorphenamine 4mg tabs (28 pack) for hayfever
Loratadine 5mg/5ml syrup 100ml
Loratadine 10mg tablets 30
Sodium cromoglicate 2% eye drops 5ml (Opticrom Aqueous 2% eye drops 5ml)
Hay Fever O16
Chlorphenamine 4mg tabs (28 pack) for hayfever
Cetirizine 10mg tabs (30)
Beclometasone 50mcg nasal spray (100 doses) (Beconase Pollenase aqueous spray)
Sodium cromoglicate 2% eye drops 5ml (Opticrom Aqueous 2% eye drops 5ml)
Heartburn/Indigestion O16
Gaviscon Advance tabs (24)
Peptac liquid aniseed/peppermint 500ml
Ranitidine 75mg (12)
Headlice
Hedrin Lotion (Dimeticone) 50ml/150ml
Derbac-M liquid (malathion 0.5% in an aqueous basis)150ml
Haemorrhoids O16
Anusol Ointment (25g)
Anusol suppositories (12)
Anusol Plus HC ointment (15g)
Anusol Plus HC suppositories (12)
Infant Decongestant U16
Normal Saline Nose Drops 0.9% (10ml pack) For Infant Decongestant
Mouth Ulcers and Teething U16
Anbesol Teething Gel
Paracetamol 120mg/5ml s/f susp100ml
Mouth Ulcers O16
Bonjela original gel (15g)
Chlorhexidine 0.2% mouthwash (300ml)
Nappy Rash U16
Clotrimazole 1% cream (20g pack) for Athletes Foot/ Infected Nappy Rash
Conotrane 100g cream

Oral Thrush U16
Miconazole Oral gel 2% (15g)
Oral Thrush O16
Miconazole Oral gel 2% (15g)
Scabies U16
Permethrin 5% Dermal Cream (30g pack) For Scabies
Chlorphenamine 4mg tabs (30) for hayfever
Chlorphenamine syrup s/f 2mg/5ml (150ml) For Hay Fever
Scabies O16
Permethrin 5% Dermal Cream (30g pack) For Scabies
Chlorphenamine 4mg tabs (30) for hayfever
Crotamiton 10% cream (30g)
Sore Throat O16
Ibuprofen 200mg tablets (24)
Benzydamine 0.15% oromucosal spray SF (30ml)
Sprains and Strains O16
Paracetamol 500mg tabs (32)
Ibuprofen 5% gel (100g)
Ibuprofen 200mg tablets (24)
Sunburn U16
Calamine cream (aqueous) (100g pack) For Sunburn
Threadworm U16
Mebendazole 100mg tablet (1 pack) For Threadworm
Threadworm O16
Mebendazole 100mg tablet (1 pack) For Threadworm
Vaginal Thrush O16
Clotrimazole 2% cream (20g)
Clotrimazole 500mg pessary (1)
Fluconazole 150mg oral cap (1)
Warts and Verrucas U16
Salactol Topical Paint (10ml pack) For Warts and Verrucas
Warts and Verrucas O16
Salactol Topical Paint (10ml pack) For Warts and Verrucas

Appendix Four – Treatment Protocols

ACUTE COUGH U16

Definition	Coughing arising from a defensive reflex mechanism. The cough may be productive (chesty)where phlegm is produced or non-productive (dry), with no phlegm. Cough can be acute (lasting less than 3 weeks), sub-acute (lasting 3–8 weeks), or chronic (lasting more than 8 weeks). Acute cough is most commonly caused by a viral upper respiratory tract infection.
Criteria for Inclusion	• Child presenting with onset of cough within the last seven days. • Children under 1 year can be treated at the pharmacist's discretion.
Exclusion Criteria	• Severe pain when coughing - including chest or shoulder painPresence of blood in phlegm • Presence of green/rusty phlegm • Asthmatic patients reporting wheeze or shortness of breath or those with severe disease. Check for worsening symptoms of asthma. • If cough symptoms have persisted beyond 3 weeks, No sign of improvement after 3 - 4 weeks orcontinual worsening of symptoms • Breathing difficulty Pain related to exertion • Moderate to severe hepatic or renal impairment. • Unexplained weight loss – Presenting over the previous 6 weeks • Voice changes – Hoarseness lasting from more than 3 weeks or continuing after the cough has settled New lumps or swellings – Located anywhere in the neck or above the collarbone • Wheezing • Recurrent night time cough
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Simple linctus s/f paediatric(200ml) 1-5 years	PO	GSL	5mls up to four times a day whenrequired
Simple linctus s/f paediatric(200ml) 6-12 years	PO	GSL	10mls up to four times a day whenrequired
Simple linctus BP s/f (200ml) 12-16 years	PO	GSL	5mls up to four times a day whenrequired

Red Flag Symptoms (When to refer)

Conditional referral

- General aches and pain, sore throat, sneezing or runny nose – probably a viral infection If cough persists beyond 3 weeks
- Tender swellings around the jaw and neck – probably swollen glands (analgesic and plenty of cool drinks) Fever (refer to acute fever protocol)

- If the cough does not improve over a few days, gets worse, or they develop warning symptoms such as coughing up green/rusty phlegm orblood in the phlegm then they should seek further advice from NHS 111 or GP.

Rapid Referral

- Severe shortness of breath or a blue tinge to the lips or severe pain in the chest – Dial 999
- Toxic fumes such as ammonia or industrial chemicals have recently been breathed in – call NHS 111 or contact the GP
- Very high temperature or shortness of breath along with a cough should be referred to rule out a diagnosis of pneumonia
- Fit of coughing due to obstruction of the airways (e.g. after swallowing food) – call NHS 111 or contact the GP

References

- https://cks.nice.org.uk/topics/cough/
- https://cks.nice.org.uk/topics/cough/management/management/
- https://www.medicines.org.uk/emc/product/2810/smpc
- https://www.medicines.org.uk/emc/product/4928/smpc

COVID-19 — follow the Public Health England advice for managing people with COVID-19 in primary care. For information on management, see the CKS topic on Coronavirus - COVID 19.
https://cks.nice.org.uk/topics/coronavirus-covid-19/

Acute Cough O16	
Definition	Coughing arises as a defensive reflex mechanism. Cough can be acute (lasting less than 3 weeks), sub-acute (lasting 3–8 weeks), or chronic (lasting more than 8 weeks).Acute cough is most commonly caused by a viral upper respiratory tract infection.
Criteria for Inclusion	Adults and children over 1 year experiencing a troublesome cough requiring soothing. The cough may be productive (chesty) where phlegm is produced or non-productive (dry), with no phlegm.
Recommended Treatments and Quantity to supply	
Chesty cough:	Simple linctus s/f (200mls) 5mls up to four times a day when required
Criteria for Exclusion Red Flag Symptoms (When to refer)	• Cough productive with green or yellow sputum • Asthmatics presenting with wheeze or reduced peak flow • Chest pain or shortness of breath • COPD • Chronic bronchitis • Recurrent nocturnal cough • Failed medication
Rapid Referral	• Difficulty breathing • Shortness of breath • Chest pain • Pain related to exertion • Rusty or blood-stained sputum • Very high temperature or shortness of breath along with a cough should bereferred to rule out a diagnosis of pneumonia • Whooping cough or croup • Refer people with an acute cough to hospital if they have any symptoms or signs suggesting a more serious illness or condition (for example, sepsis, a pulmonary embolism or lung cancer).
Follow-up Advice	• Conditional referral: • Refer to GP if cough persists beyond three weeks • Consider supply but advise patient to make a GP appointment: • A dry cough in patients prescribed an ACE InhibitorCounselling Points: • A cough is commonly associated with an upper respiratory infection and isusually mild and self-limiting, often resolving in around three weeks • There is no good evidence for or against the effectiveness of coughpreparations • Avoid smoking or smoky atmospheres. If a smoker - counsel or • Signpost to smoking cessation service • Maintain adequate fluid intake with a chesty cough • See GP or ring NHS 111, if symptoms worsen rapidly or significantly, do not improve in 3–4 weeks, or become systemically very unwell.
References	• Clinical Knowledge Summaries. Cough management. Last revised in May 2021 Available at:https://cks.nice.org.uk/topics/cough/management/management/ • Refer to SPC for individual product information http://emc.medicines.org.uk • https://www.nice.org.uk/guidance/ng120/chapter/Recommendations#referral-and-seeking-specialist-advice

COVID-19 — follow the Public Health England advice for managing people with COVID-19 in primary care. For information on management, see the CKS topic on Coronavirus - COVID 19.
https://cks.nice.org.uk/topics/coronavirus-covid-19/

ACUTE FEVER U16	
Definition	• Feeling of hotness in the body and temperature more than the normal (over 38°C/100.4F). Symptoms may include flushing and feeling sweaty.
Criteria for Inclusion	• Child presenting with feeling of hotness, flushing or feeling sweaty. Children under 1 yr can be treated at the pharmacist's discretion. • Children under 5 years – refer to latest NICE guidance (Fever in under 5s overview, NICE Pathway, online interactive flowchart)
Exclusion Criteria:	• Shortness of breath or difficulty in breathing • Concomitant rash that does fade on pressing, e.g. with glassSevere headache or continuous vomiting • Ibuprofen contra-indicated in patients with hypersensitivity to NSAIDsWorsening of asthma symptoms with NSAID previously • A body temperature over 38°C in children age 0-3 months or over 39°C in children age 3-6 months. • A child brings up dark-green vomit. • If a child looks pale, ashen, mottled or blue. • Premature child - Child born prematurely and less than 3 months of age • Response - Child does not respond normally and wakes only with difficulty, appears ill or does not smile • Unusual crying - Cries in an unusual way – weak, high pitched or continuous cry • Breathing - Breathing much faster than usual, flared nostrils, skin between the ribs or the area just below the rib cage moves abnormally during breaths • Abnormal grunting • Hydration - Child does not eat or drink much and does not pass much urine, nappies remain dry, fontanelle is bulging or sunken • Non-blanching rash – rash that does not fade on pressure • Other signs - Neck stiffness (not being able to touch chin to chest), cold limbs or fitting, other unexplained or unusual symptoms • As per NICE guidelines enclosed for children under 5 years
Action for Excluded patients:	Refer to GP or NHS 111

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	**Route**	**Class**	**Dose**
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months 6-24 months 2-4 years 4-6 years			60mg qds prn 120mg qds prn 180mg qds prn 240mg qds prn
Paracetamol suspension s/f 250mg/5ml	**PO**	**P**	
6-8 years 8-10 years 10-15 years			250mg qds prn 375mg qds prn 500mg qds prn

Paracetamol tablets 500mg (32 tabs)	**PO**	**GSL**	
12-15 years			500mg qds prn
Ibuprofen oral suspension s/f 100mg/5ml (100ml)	**PO**	**P**	
1-3 years 4-6 years 7-9 years			100mg 3 times daily 150mg 3 times daily200mg 3 times daily
10-12 years			300mg 3 times daily
Ibuprofen tabs 200mg (32)	**PO**	**P**	
12-16 years			200-400mg 3 times daily

Follow Up and Advice	**Side effects and Management**
• Use regular analgesic to reduce the temperatureIncrease fluid intake • Wear light clothing • • Make sure that the room temperature is not too warmCheck your child at night for signs of serious illness	• Very rare with paracetamol but rashes and blood disorders reported. If affected patients should stop paracetamol immediately and contact their GP. • Ibuprofen – avoid ibuprofen in children with chickenpox. the use of NSAIDs in children withvaricella is associated with an increased risk ofnecrotizing soft-tissue infections and infectionswith invasive group A beta-haemolytic streptococci • Side effects include GI irritation, hypersensitivityreactions (rashes, bronchospasm or angiooedema), fluid retention. If side effects occur advise patient to stop ibuprofen and • contact their GP or pharmacist.

Red Flag Symptoms (When To Refer)

Conditional referral

- General aches and pain, sore throat, sneezing or runny nose – probably a viral infection Earache (refer to management of earache protocol)
- Diarrhoea (refer to management of acute diarrhoea protocol)
- Tender swellings around jaw and neck – probably swollen glands (analgesic + plenty of cool drinks)

Consider supply, but patient should be advised to make an appointment to see a GP if:

- Patient is difficult to wake, not keeping fluids down or light hurts the eyes Fever has lasted more than 5 days
- Difficulty in breathing
- Patient has recently travelled abroad Severe headache or continuous vomiting
- New symptoms develop, or existing symptoms worsen

Rapid Referral

- Concomitant rash that does not fade on pressing, e.g. with glass
- Feverish illness in children

Drug interventions to reduce body temperature

- - Consider using either paracetamol or ibuprofen in children with fever who appear distressed.
- Do not use antipyretic agents with the sole aim of reducing body temperature in children with fever.

- When using paracetamol or ibuprofen in children with fever: continue only as long as the child appears distressed consider changingto the other agent if the child's distress is not alleviated.
- Do not give both agents simultaneously, only consider alternating these agents if the distress persists or recurs before the next dose is due.
- Advise parents or carers looking after a feverish child at home:
- Check the child's temperature In children aged between four weeks and five years, use either an electronic or chemical dot thermometer in the child's arm pit, or an infra-red tympanic thermometer in the ear canal.
- To offer the child regular fluids (where a baby or child is breastfed the most appropriate fluid is breast milk)

How to detect signs of dehydration by looking for the following features:

- sunken fontanelle
- dry mouth
- sunken eyes
- absence of tears
- poor overall appearance
- to encourage their child to drink more fluids and consider seeking further advice if they detect signs of dehydration

How to identify a non-blanching rash

- To check their child during the night for signs of serious illness

Following contact with a healthcare professional, parents and carers who are looking after their feverish child at home should seek further advice if:

- The child has a fit
- The child develops a non-blanching rash
- The parent or carer feels that the child is less well than when they previously sought advice The parent or carer is more worried than when they previously sought advice
- The fever lasts longer than 5 days
- The parent or carer is distressed or concerned that they are unable to look after their child.

References

- https://pathways.nice.org.uk/pathways/fever-in-under-5s

Acute Bacterial Conjunctivitis U16

Definition	Acute inflammation of the conjunctiva. An infectious condition usually affecting both eyes. Patients with bacterial conjunctivitis may present with the following symptoms; Creamy white or yellow discharge, swelling, redness, watering eyes, irritated and/or a gritty feeling.
Criteria for Inclusion	Patients presenting with symptoms of bacterial conjunctivitis.
Criteria for Exclusion	• Children under 2 years of age • Patients presenting with symptoms of conjunctivitis, which are accompanied by pain, and/or disturbance of vision and patients with allergic conjunctivitis. • Patients with glaucoma, dry eye syndrome or those patients who have had eye surgery or laser treatment in the past six months. • Patients with symptoms for more than 2 weeks. • Foreign body in the eye, pupil looks unusual, associated pain, swelling or redness around the eye Patients with contact lenses are prone to infections and should be referred to an optometrist or doctor. Contact lenses should not be worn during an eye infection and soft contact lenses should not be worn for 24 hours after the course of chloramphenicol drops is complete. • Known hypersensitivity to chloramphenicol
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Chloramphenicol 0.5% eye drops	Topical	P	One drop to be instilled every two hours for the first 48 hours, then one drop every four hours for a further three days. For further details see the information leaflet with the pack

Follow Up and Advice	Side effects and Management
• Inform the patient about how to instil the eye drops. Provide a PIL. • The importance of good hygiene should be stressed including the following; washing the hands before and after touching an infected eye, not to share towels, facecloths or make-up as this will help to minimise the spread of this infectious condition. • Discard the remaining chloramphenicol after the 5-day treatment course.	• Serious side effects include hypersensitivity reactions, and treatment must be discontinued in such cases. Sensitivity reactions such as irritation, burning, stinging, itching or dermatitis

• If the symptoms do not improve within two days of treatment, the patient should be referred to an optometristor doctor. • The patient should be advised to wash their hands before and after administration of the eye drops.	

Red Flag Symptoms (When To Refer)

Conditional referral

- If the symptoms do not improve within two days of treatment, the patient should be referred to an optometrist or doctor

Rapid referral

- If the symptoms do not improve within two days of treatment, the patient should be referred to an optometrist or doctor
- Patients with pain in their eyes
- Patients with sensitivity to light (photophobia) Patients with intense redness in one or both eyes
- Patients with associated vesicular rash which may indicate herpes zoster infection Patients with affected vision or severe pain in the eye
- Patients with glaucoma or dry eye syndrome
- Patients who have had eye surgery or laser treatment in the past 6 months
- Features of a serious cause of “Red eye” e.g. photophobia, irregular pupil shape, severe pain
- Copious discharge (that re-accumulates after being wiped away), which may indicate hyperacute conjunctivitis.

Acute Bacterial Conjunctivitis O16	
Definition	Acute inflammation of the conjunctiva (membrane covering the white of the eye and the inside of the eyelid) of the eye. It is characterised by irritation, itching, a sensation of grittiness in the eye, watering or sticky discharge, blurred vision due to the discharge that clears with blinking
Criteria for Inclusion	• Adults and children over 2 years old where a bacterial infection is suspected. • No history of recent episode of conjunctivitis.
Red Flag Symptoms When to refer	• Contact lens wearers (without approval of an optometrist) • Users of other prescribed eye drops or ointment • Dry eye syndrome or Glaucoma or Eye Injury/Eye Surgery in the last 6 months • Atypical symptoms ofconjunctivitis • Suspected foreign body in the eye • Photophobia • Where vision has been affected • Severe pain within the eye / swelling around the eye / restricted eye movement • Unusual looking pupils or cloudy cornea • Pregnancy / Breastfeeding • Recent trip abroad • Patient feels generally unwell • Previous conjunctivitis in the recent past • Hypersensitivity to chloramphenicol or to any other ingredients to the eye drops • Pupil fixed and mid-dilated or distorted from previous attacks • Family history of blood dyscrasias • Patients who have experienced myelosupression during previous exposure to chloramphenicol • Copious discharge that re-accumulates after being wiped away • Patient taking bone marrow suppressant drugs • Enlarged lymph nodes in front of the ears (associated with Chlamydia / adenoviral type) • Eye inflammation associated with a rash on the scalp or face.
Recommended Treatments and Quantity to supply	• Chloramphenicol 0.5% eye drops (10mls) One drop to be instilled every two hours for the first 48 hours, then one drop every four hours for a further three days • Chloramphenicol 1.0% eye ointment (4g) 1 drop four times a day and at night

Follow-up Advice Counselling Points	• Consult GP if no signs of improvement after 48 hrs or symptoms worsen • Correct administration of eye drops • Wash hands thoroughly and avoid sharing towels / facecloths as eye infection is highly contagious • Course of eye drops is for 5 days even if symptoms improve • The ointment is a viscous option possibly preferable when treating the young or elderly • Patients may experience a transient burning or stinging sensation with treatment • Hypersensitive reactions possible though rare • A cold compress may soothe the eye • Store the eye drops in a refrigerator and discard the drops/ointment after 5 days use • Blurred vision can occur, do not drive or operate machinery unless vision is clear.
References	• Clinical Knowledge Summaries. Conjunctivitis – Infective –Management. June 2021.Available at: http://cks.library.nhs.uk/conjunctivitis_infective • Refer to SPC for individual product information http://emc.medicines.org.uk

Acute Pain / Earache/ Headache /Temperature O16	
Definition	Pain is a subjective experience, its nature and location may vary considerably. Acute pain is often transient and with treatment directed at the cause and/or short-term pain relief, pain will usually disappear
Criteria for Inclusion	• Patients requiring relief of acute pain for e.g. dental pain, earache, migraine, tension headache, soft tissue injuries • Patients requiring relief of pain/fever associated with upper respiratory tract infections for e.g. head cold
Red Flag Symptoms (When to refer)	• Symptoms persisting for longer than 48 hours
	• Patients who appear to be abusing analgesics or chronic daily headache caused by analgesic dependence • Newly suspected migraine • Pregnancy / Breast feeding • Discharge from ear • Evidence of foreign body
Rapid Referral	• Suspected meningitis – vomiting, fever, stiff neck, light aversion, drowsiness, joint pain, fitting and rash • Rapid referral for any neurological symptoms and headache associated with any recent head trauma
Recommended Treatments and Quantity to supply	Paracetamol 500mg tablets (32) 1-2 tablets up to four times a day Ibuprofen 200mg tablets (24) 1-2 tablets up to four times a day For adults and children aged over 16 years, a stepwise strategy for managing mild-to-moderate pain is recommended: • Step 1 — paracetamol should be used. • Step 2 — paracetamol should be substituted with ibuprofen or, if ibuprofen is unsuitable
Follow-up Advice	• Conditional referral to GP: • Pain that does not respond to treatment • Patients experiencing pain more severe than that experienced previously or pain which is increasing in severity • over several days with no apparent reason

Counselling Points	• If a supply is made, the following information should be provided where applicable: • A maximum of four doses of Paracetamol can be administered in any 24 hour period to any age group • Ibuprofen should be taken with or immediately after food. If food cannot be eaten, a glass of milk should be consumed before the medication • Normal body temperature is 37°C or 98.6°F • Fever is a natural defence mechanism to an infection by a virus or bacteria • Fever should be treated with temperature reducing methods such as tepid bathing and patientsshould be advised to drink plenty of non-alcoholic fluids • Various non-pharmacological measures that can be used to aid pain relief, depending on the cause, for e.g. rest, heat, cold, massage • Consider rest, ice, compression and elevation (RICE) for soft tissue injuries • Avoidance of aggravating factors, for e.g. tyramine containing foods in cases of migraine
References	• Clinical Knowledge Summaries. Analgesia - mild-to-moderate pain https://cks.nice.org.uk/analgesia-mild-to-moderate-pain <Last revised in August 2020>

Athlete's Foot U16

Definition	Athlete's foot is a cutaneous fungal infection caused by tinea Pedis on the skin. It is characterized by itching, flaking and fissuring of the skin, often between the toes
Criteria for Inclusion	• A suspected symptomatic fungal infection of the foot which is characterised by macerated skin between the toes. • Often this is associated with itchiness. Children aged under 1 year can be treated at the Pharmacists discretion.
Criteria for Exclusion	• If toenails are black and discoloured • If fungal infection has spread under the nails • If the fungal infection has spread to other parts of the body • If unsure if it is athlete's foot (e.g. possibility of eczema, psoriasis etc) • Diabetes
Action for Excluded patients:	Patients may be referred to a to a GP practice if considered necessary by the pharmacist.

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Clotrimazole 1% cream 20g	Topical	P	Apply to the affected area 2–3 times a day and continue for at least 4 weeks. A strip of cream about half a centimetre long is enough to treat an area about the size of the hand.

Follow Up and Advice	Side effects and Management
• Make an appointment to visit the GP Practice if symptoms do not improve within 7 days • Cream may sting on application To be applied thinly • Advise patient to use dusting powder in shoes and socks as an additional measure Wash and dry feet thoroughly, especially between the toes. • Do not share towels, and wash them frequently. • Avoid scratching affected skin as this may spread the infection to other sites. Maintain good foot hygiene by wearing a different pair of shoes every 2–3 days. • Wear protective footwear when using communal bathing places, locker rooms, and gymnasiums, to reduce the risk of transmission. • Wearing clean wool or cotton socks allows the skin to breathe and can reduce the moisture that is kept in contact with the skin.	• Redness, itching and scaling. • Rarely allergic reaction. If this occurs discontinue treatment

• Provide information on sources of advice and support, such as: • The NHS information on Athlete's foot: https://www.nhs.uk/conditions/athletes-foot/ • The Patient information leaflet Athlete's foot (Tinea pedis) available on the www.patient.info website	

Red Flag Symptoms (When To Refer)

Conditional referral:

On 3rd occurrence consider supply, but advise patient to make an appointment with the GP if the patient has or is suspected of having any of the following:

- Eczema/Psoriasis
- Diabetes Candidiasis Bacterial Infection

Rapid referral:

- Signs of generalised infection especially if immunocompromised
- Toenails becoming black or discoloured
- If fungal infections start to spread under the nails or to other areas of the body

References:

- https://cks.nice.org.uk/fungal-skin-infection-foot#!prescribingInfoSub
- https://cks.nice.org.uk/topics/fungal-skin-infection-foot/management/management/

Athlete's foot O16	
Definition	Tinea Pedis – fungal infection of the foot
Criteria for Inclusion	Patients requiring relief of red itchy broken skin at first, later turning white with maceration and soreness between toes. Transmission occurs by walking barefoot on floors or carpets contaminated with infectious desquamated skin scales, always involves the interdigital space of the foot but may spread to sole and upper foot.
Red Flag Symptoms (When To Refer)	• Toenails becoming black or discoloured. Fungal infection starts to spread under the nails or to other areas of the body • If Infection is severe and extensive • Evidence of bacterial infection/history of eczema • Diabetic patients • Persistent infection not responsive to treatment • Pregnancy and breastfeeding
Rapid Referral	• Any patients presenting with symptoms of cellulitis (i.e. spreading redness, pain and tenderness)
Recommended Treatments and Quantity to supply	Clotrimazole cream 1% (20g) Apply to the affected area 2–3 times a day and continue for at least 4 weeks. A strip of cream about half a centimetre long is enough to treat an area about the size of the hand.
Follow-up Advice	Advise if symptoms do not begin to resolve within 2 weeks to make an appointment to see a GP
Counselling Points	• Feet should be washed and dried thoroughly, especially between toes, before applying the cream. • Advise patient to use dusting powders in shoes and socks as a preventative measure, since boiling socks will not kill fungal spores. • Wear footwear that keeps the feet cool and dry. • Wear cotton socks. • Maintain good foot hygiene by wearing a different pair of shoes every 2–3 days. After washing, dry the feet thoroughly, especially between the toes. • Do not share towels and wash them frequently. • Avoid scratching affected skin as this may spread the infection to other sites. • Avoid going barefoot in public places (for example use protective footwear such as flip-flops in communal changing areas). • Provide information on sources of advice and support, such as: • The NHS information on Athlete's foot: https://www.nhs.uk/conditions/athletes-foot/

	• The Patient information leaflet Athlete's foot (Tinea pedis) available on the www.patient.info website
References	• Refer to SPC for individual product information http://emc.medicines.org.uk • Clinical Knowledge Summaries. Fungal skin infection – foot - management. Last revised in April 2018. Available at: https://cks.nice.org.uk/topics/fungal-skin-infection-foot/management/management/

Bites and Stings U16

Definition	Irritation and inflammation where the skin has been bitten, small extremely itchy popular lesions usually seen
Criteria for Inclusion	Patients bitten or stung by small insects, displaying localised minor irritation to the skin
Criteria for Exclusion	• Children under 2 years old • Bites or stings around the eyes or on the face Bites or stings which have become infected Pregnancy • Patients exhibiting systemic effects, e.g. wheezing, shortness of breath, major swelling & redness
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Hydrocortisone 1% cream (15g)	Topical	P	Children at 10 years and over –apply sparingly once or twice a day for seven days
Chlorphenamine 4mg tabs (x28)	PO	P	Children over 12 years old: 1 tablet QDS
Chlorphenamine syrup 2mg/5mlss/f 150mls	PO	P	Child 1 –2 years: 1 mg BD Child 2–6 years: 1 mg QDS Child 6–12 years 2 mg QDS
Mepyramine maleate 2% cream (20g) (Anthisan®)	Topical	GSL	Children over 2 years: Apply three times a day for 3 days

Follow Up and Advice

- A cold compress can reduce pain and swelling
- Repeated application of mepyramine cream 2% to the same area for longer than three days is not recommended. Anthisan can cause localised skin reactions. Anthisan contains Ceto-stearyl alcohol and castor oil. These may cause local skin reactions (such as "contact dermatitis" which may include the following symptoms: skin redness, swelling and itching, pain or burning sensation). Methyl hydroxybenzoate in Anthisan may cause an allergic reaction.
- Wash the affected area frequently with soapy water to prevent infection
- Avoid insect bites by wearing loose clothing with long arms and legs Educate children to avoid unknown insects
- For bee stings, scrape out the sting
- If bites are thought to be due to infestation, advice that the source needs to be eradicated, for example, pest control services should be contacted for control of bedbug infestations.
- Advise people who have had a systemic reaction to an insect sting to consider carrying a medical identification bracelet or necklace.
- People who have had a previous severe systemic reaction and have been supplied with an adrenaline auto-injector (AAI) should be aware that they should seek emergency medical attention if they need to use their AAI, as these are not a substitute for emergency medical attention.

Side effects and Management
• Hydrocortisone cream should not be applied to the face, anogenital region, broken orinfected skin. • Sensitivity to hydrocortisone cream -discontinue treatment
RED FLAG SYMPTOMS (When to refer)
• If symptoms persist for more than 7 days • If the patient has had a previous systemic allergic reaction from the same bite or sting. • If the patient has a fever or persisting lesions from a bite or sting from an insect outside the UK. • If the patient been stung by an insect which is unsual or from a tropical or subtropical locale. • Patients exhibiting systemic reactions. • Patients experiencing severe allergic reactions must be referred to A&E. • Patients should be advised to seek further assistance from NHS 111 or GP if symptoms worsen
References
• https://cks.nice.org.uk/topics/insect-bites-stings/ • https://www.medicines.org.uk/emc/product/4600/smpc • https://www.medicines.org.uk/emc/product/20/smpc

Bites and Stings O16	
Definition	Itching, inflammation or irritation around the site of an insect bite or sting requiring symptomatic treatment.
Criteria for Inclusion	Evidence of local itching, erythema and swelling at the site of the insect bite/sting
Red Flag Symptoms (When To Refer)	• Suspected secondary bacterial infection as a result of scratching or may be • introduced at the time of the bite. It can present as impetigo, folliculitis, cellulitis or lymphangitis. • Pregnancy / Breastfeeding • Insect bite with fever • Affected area is face or anogenital region
Rapid Referral	• If the patient experiences shortness of breath or fever or symptoms of shock • If sting or bite is in the mouth, suck an ice cube or sip cold water and seekmedical attention • If the patient is having symptoms of a severe allergic reaction i.e. swollen lipsand eyelids / difficulty breathing / becoming pale and faint / increased generalised itchiness / aches and pains / feeling unwell, an ambulance should be called. • If the patient has had a previous systemic allergic reaction from the same bite or sting. • If the patient has a fever or persisting lesions from a bite or sting from an insect outside the UK. • If the patient been stung by an insect which is unusual or from a tropical or subtropical locale.
Recommended Treatments and Quantity to supply	Crotamiton 10% cream (30g) Apply to the affected areas up to three times a day Hydrocortisone 1% cream (15g) Apply to the affected areas up to twicetimes a day for nor more than 7 days Chlorphenamine 4mg tablets (30) Take 1 tablet up to four times a day whenneeded Cetirizine 10mg tablets (30) Take 1 tablet once a day as needed
Follow-up Advice	Conditional referral to GP: • Refer to the GP if bite becomes larger in size and redness spreadsConsider supply but advise patient to make an appointment with GP • Known allergy to bites or stings

Counselling Points	• Advise patient on side-effects caused by the drug(s). • Wash the area with soap and water • If there has been a wasp or bee sting the sting should be carefully removed fromthe • skin, trying to scrape it out rather than grabbing it (to avoid squeezing venom intothe skin) • Do not scratch the area, as this will make itch worse and increase risk of infection Apply a cold compress to reduce swelling If present • Use of insect repellent products for future potential exposure • Bites from fleas, mites and bedbugs may be due to an infestation – source shouldbe confirmed and eliminated. • If bites are thought to be due to infestation, advice the person that the source needs to be eradicated, for example, pest control services should be contacted for control of bedbug infestations. • Contact GP, If symptoms worsen or do not improve after 7 days of using Hydrocortisone Cream. • Advise people who have had a systemic reaction to an insect sting to consider carrying a medical identification bracelet or necklace. • People who have had a previous severe systemic reaction and have been supplied with an adrenaline auto-injector (AAI) should be aware that they should seek emergency medical attention if they need to use their AAI, as these are not a substitute for emergency medical attention.
References	• Clinical Knowledge Summaries. Insect bites and stings - Management. November 2011. Available at: http://cks.library.nhs.uk/insect_bites_and_stings <Last revised in September 2020> • Refer to SPC for individual product information at http://emc.medicines.org.uk

Cold Sores U16	
Definition	Infection with Herpes Simplex Virus (HSV) causing pain and blistering (fluid filled blisters) on or around the lips After primary infection, the virus lies dormant until triggered by a stimulus such as sunlight, impaired immunity, stress, upper respiratory infections.
Criteria for Inclusion	Patients who present with painful fluid filled blisters or tingling on or around the lips with a previous history of HSV (first suspected cold sore included).
Red Flag Symptoms (When To Refer)	• Children under age of 2 • Immunocompromised individuals • Sores not present on or around the lips • Severe frequent recurrence • Evidence of secondary bacterial infection for e.g. weeping pustules • Refer urgently to A&E, if the person is unable to swallow or is dehydrated; is immunocompromised with severe infection; or a serious complication is suspected.
Recommended Treatments and Quantity to supply	Aciclovir 5% cream (2g) Apply to affected sore five times a day at approximately 4 hour intervals (omitting the night time application) for 5 days. Treatment should be continued for at least 4 days.
Counselling Points	• Consult GP if lesion is spreading or complicated with a secondary bacterial infection • Hands should be washed before and after each application of the cream toreduce the chance of spreading the infection • Cold sores are caused by a virus. It remains in the nerve between cold soresand cannot be cured • The recommendation that children with oral herpes simplex infection should not be excluded from nursery orschool is based on the PHE document Guidance on infection control in schools and other childcare settings • It is advisable not to share face cloths and towels • Cold sores should not be touched as this can spread infection • Cold sores often recur in the same place and can sometimes be linked to atrigger, such as UV light (advise sunscreen with SPF of 15 ormore). • Treatment should begin as soon as possible, recovery can take 10-14 days • Cold sores are infectious for about four days after symptoms start and can be transmitted by close personal contact • Cream should be applied to the lesions or impending lesions as soon as possible, preferably during the early stages (prodrome or erythema). Treatment can also be started during the later (papule or blister) stages.
References	• Clinical Knowledge Summaries. Herpes Simplex Oral – management. December 2007. Available at: http://cks.library.nhs.uk/herpes_simplex_oral <Last revised in October 2021> • Pinewood Healthcare. Summary of Product Characteristics. Aciclovir cream 2%. April 2011. Available at: http://www.medicines.org.uk/EMC/medicine/24479/SPC/Aciclovir+5++w+w+Cream/ April 2011.

Cold Sores O16	
Definition	Infection with Herpes Simplex Virus (HSV) causing pain and blistering (fluid filled blisters) on or around the lips After primary infection, the virus lies dormant until triggered by a stimulus such as sunlight, impaired immunity, stress, upper respiratory infections.
Criteria for Inclusion	Patients who present with painful fluid filled blisters or tingling on or around the lips with a previous history of HSV (first suspected cold sore included).
Red Flag Symptoms (When To Refer)	• Children under age of 2 • Immunocompromised individuals • Sores not present on or around the lips • Severe frequent recurrence • Evidence of secondary bacterial infection for e.g. weeping pustules • Pregnancy / Breast feeding • Refer promptly to A&E, if the person is unable to swallow or is dehydrated; is immunocompromised with severe infection; or a serious complication is suspected.
Recommended Treatments and Quantity to supply	Aciclovir 5% cream (2g) Apply to affected sore five times a day at approximately 4 hour intervals (omitting the night time application) for 5 days. Treatment should be continued for at least 4 days.
Counselling Points	• Consult GP if lesion is spreading or complicated with a secondary bacterial • infection • Hands should be washed before and after each application of the cream toreduce the chance of spreading the infection • Cold sores are caused by a virus. It remains in the nerve between cold soresand cannot be cured • Primary herpes labialis lesions usually resolve within 10-14 days of symptom onset without scarring • It is advisable not to share face cloths and towels • Cold sores should not be touched as this can spread infection • Cold sores often recur in the same place and can sometimes be linked to atrigger, such as UV light (advise sunscreen with SPF of 15 or more). • Treatment should begin as soon as possible, recovery can take 10-14 days • Cold sores are infectious for about four days after symptoms start and can be transmitted by close personal contact • Cream should be applied to the lesions or impending lesions as soon as possible, preferably during the early stages (prodrome or erythema). Treatment can also be started during the later (papule or blister) stages.
References	• Clinical Knowledge Summaries. Herpes Simplex Oral – management. Available at: https://cks.nice.org.uk/topics/herpes-simplex-oral/ <Last revised in October 2021> • Pinewood Healthcare. Summary of Product Characteristics. Aciclovir cream 2%.

	April 2011. Available at: http://www.medicines.org.uk/EMC/medicine/24479/SPC/Aciclovir+5++w+w+Cream/

COLD AND FLU U16

Definition	Nasal congestion, sneezing, mild temperature, sore throat, general aches and pains are associated with the common cold. Refer to other relevant protocols as appropriate. A normal temperature in babies and children is about 36.4C, but this can vary slightly from child to child. A high temperature is 38C or more.
Criteria for Inclusion	• Children presenting with cold or flu-like symptoms. • Children under 1 yr can be treated at the pharmacist's discretion.
Criteria for Exclusion	• Concomitant rash that does not fade under pressing e.g. with glass • Symptoms don't improve after three weeks or suddenlyget worse • Patient is breathlessLight hurts the eyes • It is painful to bend the neck • Raised temperature - Persistent raised temperature - (38°C and above) for longer than 3 daysSevere headache with vomiting or severe earache • Hearing - Problems develop with hearing • Confusion - Experiencing confusion or is disorientated • Coughing blood - Coughing up blood/blood stained mucus on more than one occasion Patients with a long-term condition • Patients finding it hard to breath or develop Chest painSevere difficulty swallowing or breathing difficulties Swelling of lymph nodes in neck and/or armpits • Particular care should be taken in those who have diabetes, heart disease, respiratory problems includingCOPD, kidney disease, and those with a compromised immune system
Action for Excludedpatients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Paracetamol suspension s/f120mg/5ml (100ml)	**po**	**P**	
• 3 months – 6months • 6-24 months • 2-4 years • 4-6 years			• 60mg qds prn • 120mg qds prn • 180mg qds prn • 240mg qds prn
Paracetamol suspension s/f250mg/5ml	**po**	**P**	
• 6-8 years • 8-10 years • 10-15 years			• 250mg qds prn • 375mg qds prn • 500mg qds prn
Pseudoephedrine Linctus 30mg/5ml(100ml)	**po**	**P**	

6-12 years 12 - 15 years	Not to be used for more than five days without the advice of a doctor. Parents or carers should seek medical attention if the child's condition deteriorates during treatment.		5ml tds -qds prn 10ml tds-qds prn
Paracetamol tablets 500mg (32tabs)	**po**	**GSL**	**1 tab qds prn**
12-15 years			500mg qds prn
Follow Up and Advice		**Side effects and Management**	
• Simple analgesics to bring temperature down • Maintain a good fluid intake • Encourage rest (if possible) • Saline nasal drops may help thin and clear nasal secretions in infants who are having difficulty with feeding and should be administered immediately before feeding • Sterile sodium chloride 0.9% nasal drops: One or two drops applied to the nostrils of infants has also been reported to help feeding. • Continue but note pseudoephedrine is from 6 years + and maximum qds dosage Warm soothing drinks • Common cold does not require antibiotics for effective treatment Remind high risk patients of influenza vaccination programmes • Protect yourself and others against cold and flu by taking the following actions: • Wash your hands regularly and properly especially after touching your nose or mouth and before handling food • Always sneeze and cough into tissues, use disposable paper towels to dry your hands and face rather than shared towels • Clean surfaces regularly • Drink – Drink plenty of fluids and get plenty of rest Avoid smoking or being around smoky atmospheres • The person or carer should be advised to use paracetamol or ibuprofen if needed. For children aged under 5 years, this should only be if the child has a fever and appears distressed. • When using paracetamol or ibuprofen in children with fever, advise the carer to: • Continue only as long as the child appears distressed. • Consider changing to the other agent if the child's distress is not alleviated. • Not to give both agents simultaneously. • Only consider alternating these agents if the distress persists or recurs before the next dose is due.		• Very rare with paracetamol but rashes and blood disorders reported. If affected patient should stop paracetamol immediately and contact their GP.	
Red Flag Symptoms (When To Refer)			
Conditional referral			

- If symptoms worsen or sinus pain developsPatient becoming breathless
- Painful to bend the neck or light hurts the eyes

Rapid Referral

- Development of a rash that does not fade when you press a glass tumbler against the rash.
- If a rash does not fade under a glass, it can be a sign of sepsis (sometimes called septicaemia or blood poisoning) caused by meningitis and should call 999 straight away.
- Advise parents or carers to to take child to A&E, if their child develops dehydration, laboured breathing, or prolonged fever.

References

- https://cks.nice.org.uk/topics/common-cold/management/management/
- https://www.nhs.uk/conditions/meningitis/symptoms/
- https://cks.nice.org.uk/topics/common-cold/
- https://www.nhs.uk/conditions/fever-in-children/

Colds/Flu-like symptoms O16	
Definition	Runny/blocked nose associated with colds and upper respiratory tract infections
Criteria for Inclusion	Congestion where seasonal allergy has been excluded
Red Flag Symptoms (When To Refer)	• Recurrent nose bleeds • Pregnancy / Breastfeeding • Patients with heart or lung disease e.g. chronic bronchitis • Patients with persistent fever and productive cough
Recommended Treatments and Quantity to supply	Paracetamol 500mg tablets (32) 1-2 tablets up to four times a dayIbuprofen 200mg tablets (24) 1-2 tablets up to four times a day Xylometazoline 0.1% Nasal Spray (10mls) One spray into EACH nostril up to three times a day Menthol and Eucalyptus inhalation (100mls) Add 5mls into hot (not boiling) water and inhale the vapour
Follow-up Advice **Conditional referral:**	• If symptoms worsen or sinus pain develops, consult GP • Steam inhalation with or without menthol & eucalyptus inhalationCounselling Points • Topical decongestants must only be used for a maximum of 7 days due to the risk of causing rebound congestion upon withdrawal • Saline nasal drops may help thin and clear nasal secretions in infants who are having difficulty with feeding and should be administered immediately before feeding • Reassure the person or carer that although symptoms may be distressing, the common cold is self-limiting and complications are rare. • The natural history of the common cold is rapid onset, with symptoms peaking after 2–3 days, and typically resolving after 7 days in adults and 14 days in younger children, although a mild cough may persist for 3 weeks. • No treatments are available that can cure the common cold and most treatments are not effective at relieving symptoms. • People should be advised to follow use instructions carefully and not to use multiple products, particularly those containing paracetamol, because of the risk of overdose. • Advise that the person should consult GP if: • Fever persists for more than 3 days. • Symptoms are worsening after 5 days. • Symptoms have not improved after 10 days (note: it is normal for mild cough and congestion to persist for up to several weeks). • Concerning symptoms emerge (such as increasing symptoms of illness, lethargy, decreased responsiveness, or difficulty breathing).
References	• Clinical Knowledge Summaries. Common cold - Management. Last revised in September 2021. Available at: https://cks.nice.org.uk/topics/common-cold/management/management/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Constipation U16

Definition	A reduced frequency of stools compared to the patient's normal bowel habits/ difficulty in passing stools or a sense of incomplete emptying after a bowel movement and abdominal discomfort
Criteria for Inclusion	Significant variation from normal bowel evacuation which has not improved following adjustments to diet and other lifestyle activities (see below)
Criteria for Exclusion	• New or worsening constipation with no explanation • Nausea/vomiting • Constipation associated with drugs • Rectal bleeding with change in bowel habit Severe abdominal pain • Unintentional weight loss Co-existing diarrhoea • Tenesmus (cramping rectal pain, giving the feeling that you need to have a bowel movement) Patients currently taking regular laxatives. • Failure of previous medicines
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

If constipation is confirmed, and underlying conditions are reasonably excluded, the first step in the management of constipation should be appropriate dietary and lifestyle changes. If this is ineffective or impractical, a short course of laxatives may relieve symptoms and restore normal bowel function.

Drug	Route	Class	Dose
Lactulose (300ml) Under 12 months old 1 year - 6 years 7 years - 14 years	**PO**	**P**	 2.5ml - 5ml daily 5 - 10ml daily 10 - 15 ml daily

Follow Up and Advice	Side effects and Management
• Drink plenty of water • Eat food rich in fibre e.g. fruit, vegetables, • Take regular exercise	• Advise patient that Lactulose may take up to 48hrs to work • Flatulence may occur initially

Red & Amber Flag Symptoms (When To Refer)

- Pregnancy and breastfeeding
- Laxative dependence
- Non-responsive to treatment
- Red flags suggest a serious underlying cause or condition. If any of the following are detected, refer the child urgently to A&E (the urgency depending on clinical judgement), and do not initiate treatment for constipation in primary care. They include:
- Symptoms of constipation appearing from birth or during the first few weeks of life — may indicate Hirschsprung's disease (congenital aganglionic megacolon).
- Delay in passing meconium for more than 48 hours after birth, in a full-term baby — may indicate Hirschsprung's disease or cystic fibrosis.
- Abdominal distention with vomiting — may indicate Hirschsprung's disease or intestinal obstruction.
- Family history of Hirschsprung's disease.

- Ribbon stool pattern — may indicate anal stenosis (more likely to present in a child younger than 1 year of age).
- Leg weakness or motor delay — may indicate a neurological or spinal cord abnormality.
- Amber flags also require referral for assessment. Children with these signs may be treated for constipation by GP whilst awaiting specialist assessment. They include:
- Evidence of faltering growth, developmental delay, or concerns about wellbeing, which may indicate a systemic condition — possible coeliac disease, hypothyroidism, cystic fibrosis, and electrolyte disturbance.
- Constipation triggered by the introduction of cows' milk — see the CKS topic on Cows' milk protein allergy in children for more information.
- Concern of possible child maltreatment — follow local child safeguarding procedures. See the CKS topic on Child maltreatment - recognition and management for more information.

Conditional referral

- If constipation persists beyond one week, consult the GP
- If more than one request per month

Rapid Referral

- New or worsening constipation without explanation
- Symptoms of blood in the stools, unexplained weight loss and nausea and vomiting, severe abdominal pain

References

https://cks.nice.org.uk/topics/constipation-in-children/diagnosis/red-amber-flags/

Constipation O16

Definition	Increased difficulty and reduced frequency of defaecation compared to what is normal for that person often accompanied by straining and the passage of hard, small stools. Abdominal discomfort, cramps or a feeling of incomplete emptying may be experienced.
Criteria for Inclusion	Patients experiencing significant variation from normal bowel evacuation, which has not improved following adjustments to diet and other lifestyle activities.
Recommended Treatmentsand Quantity to supply	Ispaghula 3.5g sachets (10) 1 sachet twice a day Senna 7.5mg tablets (20) 1-2 tablets at night Lactulose solution (300mls) Take 10mls twice a dayGlycerol suppositories 4g (12) Insert one as needed

Red Flag Symptoms (When To Refer)

- Constipation associated with drugs
- Patients currently receiving laxatives as regular medicationPossibility of intestinal obstruction
- History of cycling constipation and diarrhoea Recent changes in bowel habit in patients aged 55+
- Pregnancy unless constipation is related to pregnancyBreastfeeding
- Past history of allergy to medication listed below

Rapid Referral

- New or worsening constipation without explanation
- Symptoms of blood in the stools, unexplained weight loss and nausea andvomiting, severe abdominal pain
- Associated urinary symptoms, urinary incontinence or retention, dyspareunia.
- Any family history of colorectal cancer or inflammatory bowel disease.
- Any red flag symptoms or signs that may suggest a serious underlying cause, such as colorectal cancer. See the CKS topic on Gastrointestinal tract (lower) cancers - recognition and referral for more information. https://cks.nice.org.uk/topics/gastrointestinal-tract-lower-cancers-recognition-referral/

Follow-up Advice

- Conditional Referral:
- Consult GP if constipation persists beyond one weekConsult GP if patient is regularly requesting laxatives
- Consider supply but advise patient to make appointment with GP
- Patient taking medication with recognised constipating effects

Counselling Points

- Normal bowel frequency in the UK ranges from three times a day to once every three days; anything within this range is considered normal
- Constipation may occur at any age but is more common in women, the elderly, and during pregnancy.
- Lifestyle measures such as increasing fluid and fibre and increasing exercise levels are preferred and to prevent occurrence of further events. Drink six to eight glasses of water. Avoid drinks that are caffeine containing as this may worsen constipation.
- Regular doses of laxatives are rarely required and can cause a ‘lazy’ bowel
- Senna is a stimulant laxative, effects within 8 -12 hours so dose is usually taken at night - it may colour the urine red or yellow Ispaghula is a bulk forming laxative, requires adequate intake of fluid to

avoid obstruction, effects may take several days. It should betaken immediately before going to bed. Contraindicated if there is difficulty in swallowing.

- Lactulose is an osmotic laxative, can take 2 - 4 days to work
- Sources of information and support, such as:
- The NHS patient information leaflets on Constipation (https://www.nhs.uk/conditions/constipation/)and Bowel incontinence (https://www.nhs.uk/conditions/bowel-incontinence/)

References

- Clinical Knowledge Summaries. Constipation - Management. Last revised in September 2021. Available at: https://cks.nice.org.uk/topics/constipation/
- Refer to SPC for individual product information http://emc.medicines.org.uk

Cystitis O16	
Indication	Uncomplicated lower urinary tract infection (UTI) in non- pregnant women. Lower urinary tract infection (UTI) is an infection of the bladder (also known as cystitis) usually caused by bacteria from the gastrointestinal tract.
Criteria for Inclusion	Non-pregnant women aged 16 and over and under 65 with typical symptoms of uncomplicated urinary tract infection which include: burning sensation or pain in passing urine, and passing urine frequently
Recommended Treatments and Quantity to supply	Potassium Citrate sachets (6) Take 1 sachet three times a day for 2 days Sodium Citrate sachets (6) 1 sachet three times a day for 2 days Sodium agents are best avoided with cardiac disease or hypertension Potassium agents may cause hyperkalaemia with potassium-sparing diuretics, aldosterone antagonists, ACE inhibitors. Potassium Citrate also contraindicated in renal dysfunction, ventricular arrhythmics and Addison's Disease.
Red Flag Symptoms (When To Refer)	• Young girls under the age of 16 • Symptoms that don't start to improve within a few days • Women aged 65 and over • Male patients • Pregnant or Breast-feeding women • Elderly patients with confusion suggestive of UTI • Patients with indwelling catheters • Suspected diabetes • Presence of blood in the urine • Cramp like pain in lower abdomen • Vaginal discharge • Fever or vomiting • Recurrent cystitis • Red flags such as haematuria, loin pain, rigors, nausea, vomiting, and altered mental state — consider the possibility of serious illness such as sepsis.
Counselling Points	• Acute uncomplicated UTI usually resolves within a few days. • Patients can be referred to their GP or nurse if symptoms do not improve after course of treatment. • Increase fluid intake • Wipe front to back after going to the toilet to avoid transferring germs • Try to empty the bladder when urinating • Attacks may be precipitated by use of fragranced products • Passing water following intercourse may also prevent recurrent attacks

	• Paracetamol or ibuprofen may help to alleviate the pain or discomfort
References	• Clinical Knowledge Summaries. Urinary tract infection (lower) - women - Management. Last revised in June 2021. Available at: http://cks.nice.org.uk/urinary-tract-infection-lower-women • Refer to SPC for individual product information http://emc.medicines.org.uk

Dermatitis/Allergic Type Skin Rash U16	
Definition	Three main types: • Atopic – is an inflammation of the skin that tends to flare up from time to time and usually starts in childhood. This may occur in conjunction with asthma, hay fever or rhinitis. . Atopic eczema is a chronic, itchy, inflammatory skin condition that affects people of all ages, although it presents most frequently in childhood. Around 70–90% of cases occur before 5 years of age, with a high incidence of onset in the first year of life. • Irritant – occurs due to lack of natural oil in the skin caused by soaps, disinfectants, detergents or chemicals at work or at home • Allergic – mediated by an immune reaction to a substance which has made contact with the skin. The reaction occurs on subsequent exposures after the initial exposure. Examples of allergens include cosmetics, hair dyes, nickel, chromium and some plant.
Criteria for Inclusion	Superficial inflammation of the skin, causing itching, with a red rash.
Red Flag Symptoms (When To Refer)	• Signs of weeping, crusty skin or thickening of the skin • Seborrhoeic eczema or other types of eczema • If psoriasis is suspected or confirmed • Affected areas on the face, genitalia and armpits Infected eczema • No improvement after 10 days or sooner Rashes caused by prescribed medicines • Condition is severe and widespread (>20% of the body affected) • Untreated bacterial, fungal or viral skin lesions • If condition is worsening with increased oozing, crusting and redness • Where there is associated scabies
Rapid Referral	• Evidence of infection or angio-oedema • Severe condition of the area: badly fissured / cracked skin and/or bleeding • Weight loss – history of liver/kidney disease • Rapidly worsening, painful eczema; clustered blisters; and punched out erosions
Recommended Treatments and Quantity to supply	• Zeroderm ointment (500g) Apply to affected area when needed Emollients are the first-line treatments during both acute flares and remissions of the condition. • Hydrocortisone cream 1% (15g) Apply to the affected area up to three times a day Hydrocortisone cream can only be provided for patients aged 10 and over. Not for use on the face, broken skin or genital areas, only licenced for 7 days use OTC. The use of topical steroids should be considered for red, inflamed skin.

Counselling Points	• Advise if symptoms do not start to resolve within 7 days to make an appointment to see a GP • Avoid scratching (if possible), keep nails short (use anti-scratch mittens in babies) and rub with fingers to alleviate itch • Avoid trigger factors known to exacerbate eczema such as clothing • (do not wear synthetic fibres), soaps or detergents (use emollient substitutes), animals, and heat (keep rooms cool) • Provide education on the correct use of emollients and steroids: advise to apply the emollient first, wait 30 minutes before applying the topical corticosteroid. Also advise on the use of fingertip units. • Advise to use the emollient even if the condition improves
References	• Clinical Knowledge Summaries. Eczema – atopic – Last revised in July 2021. Available at: https://cks.nice.org.uk/topics/eczema-atopic/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Dermatitis/Allergic Type Skin Rash O16	
Definition	Three main types: • Atopic – an inherited condition. This may occur in conjunctionwith asthma, hay fever or rhinitis. Atopic eczema is a chronic, itchy, inflammatory skin condition that affects people of all ages, although it presents most frequently in childhood. Around 70–90% of cases occur before 5 years of age, with a high incidence of onset in the first year of life. • Irritant – occurs due to lack of natural oil in the skin caused by soaps, disinfectants, detergents or chemicals at work or at home • Allergic – mediated by an immune reaction to a substance which has made contact with the skin. The reaction occurs on subsequent exposures after the initial exposure. Examples of allergens include cosmetics, hair dyes, nickel, chromium and some plant.
Criteria for Inclusion	Superficial inflammation of the skin, causing itching, with a red rash.
Red Flag Symptoms (When To Refer)	• Signs of weeping, crusty skin or thickening of the skin • Seborrhoeic eczema or other types of eczema • If psoriasis is suspected or confirmed • Affected areas on the face, genitalia and armpits • Untreated bacterial, fungal or viral skin lesions • In cases of severe eczema in children under 12 years of age orpregnant women • Where there is associated scabies
Rapid Referral	• Evidence of infection or angio-oedema • Severe condition of the area: badly fissured / cracked skin and/or bleeding • Weight loss – history of liver/kidney disease • Rapidly worsening, painful eczema; clustered blisters; and punched out erosions
Recommended Treatments and Quantity to supply	• Zeroderm ointment (500g) Apply to affected area when needed Emollients are the first-line treatments during both acute flares and remissions of the condition. • Hydrocortisone cream 1% (15g) Apply to the affected area up to three timesa day Not for use on the face, broken skin or genital areas, only licenced for 7 days use OTC

	The use of topical steroids should be considered for red, inflamed skin.
Counselling Points	• Advise if symptoms do not start to resolve within 7 days to make an appointment to see a GP • Avoid scratching (if possible), keep nails short (use anti-scratch mittens in babies) and rub with fingers to alleviate itch • Avoid trigger factors known to exacerbate eczema such as clothing (do not wear synthetic fibres), soaps or detergents (use emollient substitutes), animals, and heat (keep rooms cool) • Provide education on the correct use of emollients and steroids: advise toapply the emollient first, wait 30 minutes before applying the topical corticosteroid. Also advise on the use of fingertip units. • Do not use hydrocortisone for more than 7 days • Advise to use the emollient even if the condition improves
References	• Clinical Knowledge Summaries. Eczema – atopic – Last revised in July 2021. Available at: • https://cks.nice.org.uk/topics/eczema-atopic https://cks.nice.org.uk/topics/dermatitis-contact/management/management/ Last revised in July 2018 • Refer to SPC for individual product information http://emc.medicines.org.uk

DIARRHOEA U16

Definition	Loose and/or watery motions occurring more than three times over 24 hours with or without fever or abdominal pain
Criteria for Inclusion	Children presenting with signs and symptoms of diarrhoea. Children under 1 yr can be treated at the pharmacist's discretion. SMPC advised "Infants under the age of 2 years with diarrhoea should be seen by a physician as soon as possible."
Criteria for Exclusion	• Dehydration, Recent travel, drowsiness or confusion, passing little urine Sickness/Vomiting, Loss of appetite, dry mouth and tongue, sunken eyes weakness, cool hands or feet, cool hands or feet, sunken fontanelle in babies/young infants • Child appears very poorly with or without high feverBloody diarrhoea with or without mucus • Frequent episodes of diarrhoea
Action for Excluded patients:	• Refer to GP or NHS 111 • Where applicable, continue breast feeding • Continue to offer as much fluids or oral rehydration fluids as possibleFor older children, avoid solid foods until appetite returns • Avoid cow's milk until diarrhoea settles down • Refer to GP where new medicines have been started in last two weeks and are suspected to be causing diarrhoea

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	**Route**	**Class**	**Dose**
Dioralyte sachets	**PO**	**GSL**	
3 months to under 2 years (see above)	PO (freshly boiled and cooled water)	GSL	1 - 1.5 times usual 24 hour feed volume
2 years - under 12 years	PO	GSL	1 sachet in 200mls boiled and cooled water after every loose motion. Max 12in 24 hours.
12 years - 16 years	PO	GSL	1- 2 sachets in 200 ml boiled and cooled water after every loose motion. Max 16in 24 hours.

Follow Up and Advice

- Simple analgesics to bring temperature down
- Maintain a good fluid intake, Encourage rest (if possible)
- If a high temperature develops and persists, or there is dehydration, or the condition deteriorates then refer to GP or contact NHS 111
- Avoid cow's milk until diarrhoea settles down
- Eat as normally as possible. Ideally include fruit juices and soups, which will provide sugar and salt, and also foods that are high in carbohydrate, such as bread, pasta, potatoes, or rice. There is little evidence to support the advice which used to be the given to avoid solid food for 24 hours.
- Always wash your hands after going to the toilet (or changing nappies).

- The solution should be made up immediately before use and may be stored for up 24 hours in a refrigerator, otherwise any solution remaining an hour after reconstitution should be discarded. The solution itself must not be boiled.

Red Flag Symptoms (When To Refer)

Conditional referral

- Bloody diarrhoea with or without mucus
- Consider supply, but patient should be advised to make an appointment to see a GP if:
- Where patient is becoming dehydrated, showing high temperature, provide Dioralyte sachets and advise on additional fluids and rest
- If diarrhoea has lasted over 48 hours and appears to be getting worsePoorly child
- Rapid Referral
- If child is very ill, then refer to GP or Paediatric Assessment Unit

Diarrhoea O16	
Definition	The frequent passing of watery stools Symptoms may include abdominal cramps and flatulence Acute diarrhoea is usually caused by a bacterial or viral infection. Other causes include drugs, anxiety, food allergy, and acute appendicitis. Acute diarrhoea is defined as lasting less than 14 days.
Criteria for Inclusion	Symptoms of sudden onset (acute diarrhoea)
Red Flag Symptoms (When To Refer)	• Patients with chronic diarrhoea or persisting for more than 4 weeks. Chronic diarrhoea is defined as lasting for more than 4 weeks • Diarrhoea accompanied with fever, severe vomiting, signs of dehydration • Rectal bleeding/blood in the stool/ Anaemia • Patients with abdominal/rectal masses • Patients recently returned from abroad Family history of bowel or ovarian cancer • Patients with symptoms of passing blood or mucus • Patients with history of cycling constipation and diarrhoea • History of change in bowel habit • Patient taking/recently completed a course of antibiotics • Recent hospital treatment • Weight loss. • Pregnancy / Breastfeeding
Rapid Referral	• Adults with symptoms lasting more than 5 days • Children who appear ill or dehydrated or where symptoms have lasted more than 48 hrs • Signs of shock such as decreased level of consciousness, pale or mottled skin and cold extremities.
Recommended Treatments and Quantity to supply	Dioralyte sachets (6) 1- 2 sachets in 200 ml boiled and cooled water after every loose motion. Max 16 in 24 hours.
Follow-up Advice	• Conditional referral: • Elderly are more susceptible to dehydration. Advise to consult the doctor if symptoms persist beyond 48 hrs. • Advise all other patients to consult their doctor if symptoms have not improved within 7 days. • Consider supply but patient advised to make appointment to see GP: • Patients taking medication with recognised diarrhoeal effect

	• Patients with insulin dependent diabetes mellitus
Counselling Points	• Condition is usually self-limiting; replacement of lost fluids is normally the only treatment required • Eat as normally as possible. Ideally include fruit juices and soups to provide salt and sugar and foods high in carbohydrates • Drink plenty of fluids to prevent dehydration • Take care with hygiene, in particular hand washing after going to the toiletand before preparing food • If diarrhoea persists for longer than 24-48 hours the patient should be seen by a physician. • Oral rehydration therapy is useful to prevent dehydration
References	• Clinical Knowledge Summaries. Diarrhoea - adult's assessment, Last revised in May 2021. Available at: https://cks.nice.org.uk/topics/diarrhoea-adults-assessment/ • Refer to SPC for individual product information http://emc.medicines.org.uk

DRY SKIN / SIMPLE ECZEMA U16

Definition	Common dry skin conditions include simple eczema (dermatitis). Eczema is used to describe an inflammation of the skin, which causes dry, flaky skin. There is often itching which causes scratching leading to redness, breaking of the skin and soreness. Severe eczema may begin to weep where the epidermis is severely damaged. Emollients reduce water loss from the epidermis and make the skin softer and suppler. Regular use of emollients may reduce flare-ups of eczema and the need for topical cortisosteroids.
Criteria for Inclusion	Children presenting with symptoms of dry skin or simple eczema. Children under 1 yr can be treated at the pharmacist's discretion.
Criteria for Exclusion	Cracking, weeping and painful skin may suggest infection.
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
ZeroAQS Zeroderm 125g,500g	topical topical	GSL GSL	Children: apply to the skin areas as frequently as required As an emollient: Apply to the affected area as often as required. Smooth gently into the skin, following the direction of the hair growth. As a bath additive: Melt about 4g in hot water in a suitable container then add to the bath. As a soapsubstitute: Take a small amount of the ointment and lather it under warm water and use as required when washing or in the shower. Pat skin dry.

Follow Up and Advice

- Emollients should be applied as liberally and as frequently as possible
- Emphasise regular emollient use after skin washing and instead of soap
- Avoid or minimise the use of soap and detergents as they remove lipids from the skin and may exacerbate dry skin conditions
- Advise patients to avoid irritants if possible - common irritants include water (e.g. wet work), soaps, detergents, solvents, metal-working fluids, dust and friction.
- Advise patients to avoid allergens if possible - common allergens include metal (e.g. nickel, chromate), perfumes,rubber, latex and preservatives.
- Advise patients to keep nails short and avoid scratching
- § Further information can be obtained from the National Eczema Society(www.eczema.org)
- § Also see NICE guidance on Atopic Eczema in Children(www.nice.org.uk)

Side effects and Management
• Certain ingredients found in emollients can rarely cause problems for individual patients – see BNF for list. • Preservatives are more likely to be present in creams than inointments. The actual preservative used may differ • If allergy to an excipient is suspected advise the patient to stopusing the emollient concerned and contact their GP. • Patients should be made aware of the potential dangers of slippingin the bath if emulsifying ointment is used as a bath emollient – theuse of a bath mat may reduce this risk.
Red Flag Symptoms (When To Refer)
Conditional referral
• Patients with physical signs of infection such as sore pus spots (Staph. Aureus may trigger or complicate eczema flare-up and may require a short course or oral antibiotics e.g. flucloxacillin) • Exacerbations of eczema – may require topical corticosteroids on an acute basis (3-7 days for acute eczema and up to 2-3 weeks togain remission in chronic eczema) • Consider supply, but patient should be advised to make an appointment to see a GP if: • Dry skin or simple eczema is not responding to emollients or condition is worsening. Investigate and encourage regular use of emollients.
Rapid Referral
The development and rapid spread of vesicles, blisters and erosions- suggests eczema herpeticum (caused by dissemination of herpes virus in the skin) and requires treatment with a systemic antiviral agent.

EARACHE U16			
Definition	Common problem particularly in children caused by a viral or bacterial infection of the middle ear. Children can become irritable, experience pain or pressure in the ear and have problems sleeping, feeding and hearing. Other symptoms similar to those of a cold or runny nose may also occur.		
Criteria for Inclusion	Children presenting with symptoms of earache. Children under 1 yr can be treated at the pharmacist's discretion.		
Criteria for Exclusion	• Pain in the teeth or jaw • Pain after attempt to clean wax with finger or similar object Discharge from the ear • Pain not helped by analgesics such as paracetamol when taken for 1-2 days • Children under the age of 3 months		
Action for Excluded patients:	Refer to GP or NHS 111		
Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage			
Drug	**Route**	**Class**	**Dose**
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months 6-24 months 2-4 years 4-6 years			60mg qds prn 120mg qds prn 180mg qds prn 240mg qds prn
Paracetamol suspension s/f 250mg/5ml	**PO**	**P**	
6-8 years 8-10 years 10-15 years			250mg qds prn 375mg qds prn 500mg qds prn
Paracetamol tablets 500mg (32 tabs)	**PO**	**GSL**	
12-15 years			500mg qds prn
Ibuprofen oral suspension s/f 100mg/5ml (100ml)	**PO**	**P**	
1-3 years 4-6 years 7-9 years 10-12 years			100mg 3 times daily 150mg 3 times daily 200mg 3 times daily 300mg 3 times daily

Ibuprofen tabs 200mg (32)	**PO**	**P**	
12-16 years			200-400mg 3 times daily

Follow Up and Advice	**Side effects and Management**
• Maintain good fluid intake • Continue to encourage children to eat adequately. Give doses after foodRest (if possible) • Dress children in light clothes (avoid overheating) Keep children away from smoky environments • Encourage simple hygiene measures – wash hands regularly, use tissues and dispose of them after use • Avoid sticking anything into the ear - Do not 'clean' the ear out by sticking anything in it, i.e. cotton buds, pencils, fingers etc. as this may damage the ear further • Antibiotics only help in a few patients and overuse leads to build up of resistance. Recent evidence suggests that children with high temperature or vomiting were more likely to benefit from antibiotics, although it is still reasonable to wait 24-48 hours as many children will settle anyway (BMJ 2002;325:22)	• Very rare with paracetamol but rashes and blood disorders reported. If affectedpatient should stop paracetamol immediately and contact their GP.

Red Flag Symptoms (When To Refer)

Conditional referral

- Children with symptoms not responding to analgesics – within 1-2 days for children over 2 years Children or adults with worsening symptoms
- Children with high temperature or vomiting after 48 hours of symptomatic reliefNeck stiffness
- Tinnitus (ringing) or vertigo (disrupted sense of movement)

Consider supply, but patient should be advised to make an appointment to see a GP if:

- New symptoms develop (could also contact pharmacist or NHS 111)
- Hearing becomes dull

Rapid Referral

- Pain in teeth or jaw – could be dental abscess or a bad tooth
- Pain after attempt to clean ear – may have damaged lining of ear or possibly the eardrum Very severe pain, vomiting or yellow discharge – could be middle ear infection

Earwax U16

Definition	Build-up of the natural protective oily/waxy substance in the ear causing hearing loss
Criteria for Inclusion	Child presenting with Blocked ears and hearing loss.
Criteria for Exclusion	• Patients with a temperature and/or severe pain • Symptoms lasting over 5 daysPast history of ear surgery • If ear is badly blocked and hearing is impairedOtitis Externa • Perforation of the tympanic membrane • Foreign bodies within ear canal
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist.

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Olive Oil ear drops + Dropper – 10ml	Aural	GSL	Put 2 to 3 drops of medical grade olive oil in ear 3 to 4 times a day. Do this for 3 to 5 days.

Follow-up and Advice

- Use at room temperature
- If ears are still blocked, ear irrigation (syringing) may be needed.
- Advise that earwax is normal but sometimes builds up causing symptoms Advise not to poke or clean ears with cotton buds or similar objects (using cotton buds to clean the ear canal can force wax further down the canal to form a plugagainst the ear drum)
- Syringing may be necessary if treatment fails to break up wax

RED FLAG SYMPTOMS (When to Refer)

Consider supply, but patient should be advised to make an appointment to see their GP if:

- Symptoms are severe

Rapid referral:

- Foreign body in the ear canal

References:

- https://cks.nice.org.uk/topics/earwax/
- https://www.nhs.uk/conditions/earwax-build-up/

Earwax O16

Definition	Build-up of the natural protective oily/waxy substance in the ear causing hearing loss
Criteria for Inclusion	Adult presenting with Blocked ears and hearing loss.
Criteria for Exclusion	• Patients with a temperature and/or severe pain • Symptoms lasting over 5 days • The person has (or is suspected to have) a chronic perforation of the tympanic membrane. There is a past history of ear surgery. • Ear drops have been unsuccessful and irrigation is contraindicated. If ear is badly blocked and hearing is impaired • Otitis Externa • Foreign bodies within ear canal • Perforation of the tympanic membrane • Patients with grommets
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist.

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Olive Oil ear drops + Dropper – 10ml	Aural	GSL	Put 2 to 3 drops of medical grade olive oil in ear 3 to 4 times a day. Do this for 3 to 5 days.
Sodium Bicarbonate 5% eardrops 10ml	Aural	GSL	Pour a few drops (room temperature) into the affected ear and lie on one side with the affected ear facing upwards. Repeat this 2-3 times a day for 3-5 days. The plug should soften and may gradually fall out bit by bit.

Follow-up and Advice

- Use at room temperature
- If ears are still blocked, ear irrigation (syringing) may be needed. Advise that earwax is normal but sometimes builds up causing symptoms
- Advise not to poke or clean ears with cotton buds or similar objects (using cotton buds to clean the ear canal can force wax further down the canal to form a plug against the ear drum
- Syringing may be necessary if treatment fails to break up wax

Red Flag Symptoms (When To Refer)

- Previous problems with irrigation such as pain or perforation
- Perforation of the ear drum
- A history of perforation of the ear drum in the last 12months
- A mucous discharge from the ear which may indicate an undiagnosed perforation in the last 12months Had a middle ear infection in the previous 6 weeks
- Had any ear surgery in the last 18months

• Acute otitis externa (external ear canal) with a painful ear canal, or pinna Presence of purulent discharge • High fever • Earache
Consider supply, but patient should be advised to make an appointment to see their GP if:
Symptoms are severe
Rapid referral:
Foreign body in the ear canal
References:
• https://www.nhs.uk/conditions/earwax-build-up/ • https://cks.nice.org.uk/topics/earwax/management/management/

HAY FEVER U16

Definition	Seasonal allergic rhinitis characterised by nasal congestion, excessive sneezing, watery and itchy eyes. Itching can also occur in the nose, throat, mouth and ears. Congestion may interfere withsleep.
Criteria for Inclusion	Children over 1 years or adults presenting with symptoms of hay fever requiring symptomatic treatment
Criteria for Exclusion	• Children under 1 years • If symptoms occur in a particular place e.g. workplace or near animals (consider allergy to dust, animal droppings, plants, etc) • If symptoms develop when patient is at home (consider allergy to house dust mites
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Chlorphenamine s/f syrup 2mg/5ml (150ml)	PO	P	1-2 years – 1mg twice daily. Max 2mg daily 2-5 years 1mg every 4-6 hours – Maximum 6mg daily 6-12 years 2mg every 4-6 hours – Maximum 12mg daily 12 years and over 4mg every 4-6hours – Maximum 24mg daily
Chlorphenamine tablets 4mg (30 tabs)	PO	P	
Cetirizine tablets 10mg	PO	P	Over 6 years 10mg daily or 5mg bd
Cetirizine s/f liquid 5mg/5ml	PO	P	2-6 years 5mg daily or 2.5 mg bd
Loratadine tablets 10mg	PO	P	Dosing based on weight 2–11 years (body-weight 31 kg and above) 10mgonce daily
Loratadine liquid 5mg/5mls	PO	P	Dosing based on weight 2–11 years (body-weight up to 31 kg) 5mg oncedaily
Sodium Cromoglicate 2% eye drops	Gutte	P	Child and adults - 1-2 drop(s) four times a day into both eyes

Follow Up and Advice	**Side effects and Management**

• Not to exceed maximum doses • Pollen avoidance measures – watch out for pollen counts e.g. newspapers, TVweather reports • Possible drug interactions – check for any concomitant medication • Advise patient not to exceed recommended dose.	• Drowsiness. More so with chlorphenamine – • Drowsiness may diminish after a few days oftreatment. Other side-effects include antimuscarinic effects (urinary retention, dry mouth, blurred vision and GI disturbance) • If patients experience side-effects, discontinuetreatment immediately and contact their GP Side -effects can be reduced by dividing the dose.
Red Flag Symptoms (When To Refer)	
Conditional referral	
If treatment is ineffective or persists after the end of September (please note that hay fever can sometimes persist beyond September)	
Consider supply, but patient should be advised to make an appointment to see a GP if:	
If new symptoms develop (could also contact NHS 111 or their pharmacist) that are worrying to the patient, e.g. epistaxis	
Rapid Referral	
If the patient has difficulty in breathing	

Hay Fever O16	
Definition	Hypersensitivity reaction to pollen or fungal spores. Symptoms occur at the same time each year and can typically consist of seasonal sneezing, nasal itching, nasal blockage, watery nasal discharge and red, itchy, watery eyes
Criteria for Inclusion	• Adults and children with symptoms of hay fever requiring symptomatic treatment
Red Flag Symptoms (When To Refer)	• Pregnancy / Breast feeding
Rapid Referral	• Patients experiencing symptoms of wheezing and / or shortness of breath
Recommended Treatments and Quantity to supply	Chlorphenamine 4mg tablets (30) take 1 tablet four times a day Cetirizine 10mg tablets (30) Take 1 tablet once daily Beclometasone nasal spray (100 doses) Inhale 2 puffs into each nostril twice a day Sodium cromoglicate 2% eye drops (10mls) 1 drop four times a day into both eyes
Follow-up Advice	Conditional referral: • Patient should consult the GP if treatment is ineffective or symptoms persist after the end of September
Counselling Points	• Pollen avoidance measures • Pollen count can be found at www.bbc.co.uk/weather • Patient choice will play a role in treatment selection • Chlorphenamine should only be supplied if sedation will not be cause for concern; patients should be counselled about driving/operating machinery if sedation occurs • Intranasal corticosteroids are effective where rhinitis is the main symptom; they have a relative slow onset of action with maximum efficacy achieved over a few days
References	• Clinical Knowledge Summaries. Allergic rhinitis – management. January 2008. Available at: http://cks.library.nhs.uk/allergic_rhinitis • Refer to SPC for individual product information http://emc.medicines.org.uk

Heartburn / Indigestion O16	
Definition	Dyspepsia – upper abdominal discomfort, pain associated with food/hunger relieved by antacids, nausea and bloating Gastro-oesophageal reflux – heartburn, acid regurgitation, epigastric pain, belching Dyspepsia are typically present for four or more weeks, including upper abdominal pain or discomfort, heartburn, acid reflux, nausea and/or vomiting.
Criteria for Inclusion	• Patients who require relief from some of the above symptoms • Previous diagnosis of minor GI problem • A new GI problem that has lasted less than 10 days
Red Flag Symptoms (When To Refer)	• Patients whose symptoms of indigestion/heartburn have recently changed or • Pregnancy unless heartburn and indigestion are related to pregnancy • Breastfeeding
Rapid Referral	• Bleeding PR (excluding haemorrhoids) or blood in the stools • Unexplained weight loss • Vomiting with amounts of blood • Difficulty in swallowing • Pain in the chest indicative of another aetiology • Severe acute epigastric pain
Recommended Treatments and Quantity to supply	Peptac liquid aniseed/peppermint (500mls) 10-20mls after meals and at bedtime Gaviscon Advance tabs (24) 1 tablet three times a day after each meal Ranitidine 75mg (24) take 1 tablet twice daily
Follow-up Advice	• Conditional referral: • Consult GP if symptoms persist beyond 1 week • Consult GP if symptoms are not relieved by medication • Patients taking NSAIDs • Second request within one month • Recent peptic ulcer disease

Counselling Points	• Symptoms can be aggravated by stress and anxiety • Advise patients to stop smoking, moderate alcohol intake and lose weightwhere appropriate • Eat small meals slowly and regularly and avoid foods which aggravate theproblem • The sodium content of some antacids may be important when a saltrestricted diet is required in patients with renal or cardiovascular disease • Advise patients not to take ranitidine tablets for more than 2 weeks continuously. They must consult their doctor if symptoms deteriorate orpersist after 2 weeks treatment.
References	• Clinical Knowledge Summaries. Dyspepsia unidentified cause management. Last revised in October 2018. Available at: https://cks.nice.org.uk/topics/dyspepsia-unidentified-cause/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Head Lice (Under 16)	
Definition	Head lice (Pediculus humanus capitis) are parasitic insects that infest the hairs of the human head and feed on blood from the scalp. Head lice infestation is known as pediculosis capitis
Criteria for Inclusion	• People presenting with evidence of a living, moving louse seen on the scalp (most reliable method is detection combing). • A person should only be treated if a live head louse is found. All affected household members should also be treated on the same day.
Referral	• Genuine resistance suspected – e.g. if two different treatments have failed. • If resistance is suspected e.g. if large numbers of lice of all sizes are found within days of the second treatment and treatment has been carried out correctly, resistance is likely. GP may consider use of carbaryl products. Inform Public Health department at the Local Authority
Recommended Treatments and Quantity to supply	• The choice of treatment will depend on the preference of the person and/or their parents/carers after considering the advantages and disadvantages of each treatment, what has been previously tried, and the cost of the treatment. Be aware that: • Wet combing or dimeticone 4% lotion is recommended first-line for pregnant or breastfeeding women, young children aged 6 months to 2 years, and people with asthma or eczema. • Hedrin Lotion (Dimeticone) 50ml/150ml Children (aged six months and above) For topical external use only Child Apply once weekly for 2 doses, rub into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight). Adult Apply once weekly for 2 doses, rub into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight). • Derbac-M liquid (malathion 0.5% in an aqueous basis)150ml Not licensed for use in children under 6 months For topical external use only Child Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, remove by washing after 12 hours. Adult Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, remove by washing after 12 hours. • Supply enough treatment to complete a treatment course. Depending on the preference of the person and/or their parents/carers, their treatment history, the presence of any contraindications, head lice can be treated with one of the following:

	• A physical insecticide, such as dimeticone 4% lotion (Hedrin®). • A traditional insecticide, such as malathion 0.5% aqueous liquid (Derbac-M®). • Wet combing with a fine-toothed head louse comb (such as the Bug Buster® comb). • Advise the person with head lice and/or their parents/carers to read the instructions that come with the treatment to ensure that it is used safely and correctly. Highlight that: • All affected family members should be treated on the same day to avoid reinfection. • For insecticides: • Treatment should be applied to all areas of the scalp and to all of the hairs, from their roots to their tips. • The product should be left on for the time recommended by the manufacturer, then washed off. • It is generally recommended that insecticides are applied twice, at least 7 days apart, in order to treat any lice hatching from eggs before they lay more eggs themselves. • Inappropriate use can lead to treatment failure and may increase the risk of resistant lice. • The hair should be kept away from naked flames, cigarettes, and other sources of ignition during treatment with dimeticone-containing products (though not flammable, dimeticone is not water based and will not prevent hair from burning). Care should be taken if the product is spilt as it may cause a slip hazard.
	• Wet combing with a fine-toothed head louse comb (such as the Bug Buster® comb) is also an option. • For wet combing: • The recommended regimen is four sessions spaced over 2 weeks (on days 1, 5, 9, and 13). • It takes about 10 minutes to complete the process on short hair, and 20–30 minutes for long, frizzy, or curly hair. Two combing procedures are recommended at each treatment session. • Detailed information on wet combing is provided in the Bug Buster® kit and is also available on the Community Hygiene Concern website (www.chc.org).
Counselling Points	• No treatment can guarantee success, but best chance of success if performed correctly and if all affected household members are treated on the same day to avoid reinfection. • For insecticides: • - Treatment should be applied to all areas of the scalp and to all of the hairs, from their roots to their tips. • - The product should be left on for the time recommended by the manufacturer, then washed off. This varies from 15 minutes (for example with Hedrin® Once Spray Gel) to at least 8 hours (for example with Hedrin® Lotion). A contact time of 8–12 hours (or overnight) is recommended for lotions and liquids. • - Generally insecticides are applied twice, at least 7 days apart, in order to treat any lice hatching from eggs before they lay more eggs themselves. • - Inappropriate use can lead to treatment failure and may increase the risk of resistant lice. • - Hair should be kept away from naked flames, cigarettes, and other sources of ignition during treatment with dimeticone-containing products (though not flammable, dimeticone is not water based and will not prevent hair from burning).

	• Should any signs of hypersensitivity to product occur (e.g. rashes, urticaria, generalised pruritus, breathing difficulties), the product should be shampooed off immediately, and if symptoms do not resolve, medical advice sought.
References	• Refer to SPC for individual product information http://emc.medicines.org.uk • Clinical Knowledge Summaries. Head Lice, Last revised in December 2016 Available at: https://cks.nice.org.uk/topics/head-lice/management/management/

Head Lice (Over 16)	
Definition	Head lice (Pediculus humanus capitis) are parasitic insects that infest the hairs of the human head and feed on blood from the scalp. Head lice infestation is known as pediculosis capitis
Criteria for Inclusion	• People presenting with evidence of a living, moving louse seen on the scalp (most reliable method is detection combing). • A person should only be treated if a live head louse is found. All affected household members should also be treated on the same day.
Referral	• Genuine resistance suspected – e.g. if two different treatments have failed. • If resistance is suspected e.g. if large numbers of lice of all sizes are found within days of the second treatment and treatment has been carried out correctly, resistance is likely. GP may consider use of carbaryl products. Inform Public Health department at the Local Authority
Recommended Treatments and Quantity to supply	• The choice of treatment will depend on the preference of the person and/or their parents/carers after considering the advantages and disadvantages of each treatment, what has been previously tried, and the cost of the treatment. Be aware that: • Wet combing or dimeticone 4% lotion is recommended first-line for pregnant or breastfeeding women, young children aged 6 months to 2 years, and people with asthma or eczema. • Hedrin Lotion (Dimeticone) 50ml/150ml Children (aged six months and above) For topical external use only Child Apply once weekly for 2 doses, rub into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight). Adult Apply once weekly for 2 doses, rub into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight). • Derbac-M liquid (malathion 0.5% in an aqueous basis)150ml Not licensed for use in children under 6 months For topical external use only Child Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, remove by washing after 12 hours. Adult Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, remove by washing after 12 hours. • Supply enough treatment to complete a treatment course. Depending on the preference of the person and/or their parents/carers, their treatment history, the presence of any contraindications, head lice can be treated with one of the following:

	• A physical insecticide, such as dimeticone 4% lotion (Hedrin®). • A traditional insecticide, such as malathion 0.5% aqueous liquid (Derbac-M®). • Wet combing with a fine-toothed head louse comb (such as the Bug Buster® comb).Advise the person with head lice and/or their parents/carers to read the instructions that come with the treatment to ensure that it is used safely and correctly. Highlight that: • All affected family members should be treated on the same day to avoid reinfection. • For insecticides: • Treatment should be applied to all areas of the scalp and to all of the hairs, from their roots to their tips. • The product should be left on for the time recommended by the manufacturer, then washed off. • It is generally recommended that insecticides are applied twice, at least 7 days apart, in order to treat any lice hatching from eggs before they lay more eggs themselves. • Inappropriate use can lead to treatment failure and may increase the risk of resistant lice. • The hair should be kept away from naked flames, cigarettes, and other sources of ignition during treatment with dimeticone-containing products (though not flammable, dimeticone is not water based and will not prevent hair from burning). Care should be taken if the product is spilt as it may cause a slip hazard.
	• Wet combing with a fine-toothed head louse comb (such as the Bug Buster® comb) is also an option. • For wet combing: • The recommended regimen is four sessions spaced over 2 weeks (on days 1, 5, 9, and 13). • It takes about 10 minutes to complete the process on short hair, and 20–30 minutes for long, frizzy, or curly hair. Two combing procedures are recommended at each treatment session. • Detailed information on wet combing is provided in the Bug Buster® kit and is also available on the Community Hygiene Concern website (www.chc.org).

Counselling Points	• No treatment can guarantee success, but best chance of success if performed correctly and if all affected household members are treated on the same day to avoid reinfection. • For insecticides: • Treatment should be applied to all areas of the scalp and to all of the hairs, from their roots to their tips. • The product should be left on for the time recommended by the manufacturer, then washed off. This varies from 15 minutes (for example with Hedrin® Once Spray Gel) to at least 8 hours (for example with Hedrin® Lotion). A contact time of 8–12 hours (or overnight) is recommended for lotions and liquids. • Generally, insecticides are applied twice, at least 7 days apart, in order to treat any lice hatching from eggs before they lay more eggs themselves. • Inappropriate use can lead to treatment failure and may increase the risk of resistant lice. • Hair should be kept away from naked flames, cigarettes, and other sources of ignition during treatment with dimeticone-containing products (though not flammable, dimeticone is not water based and will not prevent hair from burning). • Should any signs of hypersensitivity to product occur (e.g. rashes, urticaria, generalised pruritus, breathing difficulties), the product should be shampooed off immediately, and if symptoms do not resolve, medical advice sought.
References	• Refer to SPC for individual product information http://emc.medicines.org.uk • Clinical Knowledge Summaries. Head Lice, Last revised in December 2016 Available at: https://cks.nice.org.uk/topics/head-lice/management/management/

Haemorrhoids O18	
Definition	Swollen veins which protrude into the canal) may swell and hang down outside the anus). Haemorrhoids are classed as external or internal, depending on their origin in relation to the dentate line.
Criteria for Inclusion	• Presence of haemorrhoids requiring soothing relief of itching, burning, pain, swelling and/or discomfort in the perianal area and anal canal. • Adults over 18 years • Consider supply, but the patient should be advised to make an appointment to see the GP: • Haemorrhoids of more than 3 weeks duration Suspected drug-induced constipation • Small amount of fresh blood in stool
Red Flag Symptoms (When To Refer)	• Children under the age of 18 • Pregnancy or breast feeding • Change in bowel habit (persisting alteration from normal bowel habit) • Diagnosis is unclear or a serious pathology is suspected. • Severe symptoms which cannot be managed in primary care. • Person does not respond to conservative treatment. • Recurrent symptoms which do not respond to primary care treatment.
Rapid Referral	• Associated abdominal pain/vomiting • Profuse bleeding • Extremely painful, acutely thrombosed external haemorrhoids who present within 72 hours of onset. • Internal haemorrhoids which have prolapsed and become swollen, incarcerated, and thrombosed • Perianal sepsis (a rare but life-threatening complication).
Recommended Treatments and Quantity to supply	Creams and ointments (generally used for external haemorrhoids) and suppositories (generally used for internal haemorrhoids): Anusol ointment (25g) Apply after every bowel movement Anusol suppositories (12) Insert one suppository after every bowel movement Anusol Plus HC ointment (15g) Apply after every bowel movement Anusol Plus HC suppositories (12) Insert at night, in the morning and after every bowel movement up to a maximum of 3 per day
Follow-up Advice	• Patients should consult their GP if symptoms have not started to improve within 7 days.

Counselling Points	• Relieve constipation and ensure soft stools: • Recommend an increase in dietary fibre and fluid intake (wholemeal foods, bran, vegetables and so on, with 8 glasses/12 cups or more of caffeine-free fluid a day) • Consider fibre supplements (bulk-forming agents) to enhance the dietary fibre (see protocol for constipation) • Correct insertion /application of the product • Cleansing of anal area with soap and warm water will give relief from pruritus ani. • Recommend careful perianal cleansing and to pat (rather than rub) the area dry.
References	• Clinical Knowledge Summaries. Haemorrhoids – Last revised in July 2021. Available at: https://cks.nice.org.uk/topics/haemorrhoids/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Infant Congestion U16			
Definition	Blocked stuffy nose with difficulty breathing through the nose		
Criteria for Inclusion	Child presenting with blocked nose		
Criteria for Exclusion	Saline solutions (sterile 0.9% nasal drops) can be used safely by anyone		
Action for Excluded patients:	Refer to GP if problem persists		
Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage			
Drug	**Route**	**Class**	**Dose**
Normal saline Nose drops 0.9%10ml	nasal	GSL	1 or 2 drops in each nostril
Follow Up and Advice			
Saline nasal drops may help thin and clear nasal secretions ininfants who are having difficulty with feeding and should be administered immediately before feeding			
Red Flag Symptoms (When To Refer)			
If symptoms worsen or sinus pain develops, consult GP			

Mouth Ulcers & Teething U16

Definition	A mouth ulcer is any ulcerative lesion affecting the oral mucosa, mostly occur on the inner cheek, inner lip, tongue, soft palate, floor of the mouth, and sometimes the throat. They are usually about 3-5mm in diameter. Teething is a normal physiological process in which deciduous teeth (milk teeth or baby teeth) emerge through the gums starting around 6 months of age (although the onset of teething may be earlier or later, usually between 4 and 12 months). A full set of milk teeth is usually present by the time the child reaches 2–3 years of age.
Criteria for Inclusion	Patients requiring symptomatic relief
Criteria for Exclusion	• Ulceration that has persisted for more than 3 weeks or is very red, painful and swollen. Immunocompromised patients • Temperature above 38^{0}C Oral Candiasis • Recurrent or multiple ulcers • Any sore that bleeds easily • Consider referral to GP for babies/children with oral problems
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	**Route**	**Class**	**Dose**
Paracetamol suspension s/f 120mg/5ml (100ml)	**PO**	**P**	
3 months – 6 months 6-24 months 2-4 years 4-6 years			60mg qds prn 120mg qds prn 180mg qds prn 240mg qds prn
Anbesol teething gel(10g)	Topical	P Children from 5 months of age	Babies teething and children: - Apply a pea-sized amount (0.2 grams) of Anbesol teething gel with a clean finger to the affected area. - The dose may be repeated if necessary after 3 hours, up to a maximum of 6 doses in 24 hours. - Treatment should be stopped once symptoms have resolved.

			- Not to be used for more than 7 days.

Follow Up and Advice

- Suggest the patient limits the use of sharp foods (e.g. crisps), spicy foods, hot fluids and carbonated drinks
- Try not to touch the oral mucosa with the nozzles of topically applied products as this may cause contamination
- Advise patients to wash hands before and after each application
- Good oral hygiene may help in the prevention of some types of mouth ulcers or complications from mouth ulcers.
- Avoid precipitating factors, for example, by use of a softer toothbrush.
- To relieve teething symptoms, such as:
- Gentle rubbing of the gum with a clean finger.
- Allowing the infant to bite on a clean and cool object, such as a chilled teething ring or a cold wet flannel.
- For children who have been weaned, the supervised use of chilled fruit or vegetables (such as banana or cucumber) can be considered.
- Objects that can easily be broken into hard pieces should be avoided because of the risk of choking.

Red Flag Symptoms (When To Refer)

- If ulcer persists for more than 3 weeks, then the patient should be referred to their doctor or dentist for further investigation.
- Difficulty in swallowing or chewing not associated with a sore lesion
- Any sore that bleeds easily
- FAO Pharmacist: Do not recommend the use of topical oral salicylate gels for children under 16 years of age (such as Teejel®) as these are contraindicated in this age-group.

References

- https://cks.nice.org.uk/topics/teething/management/management/

Mouth Ulcers O16	
Definition	A mouth ulcer (aphthous ulcer) is an ulcerative lesion affecting the oral mucosa
Criteria for Inclusion	Mouth ulcers requiring symptomatic treatment to alleviate pain and discomfort and aid healing
Red Flag Symptoms (When To Refer)	• Evidence of systemic symptoms • Patients taking immunosuppressant drugs or who are known to be immunocompromised/ immunosuppressed • Ulcer present for more than 3 weeks • History of frequent previous episodes • Recurrent or multiple ulcers • Any sore that bleeds easily • Non-painful lesions including any lump, thickening or red / white patches • Pregnancy / Breast feeding • Ulcers affecting extra-oral sites (i.e. genitalia) • Ulcers affecting atypical sites in the mouth (i.e. palate) • Suspected adverse drug reaction
Rapid Referral	• Difficulty with swallowing
Recommended Treatments and Quantity to supply	• Bonjela original gel (15g) - Adults and children over the age of 16. Not to be used in patients suffering from active peptic ulceration. Not to be used in patients with hypersensitivity to salicylates, Massage approximately half an inch (just over 1cm) of the gel into sore area not more than once every 3 hours as needed • Chlorhexidine 0.2% mouthwash (300mls) Gargle with 10mls twice a day
Follow-up Advice	• Conditional referral: • If symptoms persist or ulcer(s) returns, consult GP • Consider referral to GP for babies/children with oral problems
Counselling Points	• Good oral hygiene to avoid risk of secondary infection • Where possible manage precipitating factors: oral trauma, stress and anxiety, • certain foods (crisps, spicy food, hot fluids, carbonated drinks), smoking • Use a softer toothbrush. • Advise patient to visit the dentist regularly

	• If recommending Chlorhexidine mouthwash, counsel and advise the patientabout teeth staining and advise not use it for more than 1 month.
References	• http://cks.library.nhs.uk/aphthous_ulcer • Refer to SPC for individual product information http://emc.medicines.org.uk

Nappy Rash U16

Definition	Nappy rash is an irritant contact dermatitis confined to the nappy area. A painful and raw area of skin around the anus and buttocks due to contact with frequent irritant stools or reddening over the genitals and napkin area due to urine-soaked napkins.
Criteria for Inclusion	Mild to moderate red rash or sore skin confined to the nappy area
Criteria for Exclusion	• Infants with a fungal infection (characterised by a bright red rash which extends into the folds of the skin). Infants with a bacterial infection of the skin – may be accompanied by fever. Broken skin. • Severe, prolonged or recurrent fungal infection Nappy rash accompanied by oral thrush Ulceration of affected area • Nappy rash that is causing discomfort
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Conotrane 100g	Topical	GSL	Apply after nappy change
Clotrimazole 1% cream 20g	Topical	P	Apply thinly twice daily and continue for 2 weeks after infection clears for children aged 1year and over. At Pharmacist discretion to treat if candidal infection is suspected or refer to GP.

Follow Up and Advice	Side effects and Management
• If candidal infection: not to use a barrier cream until after infection has settled • Advising the parents/carers on self-management strategies, such as using a nappy with high absorbency; leaving nappies off for as long as possible; changing the nappy frequently and as soon as possible after wetting or soiling; using water, or fragrance- and alcohol-free baby wipes; drying gently after cleaning; avoiding potential irritants such as soaps and bubble bath. • Expose skin to fresh air	• Sensitivity to Imidazoles- discontinue use and refer to GP

Red Flag Symptoms (When To Refer)

- Signs of infection
- Infant with rash and satellite lesions
- Nappy rash that is a bright shade of red, very warm or swollen
- Baby has a high temperature or seems distressed, in addition to the nappy rash.

References

- https://cks.nice.org.uk/topics/nappy-rash/

Oral Thrush U16

Definition	Oral thrush is an infection of yeast fungus, Candida albicans, in the mucous membranes of the mouth.
Criteria for Inclusion	Child presenting with associated symptoms ranging from asymptomatic infection to a sore and painful mouth with a burning tongue and altered taste. White patches on an erythematous background are usually seen on the buccal mucosa, tongue or gums.
Red Flag Symptoms/Exclusion Criteria	• Children under 4 months • Children under 6 months that were born pre-termImmunocompromised patients • Bleeding events have been reported with concurrent use of miconazole oral gel and warfarin • Patients looking ill • History of recurrent infection
Action for Excluded patients:	• Patients may be referred to a dentist, GP or midwife as appropriate if considered necessary by the pharmacist

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Miconazole (Daktarin) oral gel 15g	Oral	P children aged 4 months and over	Children 4 months to 24 months: Apply 1.25 ml (1/4 measuring spoon) of gel fourtimes a day, after meals. Space doses out evenly throughout the day. Children 2 years of age and older: Apply 2.5 ml (1/2 measuring spoon) ofgel four times a day, after meals. Continue treatment for at least a weekafter symptoms have disappeared

Follow Up and Advice

- Treatment with miconazole gel should continue for at least a week after symptoms have cleared
- Oral thrush can be a sign of a serious underlying systemic disease Recommend registration with an NHS dentist if the child is not alreadyregistered
- Highlight the potential for drug induced oral thrush, broad spectrum antibiotics are the most common cause
- Breastfeeding mothers may apply miconazole to their nipples to prevent re-infection
- Advise on good dental hygiene.
- If the child is using an inhaled corticosteroid, advise the following: good inhaler technique; rinsing the mouth with water (or cleaning the teeth) after inhalation, to remove any drug particles; using a spacer

device to reduce the impaction of particles in the oral cavity; and stepping down the dose of inhaled corticosteroid when appropriate.
Side effects and Management
• Occasional exacerbation of local infection • Strange taste in mouth.
Red Flag Symptoms (When To Refer)
• Consider supply, but patient should be advised to make an appointment to see the GP: • Suspected differential diagnosis • If symptoms persist beyond one week
Rapid referral:
• Suspected oral neoplasia • Suspected systemic condition
References:
• CKS Last revised in May 2021 • https://cks.nice.org.uk/topics/candida-oral/

Oral Thrush O16	
Definition	An infection of yeast fungus, Candida Albicans, in the mucous membrane of the mouth
Criteria for Inclusion	• Symptoms vary, ranging from asymptomatic infection to a sore and painful mouth with a burning tongue and altered taste • White patches on an erythematous background are usually seen on the buccal mucosa, tongue or gums.
Red Flag Symptoms (When to Refer)	• Patients undergoing chemotherapy or immunocompromised individuals • Bleeding events have been reported with concurrent use of miconazole oral gel and warfarin • Patients taking DMARDs • Patients looking ill • History of recurrent infection • Pregnancy and Breast feeding • Admission to hospital should be arranged if there is widespread infection (such as oesophageal candidiasis characterized by difficulty or pain on swallowing, or retrosternal pain), or the person is systemically unwell.
Recommended Treatments and Quantity to supply	Miconazole Oral gel 2% (15g) Apply 2.5 ml (1/2 measuring spoon) of gel four times aday, after meals. Space your doses out evenly throughout the day.
Follow-up Advice	Oral thrush can be a sign of a serious underlying systemic disease
Conditional referral:	• If symptoms persist beyond 1 week - Consider supply, but advise patient to make appointment with GP • Diabetes • Haematinic deficiencies • Oral candidiasis is uncommon in people other than infants, denture wearers, and the elderly. In otherwise healthy people, it may be the first presentation of an undiagnosed risk factor.
Counselling Points	• Hold gel in the mouth for as long as possible before swallowing • Treatment with Miconazole gel should continue for at least a week after clearance • If possible, address the cause: • Dentures • Diabetes control • Rinse mouth after using steroid inhalers • Advise on good dental hygiene. • If the person is a smoker, offer advice on smoking cessation.
References	• Clinical Knowledge Summaries. Candida - oral - Management.Last revised in May 2021. Available at: https://cks.nice.org.uk/topics/candida-oral/

	• Refer to SPC for individual product information http://www.medicines.org.uk/EMC/medicine/7301/SPC/Daktarin+Oral+Gel/

Scabies U16

Definition	Contagious and intensely itchy skin infestation caused by a mite. Sites usually affected include; finger webs, wrists and palms of hands, soles of feet and external genitalia in both sexes which can lead to severe itching
Criteria for Inclusion	• Intense itching and/or rash, generally symmetrical on the body. • The skin develops thick crusts which are highly contagious Patients infested with scabies and symptomatic close contacts
Criteria for Exclusion	• Immunocompromised patients. • Infants and children below twoyears old.
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Permethrin 5% dermal cream	Topical	P	Children aged 2 and over: apply to the whole body and wash off after 8-12 hours; if hands are washed with soap within 24 hours, they should be retreated. Larger patients may need 2 x30g packs
Chlorphenamine s/f syrup 2mg/5ml (150ml)	PO	P	2-5 years: 1mg every 4-6 hours – Maximum 6mg daily 6-12 years: 2mg every 4-6 hours –Maximum 12mg daily
Chlorpheniramine tablets 4mg (30tabs)	PO	P	12 years and over: 4mg every 4-6 hours– Maximum 24mg daily

Follow Up and Advice	Side effects and Management
• All members of the affected household should be treated simultaneously. Family • members aged over 16 eligible for the Pharmacy First Service should haveindividual consultations • Attention should be paid to the webs of the fingers and toes and lotion brushedunder the ends of nails. • It is now recommended that permethrin should be applied twice, one week apart • Washing clothing and bed linen in hot water is not essential.	• Discontinue if hypersensitivity occurs • Drowsiness. More so with chlorphenamine – Drowsiness may diminish after a few days of treatment. Other side-effects include antimuscarinic effects (urinary retention, drymouth, blurred vision and GI disturbance)

• Infected patients should be warned about the mite's contagious nature Pruritis may continue for days after successful scabies eradication. • Consider symptomatic treatment for itching. Incubation is usually 4-6 weeks in patients without previous exposure • The patient should be referred to GP if treatment fails after two courses	
Red Flag Symptoms (When To Refer)	
• Signs of bacterial infection • Previous treatment failures	

Scabies O16	
Definition	Scabies is an intensely itchy skin infestation caused by the human parasite Sarcoptes scabiei
Criteria for Inclusion	• Intense itching and/or rash, generally symmetrical on the body. • A definite diagnosis can be made on finding burrows in the skin, usually on the hands. However, these are not often seen. Burrows are very small (0.5 cm or less) curving white lines, sometimes with a vesicle at one end. • The skin develops thick crusts which are highly contagious
Red Flag Symptoms (When to Refer)	Signs of bacterial infection
Recommended Treatments and Quantity to supply	Permethrin 5% dermal cream (2x30g) apply to the whole body and wash off after 8-12 hours; if hands are washed with soap within 24 hours, they should be retreated. Largerpatients may need 2 x 30g packs Permethrin 5% cream is first-line treatment. Crotamiton 10% cream (30g) Apply to the affected areas up to three times a day Chlorphenamine 4mg tablets (30) take 1 tablet four times a day
Follow-up Advice	• All members of the affected household should be treated simultaneously. Family members aged over 16 eligible for the Pharmacy First Service should have individual consultations • Apply the insecticide twice, with applications one week apart • Itching may persist for 2-3 weeks after successful treatment. During this time no new lesions should develop. • If treatment fails, patients should be advised to refer to their GP.
Counselling Points	• Simultaneously (within 24h) treat all members of the household, close contacts, and sexual contact with a topical insecticide (even in the absence of symptoms) • Consider symptomatic treatment for itching • Their bedding, clothing, and towels (and those of all potentially infested contacts) should be decontaminated by washing at a high temperature (at least 60°C) and drying in a hot dryer, or dry-cleaning, or by sealing in a plastic bag for at least 72 hours. • Itching may continue for up to two weeks after successful treatment of scabies, however, if itching persists for longer than 2–4 weeks after the last treatment application, advise the person to seek follow-up with GP • Advise to avoid close body contact with others until their partners and close contact have been treated • Infection only spreads through direct skin-to-skin contact with another human being • Incubation is usually 4-6 weeks in patients without previous exposure

References	• Clinical Knowledge Summaries. Scabies – management. Last revised in November 2017. Available at: https://cks.nice.org.uk/topics/scabies/management/management-of-scabies/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Sore Throat O16	
Definition	A painful throat often accompanied by viral symptoms. Common causes of sore throat in primary care are usually not life-threatening and include common cold, influenza, streptococcal infection, and infectious mononucleosis.
Criteria for Inclusion	A sore throat requiring soothing
Red Flag Symptoms (When to Refer)	• Difficulty in swallowing • Patients on disease modifying drugs or other immunosuppressant drugs • Pregnancy/ Breastfeeding • Sore throat lasting more than a week • Recurrent bouts of infection • Hoarseness of more than 3 weeks' durationPatients with a weakened immune system • Failed medications
Rapid Referral	• Refer patients immediately if they have stridor, breathing difficulty, clinical dehydration, or a condition that is immediately life-threatening such as acute epiglottis or Kawasaki disease. • Patients known to be immunosuppressed (accompanied by other clinical symptoms of blood disorders) • Patients with a suspected serious but not immediately life-threatening causefor sore throat (such as cancer or HIV). • Patients presenting with severe symptoms (inability to swallow, acute onset,high temperature, difficulty in breathing) • Signs of marked systemic illness or sepsis.
Recommended Treatments and Quantity tosupply	Ibuprofen 200mg tablets (24) 1-2 tablets up to four times a day Benzydamine 0.15% oromucosal spray SF (30ml) Spray 4-8 puffs to the throat every 1.5-3 hours
Follow-up Advice	• Conditional referral: • If symptoms persist for more than one week, consult GP • Consider supply, but advise patient to make an appointment with GP: • Symptoms suggesting oral candidiasis/tonsillitis
Counselling Points	• Sore throats are usually a self-limiting illness (whether caused by viral or bacterial infection) and will resolve in 7-10 daysgargle with warm salty water • drink plenty of water – but avoid hot drinks • avoid smoking or smoky places Giving simple advice, if appropriate, for example, regular use of paracetamol or ibuprofen to relieve

	pain and fever, and adequate fluid intake to avoid dehydration until the discomfort and swelling subside. Ibuprofen and paracetamol can be used as an antipyretic and/or analgesi
References	• Clinical Knowledge Summaries. Sore throat - acute - Management. Last revised in January 2021. Available at: https://cks.nice.org.uk/topics/sore-throat-acute/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Sprains and Strains O16	
Definition	A sprain is an injury to a ligament as a result of abnormal or excessive forces applied to a joint, but without dislocation or fracture. A muscle strain (or 'pull') is stretching or tearing of muscle fibres. Most muscle strains happen for one of two reasons: either the muscle has beenstretched beyond its limits or it has been forced to contract too strongly.
Criteria for Inclusion	Signs and symptoms of mild sprain (mild stretching of the ligament complex without joint instability or strain) or mild strain (when only a few muscle fibres are stretched or torn; although the injured muscle is tender and painful, it has normal strength).
Red Flag Symptoms (When To Refer)	• Children under 12 years of age • Moderate to severe sprain or strainBruising and/or swelling • Arthritis
Rapid Referral	• Possible fracture or dislocation • Damage to nerves or circulation. • Wound penetrating the joint or known bleeding disorder. • A serious complication such as haemarthrosis or septic arthritis. • Tendon rupture. • A complete tear, or tear of more than half the muscle belly. • A large intramuscular haematoma.
Recommended Treatments and Quantity to supply	Paracetamol 500mg tablets (32) 1-2 tablets up to four times a day Ibuprofen 200mg tablets (24) 1-2 tablets up to four times a day Ibuprofen gel 5% (100g) Apply up to three times a day to affected area

Counselling Points	• Advise the person to manage their injury using PRICE: o Protection — • protect from further injury (for example by using a support or high-top, lace-up shoes). o Rest — avoid activity for the first 48–72 hours following injury and consider the use of crutches. o Ice — apply ice wrapped in a damp towel for 15–20 minutes every 2–3 hours during the day for the first 48–72 hours following the injury. Do not leave ice on while asleep. o Compression • — with a simple elastic bandage or elasticated tubular bandage, which should be snug, but not tight. Remove before going to sleep. o Elevation —advise the person to rest with their leg elevated and supported on a pillow until the swelling is controlled, and to avoid prolonged periods with the leg not elevated. • Advise the person to avoid HARM in the first 72 hours after the injury: - Heat (for example hot baths, saunas, heat packs). - Alcohol (increases bleeding and swelling and decreases healing). - Running (or any other formof exercise which may cause further damage). - Massage (may increase bleeding and swelling). § For sprains: - Do not immobilize the joint. Begin flexibility (range of motion) exercises as soon as they can be tolerated without excessive pain. § For strains: - Immobilize the injured muscle for thefirst few days after the injury. Consider the use of crutches in severe injuries. • - Start active mobilization after a few days if the person has pain-free use ofthe muscle in basic movements and the injured muscle can stretch as muchas the healthy contralateral muscle.
References	• Clinical Knowledge Summaries. Sprains and strains – management. Last revised in April 2020 Available at: https://cks.nice.org.uk/topics/sprains-strains/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Sunburn U16

Definition	After exposure to too much UV light, skin becomes red and painful and may later peel orblister
Criteria for Exclusion	Severe sunburn in children and babies (need rapid referal to A&E)
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Calamine aqueous cream 100g	Topical	GSL	Apply as necessary

Red Flag Symptoms (When to Refer)

- Severe burns/ sunburn in babies and children
- Suspected melanomas
- Skin is blistered or swollen
- Paient temperature is very high, or feel hot and shivery
- Feel very tired, dizzy and sick
- Have a headache and muscle cramps

Counselling Points

- get out of the sun as soon as possible
- cool your skin with a cool shower, bath or damp towel (take care not to let a baby or young child get too cold)
- apply aftersun cream or spray, like aloe vera
- drink plenty of water to cool down and prevent dehydration
- take painkillers, such as paracetamol or ibuprofen for any pain
- cover sunburnt skin from direct sunlight until skin has fully healed

References

- https://www.nhs.uk/conditions/sunburn/

Threadworm U16

Definition	Infestation by the threadworm parasite resulting in symptoms of peri-anal itching, especially at night. Confirmed by presence of cotton-like threadworms in the faeces oraround the anus. In females, the genital area can also be involved and presentation may include pruritus vulvae.
Criteria for Inclusion	• Sore, itchy bottom (anus) which is worse at night • Worms may be visible (about 10mm long) in stools and/or around anus.Re-infection following treatment within the previous 2-3 weeks • Close family contacts of the patient presenting with the infestation
Criteria for Exclusion	• Children under 2 years old • Pregnant or breastfeeding women • Consult GP if signs of bacterial infection (mucus discharge, red and inflamed skinaround the anus) • Patients who have recently returned from tropical travelLoss of appetite, weight loss, insomnia
Action for Excluded patients:	Patients may be referred to their GP if considered necessary by the pharmacist

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Mebendazole (Ovex) 100mg – 1 tablet	Oral	P	Patients over 2 years old:Take 1 single tablet. (If re-infection occurs, a second dose can be taken after 14days via a follow up consultation).

Follow Up and Advice	Side effects and Management
• All members of the family over 2 years old, should be treated at the same time to obtain maximum benefit even if they are asymptomatic. • Treatment needs to include hygiene measures to prevent ova being transferred from anus to mouth and re-infection for 14 days after treatment. • Wash hands and scrub nails before meals and after going the toilet Bathing immediately after rising will remove the eggs laid during the night • Wash bed-linen and towels frequently and change night and under wear daily	• Rarely abdominal pain, diarrhoea, hypersensitivity reactions. Re-assure patient

Red Flag Symptoms (When To Refer)

- Recent tropical travel
- Other type of worm infection

Rapid referral:

- Heavy cases or persistent cases.

References

- https://cks.nice.org.uk/topics/threadworm/

Threadworms O16	
Definition	Intestinal helminth infection (pin-shaped, white/cream coloured approximately100mm long and less than 0.5mm wide)
Criteria for Inclusion	• Threadworms may cause itching around the perianal region, particularly atnight. In females, the genital area can also be involved and presentation may include pruritus vulvae. • Threadworms appear in faeces but can sometimes be difficult to see.
Red Flag Symptoms (When to Refer)	• Loss of appetite, weight loss, insomnia • Pregnant women / Breast feeding • Consult GP if there are signs of bacterial infection (mucus discharge/ redand inflamed skin around the anus)
Recommended Treatments andQuantity to supply	Mebendazole 100mg chewable tab: Take 1 single tablet. (If re-infection occurs, a second dose can be taken after 14 days via a follow up consultation).
Follow-up Advice	Conditional referral: • If re-infection suspected, repeat treatment after 14 days – a new consultation will be needed
Counselling Points	• All members of the family should be treated at the same time to obtainmaximum benefit even if they are asymptomatic • Treatment needs to include hygiene measures to prevent ova being transferred from anus to mouth and re-infection • Wash hands and scrub nails before meals and after going the toilet • Bathing immediately after rising will remove the eggs laid during the night • Wash bed-linen and towels frequently and change night and under wear daily • Change bed linen and nightwear daily for several days after treatment. • Do not shake out items as this may distribute eggs around the room. • Washing/drying in a hot cycle will kill pinworm eggs. • Thoroughly dust and vacuum (including vacuuming mattresses) and clean the bathroom by 'damp-dusting' surfaces, washing the cloth frequently in hot water.
References	• Clinical Knowledge Summaries. Threadworm management. Last revised in February 2018. Available at: https://cks.nice.org.uk/topics/threadworm/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Vaginal Thrush O16	
Definition	Vulvovaginal candidiasis caused by yeast infection
Criteria for Inclusion	• Adult females (Over 16 - Under 60) with a previous diagnosis of thrush who are confident it is a recurrence of the same symptoms • Presenting symptoms include itching / irritation to vaginal area with or without a creamy white, non-odorous discharge, pain or burning on urination • Symptomatic male partners of an infected female (a separate consultationform must be completed)
Red Flag Symptoms (When to Refer)	• Patients under 16 and over 60 years • First time symptoms • More than 2 episodes in 6 months • Personal history of or recent STD • Known hypersensitivity to imidazoles or other vaginal antifungal products.
Rapid Referral	• Irregular or abnormal vaginal bleeding • Foul smelling discharge • Fever • Associated lower abdominal pain or dysuria
Recommended Treatments and Quantity to supply	Clotrimazole 2% cream (20g) Apply to the affected area two or threetimes a day and rubbed in gently. Treatment should be continued untilsymptoms of the infection disappear. Clotrimazole 500mg pessary (1) Insert 1 pessary at night Fluconazole 150mg oral cap (1) Take 1 capsule immediately with glassof water
Follow-up Advice	Refer patients to GP, FP Clinic or GUM
Conditional referral:	• If symptoms are unresolved 7 days after treatment. Consider supply but advise patient to make appointment with GP: • Diabetic • Post-menopausal women
Counselling Points	• Advise patient to wear cotton underwear and loose-fitting clothes • Avoid perfumed products • Remind GP that they are prone to thrush if they are prescribed oralantibiotics or other medication • Clotrimazole may affect condom durability • Use simple emollients as a soap substitute to wash and/or moisturize the vulval area.

	• Avoid contact with potentially irritant soap, shampoo, bubblebath, or shower gels, wipes, and daily or intermenstrual 'feminine hygiene' pad products. • Avoid vaginal douching. • Avoid wearing tight-fitting and/or non-absorbent clothing, which may irritate the area.
References	• Clinical Knowledge Summaries. Candida - female genital - Management.Last revised in September 2021. Available at: https://cks.nice.org.uk/topics/candida-female-genital/ • Refer to SPC for individual product information http://emc.medicines.org.uk

Warts and Verrucas U16

Definition	Warts are small (often hard) benign growth on the skin caused by a virus, usually occurring on the face, hands, fingers, elbows and knees. Verrucas (plantar warts) occur on the soleof the foot, usually painful and may be covered by a thick callus.
Criteria for Inclusion	Symptoms and signs suggestive of a wart or verruca.
Red Flag Symptoms (When to Refer)	• Warts on face, ano-genital region or large areasDiabetes mellitus • Impaired peripheral blood circulation • Broken skin or redness around area of wart / verrucaSuspect skin cancer • Multiple recalcitrant warts and compromised immunity. • Extensive warts. • Persistent warts that are unresponsive to available primary care treatments.
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Salactol topical paint 10ml	Topical (Extremely flammable)	P	Apply topically once daily usually at night.

Follow Up and Advice	Side effects and Management
• Plantar warts should be coveredwith an adhesive plaster • Before applying the treatment to your wart, use an emery board • or pumice stone to file it down a little (avoid sharing the board or pumicestone with others). Repeat this about once a week while you are treatingyour warts. • Each time you treat your wart, soak it in water for about five minutes firstto soften it, then follow the instructions that come with the medication. • Using the applicator provided, carefully apply a few drops of Salactol to the lesion, allowing each drop to dry before applying the next one. • You may need to apply the treatment every day for 12 weeks or longer.You should stop the treatment if your skin becomes sore.	• Stinging, dryness and peeling

When to refer

- See exclusion criteria

References

- https://cks.nice.org.uk/topics/warts-verrucae/

Warts and Verrucas O16

Definition	Warts are small (often hard) benign growth on the skin caused by a virus, usually occurring on the face, hands, fingers, elbows and knees. Verrucas (plantar warts) occur on the soleof the foot, usually painful and may be covered by a thick callus.
Criteria for Inclusion	Symptoms and signs suggestive of a wart or verruca.
Red Flag Symptoms (When to Refer)	• Warts on face, ano-genital region or large areasDiabetes mellitus • Impaired peripheral blood circulation • Broken skin or redness around area of wart / verrucaSuspect skin cancer • Multiple recalcitrant warts and compromised immunity. • Extensive warts. • Persistent warts that are unresponsive to available primary care treatments.
Action for Excluded patients:	Refer to GP

Recommended Treatments, Route and Legal Status. Frequency of administration & Maximum dosage

Drug	Route	Class	Dose
Salactol topical paint 10ml	Topical (Extremely flammable)	P	Apply topically once daily usually at night.

Follow Up and Advice	Side effects and Management
• Plantar warts should be coveredwith an adhesive plaster • Before applying the treatment to your wart, use an emery board • or pumice stone to file it down a little (avoid sharing the board or pumicestone with others). Repeat this about once a week while you are treatingyour warts. • Each time you treat your wart, soak it in water for about five minutes firstto soften it, then follow the instructions that come with the medication. • Using the applicator provided, carefully apply a few drops of Salactol to the lesion, allowing each drop to dry before applying the next one. • You may need to apply the treatment every day for 12 weeks or longer.You should stop the treatment if your skin becomes sore.	• Stinging, dryness and peeling

When to refer

- See exclusion criteria

References

- https://cks.nice.org.uk/topics/warts-verrucae/