Sussex Community NHS
NHS Foundation Trust

Management of Adults with Lower Limb Cellulitis in the Brighton & Hove area by the Community IV therapy team

Guideline

Date 2016/19
Version V4

December 2016

This document remains valid whilst under review

TARGET AUDIENCE (including temporary staff)	
People who need to know this document in detail	Registered Nurses within Community Intravenous Therapy Team and Community Short Term Service
People who need to have a broad understanding of this document	General Practitioners in the Brighton & Hove CCG area
People who need to know that this document exists	

Author: IV Therapy Specialist Nurse

Approved by: Medicines Safety and Governance Group Date: 13/12/2016

Ratified by: Chief Pharmacist Date: 13/12/2016

Date of next review: December 2019

VERSION CONTROL

Record of Changes		
Date	Version	Changes / Comments
14/01/2010	1.0	Updated guidance for use on the ratified pathway.
12/05/2010	1.2	Antimicrobial protocol changed.
17/06/2010	1.3	Medicines committee amendments recommended
13/02/2012	1.4	Revision of antimicrobial protocol amendments made.
13/03/2012	2.1	Reviewed at Medicines Management Committee Meeting (Brighton & Hove CCG) -amendments made.
02/07/2012	2.2	Clinical Governance and Patient Safety Committee - amendments made.
28/08/2012	2.3	Sussex NHS PCT – no comments
28/05/2014	3.1	Reviewed and updated
01/09/2014	3.2	Updated following comments from Brighton & Hove CCG
27/04/2015	3.3	Fax number updated on page 10
21/11/2016	4.0	Reviewed and updated into new template. Sainsbury's, West Hove removed from participating pharmacy list

CONTENTS

1. INTRODUCTION

These guidelines set out the quality assurance systems that need to be in place within SCFT, for registered practitioners to ensure the safe administration of medicines by intravenous route, and the safe care and management of the intravenous line (National Patient Safety Agency (NPSA) 2007). The guidelines have been developed in order to standardise the treatment of patients presenting with lower limb cellulitis in primary care, and to support the development of a community intravenous therapy service.

Cellulitis in adults is a common medical condition comprising an acute bacterial infection of the skin and subcutaneous tissues. It is defined by Crest (2005) as an acute, non-contagious, infection of the skin and is characterised by erythema, oedema and warmth, accompanied by pain and tenderness. It is caused by an acute spreading bacterial infection that extends beyond the dermis, deep into subcutaneous tissues and may follow a skin abrasion or other similar trauma.

Research data into risk factors for cellulitis is limited, however factors that may predispose to cellulitis include:

- Potential site of entry – insect bite/leg ulcer/traumatic wound/tinea pedis
- Lymphoedema
- Leg oedema
- Venous insufficiency/peripheral vascular disease
- Obesity

UK hospital incidence data reported 69,579 episodes of cellulitis. The National Health Service (NHS) Institute for innovation and Improvement noted that there were 45522 inpatient admissions for cellulitis in 2003/4 costing the NHS £387 million. Cellulitis is one of 19 conditions highlighted by the Department of Health (DOH) as having high potential for care provision in an ambulatory setting.

1.1 Purpose

The purpose of this document is to ensure patients receive safe and effective intravenous therapy by registered professionals in their own homes, other community settings and Trust premises and to enhance patient care through early discharge from hospital or by preventing hospital admission.

The standards and recommendations include: ‘The Royal College of Nursing (RCN) Intravenous forum’, ‘Standards for Infusion Therapy’ (November 2010) and the NPSA on ‘Promoting Safer Use of Injectable Medicines' (2007). These are all incorporated into this guideline to promote best practice.

1.2 Scope

These guidelines have been produced in order to support the clinician to identify those patients who may safely receive intravenous antibiotic therapy in the community.

They should be used to:

- Provide a systematic classification of patients with cellulitis.
- Identify patients who may be suitable for intravenous antibiotic therapy in the community.
- Ensure all patients with cellulitis in primary care are treated and followed up appropriately.

The guidelines apply to all patients, where lower limb cellulitis is the primary diagnosis for patients in Brighton and Hove area of Sussex Community NHS Foundation Trust (SCFT).

2. MANAGEMENT OF ADULTS WITH LOWER LIMB CELLULITIS IN THE BRIGHTON & HOVE AREA BY THE COMMUNITY IV THERAPY TEAM

2.1 Inclusion and Exclusion Criteria

2.1.1 Inclusion Criteria

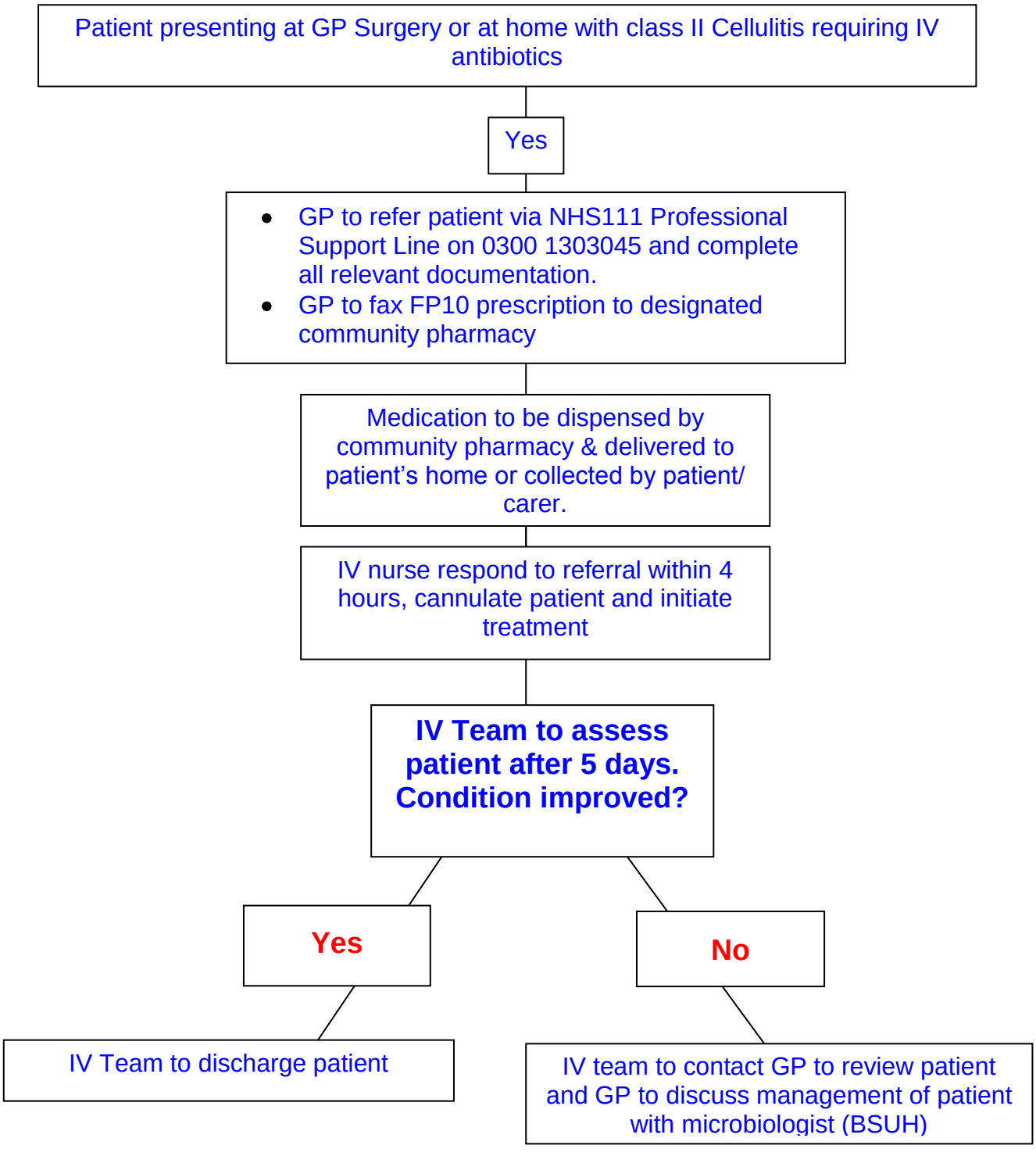
- Patient presenting with clinical signs of lower limb class 11 cellulitis (see section 2.6)
- 18 years or older
- Registered with a GP within Brighton and Hove area of SCFT
- Patient has capacity, is fully informed of planned treatment and is able to give consent, except in the case of nursing home residents where the patient may lack capacity but the prescribing doctor may decide to treat in the patient's best interest.
- Has 24 hour access to telephone at home
- Has access to carer/relative/friend who understands planned treatment.

2.1.2 Exclusion Criteria:

- Previous severe anaphylactic reaction
- Signs of systemic instability:
    - Hypotension systemic blood pressure <90 mmHg or a reduction of >40mmHg from baseline
    - New confusion
- Signs of systemic upset: >1 of
    - Temperature >38C or <36C
    - Respiratory rate >20 breaths per minute
    - Pulse >90 beats per minute
- Cellulitis of the face/peri-orbital cellulitis.
- Diarrhoea/Vomiting
- Unstable diabetes/hyperglycaemia

- Signs of rapid extension/necrosis
- Lymphangitis
- Immunocompromised patients
- History of intravenous drug abuse
- Pregnancy unless there is prior hospital consultant approval

2.2 Pathway for patients with a primary diagnosis of cellulitis requiring intravenous antibiotic therapy



2.3 Investigations

- Appropriately trained staff to make a full patient physiological observations including: temperature, blood pressure, heart rate, respiration rate, capillary blood glucose (where appropriate).
- Appropriately trained staff to take a full patient history including risk factors for cellulitis.
- Assess and record cellulitis area using daily Indicator chart (appendix B).
- Mark and date erythematous edges with surgical marker pen.
- Appropriately trained staff to assess level of pain using pain scoring system and obtain analgesia if appropriate.
- Photograph of affected limb may be taken in line with SCFT wound care guidelines.
- Full Blood count (if requested by GP).
- Urea & Electrolytes (if requested by GP).
- Liver function test (if requested by GP).
- C Reactive Protein (if requested by GP).
- Glucose (if requested by GP).
- Blood cultures should not be undertaken routinely, as only 2-4% is positive and contaminants may outnumber pathogens.
- If not already done by referring GP, and only if the skin is broken and or oozing, swab the affected area and send for microscopy, culture and sensitivity.

2.4 Roles and responsibilities

All practitioners involved are expected to refer to and follow SCFT's. IV Therapy Policy for adults and children

2.4.1 Patient

The patient must be able to consent, willing to have IV treatment at home and meet the suitability criteria. They must have contact numbers for those involved in their care and must receive advice about who to contact and when.

2.4.2 General Practitioner (GP)

The GP will have medical responsibility for any patients being seen on the pathway and will be expected to review patients if requested by the IV therapy team at the end of the course of treatment, or earlier if indicated, and make decisions about the continuation/discontinuation of IV treatment.

If the patient is suitable for the Cellulitis Pathway, the referring GP will complete an FP10 prescription as per suitable regimen (see section 2.6) for all required IV medications and send to the nominated pharmacy within their area (see Appendix H), either via the patient or by fax.

The GP must ensure that a prescription for all medication, diluents and flushes is sent to a designated community pharmacy and arrangements are in place for the medication to be delivered to the patient or collected by a relative.

The referring GP will also complete the relevant SCFT IV medication Administration Chart (Appendix C, D, E, F or G) and fax directly to the IV team. The IV team require this completed chart for the authorisation to administer the IV medication; treatment is unable to be commenced without it.

All relevant documentation must be checked and signed off by the GP before being faxed to the IV team.

If the patient has not improved after 5 days treatment, the IV therapy team will contact the GP who will discuss further management of the patient with the microbiologist (BSUH).

2.4.3 Community Intravenous Therapy Team – referrals

The IV team will accept referrals between 08.00 and 16.30 hours, 7 days a week including bank holidays. Referrals received after 16.30 hours will be seen on the next working day, if appropriate. Referrals must be made via the NHS111 Professional Support Line.

Once all relevant documentation has been received, the IV team will contact the patient and arrange to visit, within 4 hours.

The IV team will complete all relevant documentation and undertake a nursing assessment. All documentation should be managed in accordance with the SCFT Health Record Keeping Policy.

Referral to the Integrated Primary Care Team (IPCT) will be requested should on-going care be required to support the person in their own home and / or management of any wound due to the cellulitis. Any other care being provided by other services during this period should continue in order to support the patient at home.

Should a GP need to contact the Community IV team they should contact the Professional Support Line on 0300 1303045.

The IV team will liaise with the GP should there be any problems with treatment at home.

A discharge summary letter will be sent to the GP at the end of the treatment with details of treatment and any referral details.

2.4.4 Integrated Primary Care Team

IPCT will not be part of the pathway but may be involved with the care of the patient for wound management and IV therapy (if appropriate).

2.4.5 Microbiologist / Infectious Diseases Consultant

The role of the local acute trust microbiologist / Infectious Diseases Consultant is to provide advice and support on antimicrobial therapy used within the pathway.

2.5 Resources for Implementation

SCFT will produce and provide education leaflets for patients on the pathway.

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2.6 Management of Cellulitis in adults

Assessment of cellulitis severity modified from the Eron classification	
Classification	Symptoms / Indications
Class I (Mild) *For outpatient / home oral antibiotic management*	- Not systemically unwell - No uncontrolled co-morbidities - Not previously treated with antibiotics or not adequately treated with oral antibiotics for the same complaint - Can be managed on oral antibiotics in the community
Class II (Moderate) *For outpatient / home IV antibiotic management*	- Systemically ill but no more than 1 out of: tachypnoea (>20 breaths per min), tachycardia (>90 beats per min) or pyrexia (>38°C) and / or systemically well but with a co-morbidity such as peripheral vascular disease, chronic venous insufficiency or morbid obesity - Meets inclusion criteria for community IV therapy - Cellulitis has not responded to oral antibiotic treatment
Class III / IV (Severe) *For admission to hospital*	- Has significant systemic upset (or 2 or more of the criteria above) - Uncontrolled co-morbidities - Diabetes with metabolic decompensation

Patient presenting at GP surgery / home with Class I (mild) cellulitis requiring oral antibiotics

Patient presenting at GP surgery / home with Class I I (moderate) cellulitis requiring IV antibiotics

Complete and sign appropriate IV therapy Medicines Instruction Chart and fax to IV Therapy Service on 01273 242291 (send original to IV Therapy Team, BGH)

Appendix C

Appendix D/F

Make IV referral to NHS 111 Professional Support Line on 0300 1303045

Complete FP10 and send to:
Brighton & Hove (East), Asda Pharmacy,
The Marina, Brighton BN2 5UT
Tel: 01273 811211

Management	
Class I (Mild) *For outpatient / home oral antibiotic management*	Flucloxacillin capsules 500mg QDS for 7 days PENICILLIN ALLERGY Clarithromycin tablets 500mg BD for 7 days
Class II (Moderate) *For outpatient / home IV antibiotic management*	1st line Ceftriaxone IV 2g OD for 5 days 2nd line PENICILLIN ALLERGY or history of *C. difficile* **Under 100kg:** Day 1 Teicoplanin IV 800mg OD * Day 2 – 5 Teicoplanin IV 400mg OD **100kg or over:** Day 1 Teicoplanin IV 1.2g OD * Day 2 – 5 Teicoplanin IV 600mg OD
Note: *This dosing is outside marketing authorisation, however the regime has been agreed by Chief Pharmacist SCFT, Consultant Microbiologist and Lead antimicrobial pharmacist BSUH. Emails on file 04/05/2012, 09/05/2012, 08/08/14	

2.7 Antibiotic Treatment

If intolerant or allergic to alternative treatments, please discuss with microbiology at BSUH.

Local management of Cellulitis

- Ensure adequate analgesia
- Management of pyrexia
- Consideration of hydration – oral/IV

3. KEY PERFORMANCE INDICATORS / MONITORING COMPLIANCE

- Reducing the number of hospital admissions for patients diagnosed with Class 11 'moderate' cellulitis.
- Maximising pathway referrals from GPs within the Brighton and Hove area of SCFT.

3.1 Sussex Community NHS Foundation Trust

Service managers will be responsible for monitoring compliance within the service through a variety of methods e.g. direct observation of practice, supervision, incident reporting and patient satisfaction audit.

3.2 Clinical Commissioning Group (CCG) and Audit

The pathway will be monitored through feedback audits and at regular meetings with the CCG. Data will also be collated from all services involved, as requested by the Commissioners, who will also continue to monitor the Pathway progress.

4. RESPONSIBILITIES

See also 2.4

Senior Managers must authorise deviation from any policy and procedure and ensure that the reasons have been clearly documented.

All Staff must seek senior management approval before deviating from any procedure or guideline; AND clearly document the reasons that the procedure or guideline was not followed.

5. ASSOCIATED DOCUMENTS AND REFERENCES

CREST – Clinical Resource Efficiency Support Team. 2005. Guidelines on the Management of Cellulitis in Adults. http://www.acutemed.co.uk/docs/Cellulitis%20guidelines,%20CREST,%2005.pdf

Corwin, Pet al. 2005. Randomised Controlled Trial of Intravenous Antibiotic Treatment for Cellulitis at Home Compared with Hospital. British Medical Journal 330:129

Delivery quality & Value: 2008. Directory of ambulatory emergency care for adults-NHS. Institute for Innovation and Improvement. London . HMSO

Eron, L.J (2000) Infections of skin and soft tissue: outcomes of a classification scheme. Clinical Infectious Diseases 31:287

Eron, L., King P. & Marineau M. 2004). Antibiotic Selection and Hospital Discharge of Patients with Cellulitis. Infections in Medicine. 21(8):381-389

Musette P. Benjichou J. 2004. Determinants of Severity for Superficial Cellulitis (Erysipelas) of the leg. Journal of Internal Medicine. 446-450.

MRSA risk assessment . 2010. Antimicrobial Stewardship Group. Hospital Infection Prevention & Control Committee .Brighton and Sussex University Hospital Trust.

Nathwani, D. 2001. The Management of Skin and Soft Tissue Infections: Outpatient Parenteral Antibiotic Therapy in the United Kingdom. Chemotherapy 47 (1):17-23.

National Patient Safety Agency.2011. Department of Health .HMSO.

Royal College of Nursing.2010. Standard of Infusion Therapy.London: RCN

Swartz, M. N. 2004 .Cellulitis. New England Journal of Medicine. 350, 904-912.

Tice, A. D et al. 2004 .Practice guidelines for outpatient parenteral antimicrobial therapy. Clinical Infectious Disease. 38:1651-1672.

6. EQUALITY ANALYSIS

The Trust aims to design and implement services, policies & other procedural documents and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.
Under the Equality Act 2010, policy or other procedural document authors have a statutory duty to give “due regard” to issues of race, disability, gender (including transgender), religion or belief, age, sexual orientation and human rights when developing their policy or other procedural document. This means that policy or other procedural document authors have to assess the potential for their document to discriminate on any of these grounds. Alternatively, the impact of the policy or other procedural document on these groups might be positive or the same for everyone.

These guidelines are linked to the umbrella Medicines Policy.

Appendix A Suitability Criteria

Patient Name : GP Name:	
NHS Number: DOB:	

Patients must meet all criteria	**Yes**	**No**	**Variance**
1. The Patient is over 18 years old.			
2. The patient has family (or similar) support			
3. Mental capacity: Is the patient able to consent to treatment and understand implications of IV treatment at home? NB: Consider mental capacity assessment.			
4. The patient and carer agree to undertake IV treatment at home?			
5. The patient can independently carry out activities of daily living or has caregiver nearby?			
6. The patient has access to a telephone at home?			
7. The patient is registered with a GP in Brighton and Hove?			
8. The patient has no previous history of anaphylactic reaction?			
9. If the patient is diabetic, is the diabetes is stable?			
10. If patient is on Warfarin, arrangements are made for INR testing?			
11. The patient is accessible to nursing staff.			
12. The patient has no history of intravenous drug abuse			
13. The patient is not pregnant			
Please indicate below if the patient:			
a) has a previous history of Clostridium Difficile			
b) is a known MRSA carrier			

REFERRAL RECEIVED BY	
Name:	DATE: TIME:

The patient has been assessed as suitable for community IV therapy Yes / No

NB If there is a variance recorded, please discuss with the IV specialist nurse or GP for clarification regarding commencing IV treatment at home.

Name of assessor (Print)	Designation	Signature

Appendix B Daily Indicator Chart

Affix Patient label here

Daily Indicator Chart for Patients with Cellulitis

Receiving Intravenous Antibiotic Therapy

Please complete **one chart for each day** of IV Therapy

Date: _____ Day 1 2 3 4 5 6 7

Assessed by: _____

PRIMARY INDICATORS

COMMENTS

PAIN

Pain Free **Severe**

0	1	2	3	4	5	6	7	8	9	10

TEMPERATURE

Less than 37°C	**Greater than 37°C**

BLOOD PRESSURE

	Hypotensive

PULSE

60	**80**	**100**	**120**

INFLAMMATION & DEMARCATION

Reducing (cm inside line)	**Static**	**Static**	**Increasing (cm outside line)**

REDNESS & WARMTH

Reducing Redness	Static	Static	Increasing Redness

Pain score
Temperature
Blood Pressure
Pulse/respiratory rate
Inflammation & Demarcation Draw around edge of cellulitic area on day 1
Redness & Warmth

SECONDARY INDICATORS

BLISTERING

Decreasing	Static	Static	Increasing

OEDEMA

Decreasing	Static	Static	Increasing

EXUDATE

Decreasing	Static	Static	Increasing
Clear		Purulent	

LEVEL OF MOBILITY

Improved	Unchanged	Unchanged	Deteriorated

Blistering
Oedema
Exudate
Level of Mobility

APPENDIX C – CEFTRIAXONE
INTRAVENOUS THERAPY MEDICINES INSTRUCTION CHART

Chart Number: _____

Sussex Community NHS
NHS Foundation Trust

Title		Name		DOB		NHS Number	
KNOWN ALLERGIES				Instruction Chart valid until: (end date / review date)			

Hospital	N/A	Consultant	N/A	GP	
Ward	N/A	Contact/Bleep No	N/A	Surgery	

DRUG	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Ceftriaxone	2g	IV	OD		

DILUENT	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Sodium Chloride 0.9% for injection	40ml	IV	OD		

INFUSION (if required)	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
	N/A	N/A	N/A	N/A	N/A	N/A	N/A

FLUSH	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Sodium Chloride 0.9% for injection	10ml	IV	PRN		

APPENDIX D – TEICOPLANIN <u>for patients under 100kg</u>
INTRAVENOUS THERAPY MEDICINES INSTRUCTION CHART
Chart Number: _____

Sussex Community NHS
NHS Foundation Trust

Title		Name		DOB		NHS Number		Weight	
KNOWN ALLERGIES				Instruction Chart valid until: (end date / review date)					

Hospital	N/A	Consultant	N/A	GP	
Ward	N/A	Contact / Bleep No	N/A	Surgery	

DRUG	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Teicoplanin (Day 1)	800mg	IV	Once Only		

DRUG	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Teicoplanin (days 2-5)	400mg	IV	OD		

DILUENT	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Water for Injection	3ml per vial	IV	OD		

FLUSH	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Sodium Chloride 0.9% for injection	10ml	IV	PRN		

APPENDIX E – CONTINUATION OF TEICOPLANIN <u>for patients under 100kg</u>
INTRAVENOUS THERAPY MEDICINES INSTRUCTION CHART
Chart Number: _____

Sussex Community NHS
NHS Foundation Trust

Title		**Name**		**DOB**		**NHS Number**		**Weight**	
KNOWN ALLERGIES				**Instruction Chart valid until: (end date / review date)**					

Hospital	**N/A**	**Consultant**	**N/A**	**GP**	
Ward	**N/A**	**Contact /Bleep No**	**N/A**	**Surgery**	

DRUG	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
		Teicoplanin	**400mg**	**IV**	**OD**		

DILUENT	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
		Water for Injection	**3ml per vial**	**IV**	**OD**		

INFUSION (if required)	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
	N/A	N/A	N/A	N/A	N/A	N/A	N/A

FLUSH	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
		Sodium Chloride 0.9% for injection	**10ml**	**IV**	**PRN**		

APPENDIX F – TEICOPLANIN <u>for patients 100kg or over</u>
INTRAVENOUS THERAPY MEDICINES INSTRUCTION CHART Chart Number: _____

Sussex Community NHS
NHS Foundation Trust

Title		Name		DOB		NHS Number	
KNOWN ALLERGIES				Instruction Chart valid until: (end date / review date)			

Hospital		Consultant		GP	
Ward		Contact/Bleep No		Surgery	

DRUG	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Teicoplanin (Day 1)	1.2g	IV	Once Only		

DRUG	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Teicoplanin (Days 2-5)	600mg	IV	OD		

DILUENT	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Water for Injection	3ml per vial	IV	OD		

INFUSION	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Sodium Chloride for injection 0.9%	100ml	IV	Once Only for Teicoplanin 1.2g		

FLUSH	Date	Name of Medicine	Dose	Route	Frequency	Prescriber's Name	Prescriber's Signature
		Sodium Chloride 0.9% for injection	10ml	IV	PRN		

APPENDIX G – CONTINUATION OF TEICOPLANIN <u>for patients 100kg or over</u>
INTRAVENOUS THERAPY MEDICINES INSTRUCTION CHART
Chart Number: _____

Sussex Community NHS
NHS Foundation Trust

Title		**Name**		**DOB**		**NHS Number**		**Weight**	
KNOWN ALLERGIES				**Instruction Chart valid until: (end date / review date)**					

Hospital	**N/A**	**Consultant**	**N/A**	**GP**	
Ward	**N/A**	**Contact/Bleep No**	**N/A**	**Surgery**	

DRUG	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
		Teicoplanin	**600mg**	**IV**	**OD**		

DILUENT	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
		Water for Injection	**3ml per vial**	**IV**	**OD**		

INFUSION (if required)	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
	N/A	N/A	N/A	N/A	N/A	N/A	N/A

FLUSH	**Date**	**Name of Medicine**	**Dose**	**Route**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature**
		Sodium Chloride 0.9% for injection	**10ml**	**IV**	**PRN**		

APPENDIX H: NOMINATED PHARMACISTS SUPPLYING INTRAVENOUS ANTIBIOTICS AND ASSOCIATED SUPPLIES

Brighton & Hove (east)
Asda Pharmacy Department
The Marina
Brighton
Tel: 01273 606611 ext 319
Fax: 01273 628613
Opening times
Mon-Thurs 09.00-20.00
Friday 09.00-21.00
Sat 09.00-20.00
Sunday 11.00-17.00

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RATIFICATION CHECKLIST

Medicines Safety and Governance Group meeting 13th December 2016

Agenda Item: The meeting administrator should be able to provide this

Procedure Title: **Management of Adults with Lower Limb Cellulitis in the Brighton & Hove area by the Community IV therapy team**

Procedure Author: Clinical Nurse Specialist IV Therapy

Presented By: **Clinical Nurse Specialist IV Therapy**

Purpose: **Ratification**

Checklist for Ratification				
1.	**Reason for Review:**			
	Reason for the Procedure review: a) Review date due or expired (August 2016)			
2.	**Summary**			
	Please give a brief overview of the following: • Updated into new format • Removal of Sainsbury's West Hove from nominated pharmacy list			
3.	**Format**			
	Has the standard SCT template been used?	**Yes**	**Comments**:	
4.	**Consultation**			
	Name		**Group Member**	**Response Y/N**
	Antimicrobial Pharmacist SCFT *Medicines Management committee Brighton & Hove CCG* *Medical Advisor Brighton & Hove CCG* *Pharmaceutical Advisor Brighton & Hove CCG* *Urgent Care Lead Brighton & Hove CCG* *Planned Care Lead Brighton & Hove CCG* *Consultant Microbiologist BSUH* *Lead Antimicrobial Pharmacist BSUH* *Infectious Disease Consultant BSUH*			
5.	**Dissemination/Implementation Process**			
	Via Pulse. Via Community IV therapy teams			

6.	**Cost/Resource Implications**		
	Does this procedure have any cost and/or resource implications?:		N
	Please provide details of the cost/resource implications: *eg training, equipment, additional staff*		
	Has this been agreed by the accountable Director?		Y/N
	Name	**Job Title**	**Date**
7.	**Approval**		
	Please state the name of the Group that has approved this document?	Name: Medicines Safety and Governance Group	
	Date of Group Approval:	Date: 13th December 2016	
8.	**Equality Analysis**		
	Has the Equality Impact Assessment been completed?	**Yes/No** (please delete)	Comments
9.	**Review**		
	Please state the timescale for review:	3 years	

DECISION OUTCOME AND RECOMMENDATIONS

For completion by the Chair of the Group or Committee considering ratification.		
Is the Committee / Group satisfied and assured that due process has been followed in order to produce or review the Procedure?	**Yes/~~No~~** (please delete)	Comments:
Is the Committee / Group satisfied and assured with the consultation on the Procedure?	**Yes/~~No~~** (please delete)	Comments:
Does anybody (Group or individual) else need to be consulted prior to ratification?	**~~Yes/~~No** (please delete)	Please state who:
Other Comments	This is review of an existing document.	
Outcome:		

Management of Adults with Lower Limb Cellulitis in the Brighton & Hove area by the Community IV therapy team

Was the Procedure Ratified?	**Yes**
Other comments: Including strengths and good practice.	
Additional actions required for ratification: Must be SMART	
Signature of Chair: Iben Altman **(Chief Pharmacist)** **Date: 13/12/2016**	