Australian Capital Territory

Health (Scope of Practice for Nurse Practitioner Positions) Approval 2005 (No 1)*

Notifiable instrument NI2005-455

made under the

Health Regulation 2004 - section 11 (Scope of Practice for nurse practitioner positions)

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1 Name of instrument

This instrument is the *Health (Scope of Practice for Nurse Practitioner Positions) Approval 2005 (No 1)*.

2 Commencement

This instrument commences on the day after notification.

3 Scope of Practice for nurse practitioner positions

Under section 11, scope of practice for nurse practitioner positions have been approved for the following:

a) Aged Care Nurse Practitioner, Aged Care and Rehabilitation Service, ACT Health.
b) Aged Care Nurse Practitioner, Mirinjani Retirement Village, Uniting Care Ageing, South Eastern Region.
c) Sexual Health Nurse Practitioner, Canberra Sexual Health Centre, The Canberra Hospital, ACT Health.
d) Wound Care Nurse Practitioner, Continuing Care Program, Community Health, ACT Health.
e) Emergency Department Nurse Practitioner, Calvary Healthcare.

The scope of practice for each of the nurse practitioner positions is attached.
As these positions are 'new' positions the clinical practice guidelines and medication formularies are a work in progress and may change. These will be finalised within the first three months of the position being established after they have received the endorsement of the ACT Nurse Practitioner Clinical Practice Guideline Development Standing Committee.

Dr Tony Sherbon
Chief Executive
25 November 2005

*Name amended under Legislation Act, s 60

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Comprehensive Geriatric Assessment

The prevalence of co-morbidities in this population lends itself to a client-focused model in establishing therapeutic goals, which lead to a comprehensive problem solving and life enhancing approach. This means that the older person may consult the nurse practitioner with an individual health concern in any one or more of the following areas and the assessment will be tailored to the individual. [1] Consideration will always be given to issues that may arise in relation to cultural and linguistic differences.

⇓

A **Cognition**	**B** **Comfort**	**C** **Continence**	**D** **Mobility**	**E** **Infection**
Dementia **D**epression **D**elirium **D**rugs	**E**nvironmental **P**athophysiological **S**piritual **E**motional	**B**ladder **B**owel	**F**alls **I**solation **T**ransport	**S**kin/integument Genitourinary tract **R**espiratory **E**nteric

[1] Boult C. Comprehensive Geriatric Assessment. In: Beers M, Berkow R, eds. The Merck Manual of Geriatrics: Medical Services, USMEDSA, USHH, 2000-2003

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1. C Assessment

Consider conditions for referral to other health care professional.
Any conditions outside scope of practice eg Myocardial infarction

Patient history
Presenting Issue
Physical Health
Functional Ability
Family/social Hx
Pharmacological Hx[2]
Informant Hx
Nutrition and hydration

Examination as appropriate
Cognition MMSE[3] GDS[4] CAM[5]
GCS[6]
Sensorium
CNS
Respiratory
CVS
GIT
Genitourinary
Musculoskeletal/Skeletal
Mobility[7]
Skin

Investigations for consideration
As indicated eg FBC, UEC

[2] OLDER PEOPLE & QUALITY USE OF MEDICINES: Exploring the role of the Primary Health Nurse in domiciliary medication review & management. *May 2002*

[3] Folstein MF, Folstein SE, Mc Hugh PR, "Mini Mental State" a practical method for grading the cognitive state of patients for the clinician *J Psychiatr Res. 1975; 12:196-198.*
[4] YeSavage J Differential Diagnosis Between Depression and Dementia American Journal of Medicine 1993 94:5A 235
[5] Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the Confusion Assessment Method; a new method for detection of delirium. Ann Intern Med. 1990;113:941-8.
[6] Teasdale G, Jennett B (1974), Assessment of coma and impaired consciousness: a practical scale. Lancet 2:81-84.
[7] QuickScreen© Prince of Wales Medical Research Institute.

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2. Diagnosis/

3. Management

3a. Conditions for referral to other health care professional: compromising exacerbation or new presentation

Cardiac Failure
Diabetes
Malignant Hypertension
Parkinson's disease/parkinsonism
Dementia
Arthritis
Depression
Psychosis
Myocardial infarction
Cerebrovascular accident
Fracture
Sepsis
Any other condition outside scope of practice

3b. Treatment/Management options

- **Cognition**[8]
  Reversible causes within scope of practice see below
- **Comfort**[9]
  Environmental,
  Pathophysiological,
  Spiritual
  Emotional
- **Continence** [10]
  Constipation /Impaction
  Diarrhoea
  Spurious diarrhoea
  Faecal Incontinence
  Urge and Stress incontinence
  Neuropathies
- **Mobility**[11]

3c. Health Promotion/Illness Prevention

Integrated Management of Comorbidities/Risk management
Falls Screen
Waterlow Scale[12]
Osteoporosis
Pain Management
Polypharmacy
Mild Cognitive Impairment
Depression
Smoking Cessation
Substance abuse
Sensory Input
Weight Management
Exercise
Oral Hygiene
Care of Skin and Integument.
Continence Promotion

[8] Guideline A
[9] Guideline B
[10] Guideline C
[11] Guideline D
[12] Waterlow J. Pressure sores: a risk assessment card. *Nurs Times* 1985; 81: 49-55.

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Falls
Isolation
Transport,

- **Polypharmacy**
  Compliance
  OTC
  Multiple Prescribers
  Adverse Drug Reactions/interactions
- **Infections**
  Skin
  Genitourinary tract
  Respiratory
  Enteric

Eye
Mouth

Advanced Care Directives
Elder Abuse/Restraint
Family/Carer Support
Social Integration.

Non-pharmacological approaches

- Rest
- Sleep hygiene
- Activity
- Optimal Positioning
- Identifying pain behaviour
- Diversion

Pharmacological agents
Antibiotics and antifungals
Antiemetics
Analgesia
Laxatives
Vitamins and Supplements
Drugs affecting Bones
Bronchodilators
Ocular Lubricants
Vaccinations
Topical Agents
Complimentary Medicines

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4. Follow up

Review as clinically indicated

- Monitor test results
- Evaluate therapeutic response
- Refer as appropriate.

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A. CLINICAL GUIDELINE FOR COGNITION: In Australia there was over 162,000 people with dementia in 2002. The prevalence of dementia is growing rapidly and the socio-economic and disability burden of dementia is severe. People with dementia have higher than average use of medical services, longer hospital stays and increased pharmaceutical costs.[13] Depression in later life is a significant public health problem, albeit under treated and under recognized, particularly in non psychiatric settings such as primary care practice, general hospitals and nursing homes[14] Delirium occurs frequently in older hospitalised patients and is implicated in increased mortality and morbidity, prolonged hospital stay and risk of institutionalisation.[15] The recognition and management of elderly individuals with dementia and/or depression who experience a superimposed delirium is a complex challenge across the aged care continuum.

1. Assessment

Consider conditions for urgent referral to other health care professional eg
Any condition outside the scope of practice eg life threatening depression

Patient history
See Comprehensive Assessment*
- Collaborative *(See glossary)*
- Cognitive
- Education
- Family/Social

Examination as appropriate
See Comprehensive Assessment*
- Social Competence
- Process and Planning
- Gnosis
- Frontal changes

Investigations for consideration As clinically indicated eg
Dementia Screen

[13] The Dementia Epidemic: Economic Impact and Positive Solutions For Australia. *Access Economics* Canberra March 2003. pg 41.
[14] Mulsant B& Gangulu M,. Epidemiology and Diagnosis of Depression in Late Life *Journal of Clinical Psychiatry 1990:60*
[15] Gleason O Delirium *American Family Physician* March 2003 vol 67n5

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2. Diagnosis/ interpretation

Dementia
Alzheimer's Disease
Vascular Dementia
Lewy Body Disease
Alcohol Related Dementia
Frontal Type Dementia

Depression
Previous episode
Vegetative signs
Grief reaction
Loss
Mania
Psychosis
Diurnal variation
Suicidal Ideation
Family Hx

Delirium
Causation
Pattern of onset
Duration
Fluctuating consciousness

3. Management

3a. Conditions for referral to other health care professional: Compromising exacerbation or new presentation
Any condition outside of scope of practice eg Psychosis

3b. Conditions for NP treatment/Management
- Polypharmacy
- Hydration
- Electrolyte and metabolic disturbances
- Pain
- Constipation
- Infection
- Carer Stress

3c. Health Promotion / Illness Prevention
- BPSD[16]Management
- Communication
- Guardianship and Administration

[16] Behavioural and Physiological Symptoms of Dementia. "Recommendations for the management of behavioural and psychological symptoms of dementia." N. Herrmann. in The Canadian Journal of Neurological Science. 2001 Feb; 28 Suppl 1: S96 – 107.

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- Elder Abuse

Non-pharmacological approaches

- Environmental
- Pain Mx
- Referral to: Alzheimer's Association, ACAT, Carers Association, Day Care Programs Office Of public advocate

Pharmacological agents

Hydroxocobalamin Chloride
Folic Acid
Thiamine
Address all reversible causes, refer to pharmacological agents in Comfort, Continence, Mobility and Infection guidelines

4. Follow up

Review as clinically indicated

- Monitor test results
- Evaluate therapeutic response

Refer as appropriate.

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B.CLINICAL GUIDELINE FOR COMFORT: It is estimated that up to 140,000 people in Australia's 3000 government subsidized residential aged care facilities have pain.[17] The management of pain in the elderly patient presents many challenges: pain syndromes are often due to chronic diseases that are not curable; the metabolic and pharmacodynamic changes that accompany aging complicate the prescribing of analgesics; cognitive dysfunction compounds pain assessment; functional ability may be impaired; and psychosocial issues often need to be addressed.[18]

1. Assessment

Consider conditions for urgent referral to other health care professional, eg
Any condition outside the scope of practice eg Unexplained/ uncontrolled pain

Patient history
See Comprehensive Assessment *
Review medications i.e. current analgesia
Mobility
Pain limitations
Cognition

Examination as appropriate
See Comprehensive Assessment
Select Pain Assessment tool[19][20]

Investigations for consideration As clinically indicated eg
X ray

[17]Goucke R. Farrell M, and Scherer S, Conference Proceedings, Neuroscience Forum 2004. *Pain and Dementia*
[18] David J. Hewitt & Kathleen M. Foley in *Geriatric Medicine* 3rd Edition. 1997
[19] **Abbey** J. Piller N. De Bellis A. Esterman A. Parker D. Giles L. Lowcay B. The **Abbey** pain scale: a 1-minute numerical indicator for people with end-stage dementia. [Journal Article, Questionnaire/Scale, Research, Tables/Charts] *International Journal of Palliative Nursing. 2004 Jan; 10(1): 6, 8-13. (21 ref)*
[20] **Melzack** R. The McGill Pain Questionnaire: Major properties and scoring methods. Pain 1975; 1, 275-295.

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2. Diagnosis/ interpretation

3. Management

3a. Conditions for referral to other health care professional: Compromising exacerbation or new presentation

Any condition outside of scope of practice eg acute medical/surgical presentations such acute abdomen.

3b. Conditions for NP treatment/Management

- Inadequate pain management
- Chronic conditions
- Osteoarthritis
- Lower back pain
- Constipation
- Acute post-operative/procedural pain.

3c. Health Promotion/Illness Prevention

Exercise
Weight Loss
Social Integration

Non-pharmacological approaches

Heat and cold packs
Massage
Gentle Exercise
Aromatherapy
Diversional therapy

Pharmacological agents

Analgesia
Paracetamol
Codeine phosphate with paracetamol
Antiemetics
Domperidone
Metoclopramide hydrochloride
Agents Affecting Bones
Calcium Carbonate
Ergocalciferol

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4. Follow up

Review as clinically indicated

- Monitor test results
- Evaluate therapeutic response

Refer as appropriate.

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C. CLINICAL GUIDELINE FOR CONTINENCE:

30% of people over the age of 80 are reported to have incontinence. Incontinence often plays a major part in the decision to place people into residential care. It is further complicated in the target population by co morbidities.[21]

1. Assessment

Consider conditions for urgent referral to other health care professional, eg
Any condition outside the scope of practice eg gross haematuria

Patient history
See Comprehensive Assessment*
Reproductive Hx
Enuretic Hx
Patterns of Elimination
Mobility

Examination as appropriate
Abdominal Palpation/auscultation
Bladder Palpation
PR Examination

Investigations for consideration As clinically indicated eg
MSU, stool cultures

2. Diagnosis/ interpretation

3. Management

3a. Conditions for referral to other health care professional: Compromising exacerbation or new presentation
Any condition outside of scope of practice

3b. Conditions for NP treatment/Management

- UTI
- Constipation
- Simple Diarrhoea
- Spurious Diarrhoea
- Functional Incontinence
- Reversible causes eg medication

3c. Health Promotion/Illness Prevention
Good bladder and bowel habits
Product Advice
Dietary Advice
Environmental Cues
Funding Options

[21] Millard R. The prevalence of urinary incontinence in Australia: A demographic survey conducted in Sydney in 1983. *Australian Continence Journal* 1998;4(4):92 - 99

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Non-pharmacological approaches
Toileting Regimen
Pelvic Floor Exercises
Bladder Retraining
Nutrition/Hydration
Psychosocial Support
Equipment
Cranberry Supplements

Pharmacological agents
Management of UTI
Trimethoprim
Cephalexin
Amoxycillin Trihydrate& Clavulanate
Management of Urge and Stress Incontinence.
Oestriol Cream
Management and Prevention of Constipation
Frangula Sterculia
Psyllium Hydrophillic Mucilliod
Sorbitol
Movicol
Docussate Sodium
Bisacodyl
Sennosides A&B
Glycerine Suppositories
Sodium Magnesium Enema
Phosphate Enema

4. Follow up

Review as clinically indicated

- Monitor test results
- Evaluate therapeutic response

Refer as appropriate.

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D. CLINICAL GUIDELINE FOR MOBILITY: Australian and overseas studies of community dwelling older people have identified that one in three people aged 65 years and over fall each year. The rate of falls and associated injuries is even higher in hospitals and residential settings. The effect of falls is costly to the individuals in terms of health, function and quality of life.[22]

1. Assessment

Consider conditions for urgent referral to other health care professional, eg
Any condition outside the scope of practice eg traumatic fracture

Patient history
See Comprehensive Assessment *
Falls Hx
Review medications which may contribute to falls
Mobility
Pain limitations
Cognition
Nutrition/hydration

Examination as appropriate
See Comprehensive Assessment
Falls Kit[23]
Lying and Standing Blood Pressure.

Investigations for consideration As clinically indicated eg
Vit D level

[22] 'An analysis of research on preventing falls and falls injury in older people': Community, residential care and hospital settings" (2004 Update) National Ageing Research Institute.
[23] QuickScreen © Prince of Wales Medical Research Institute.

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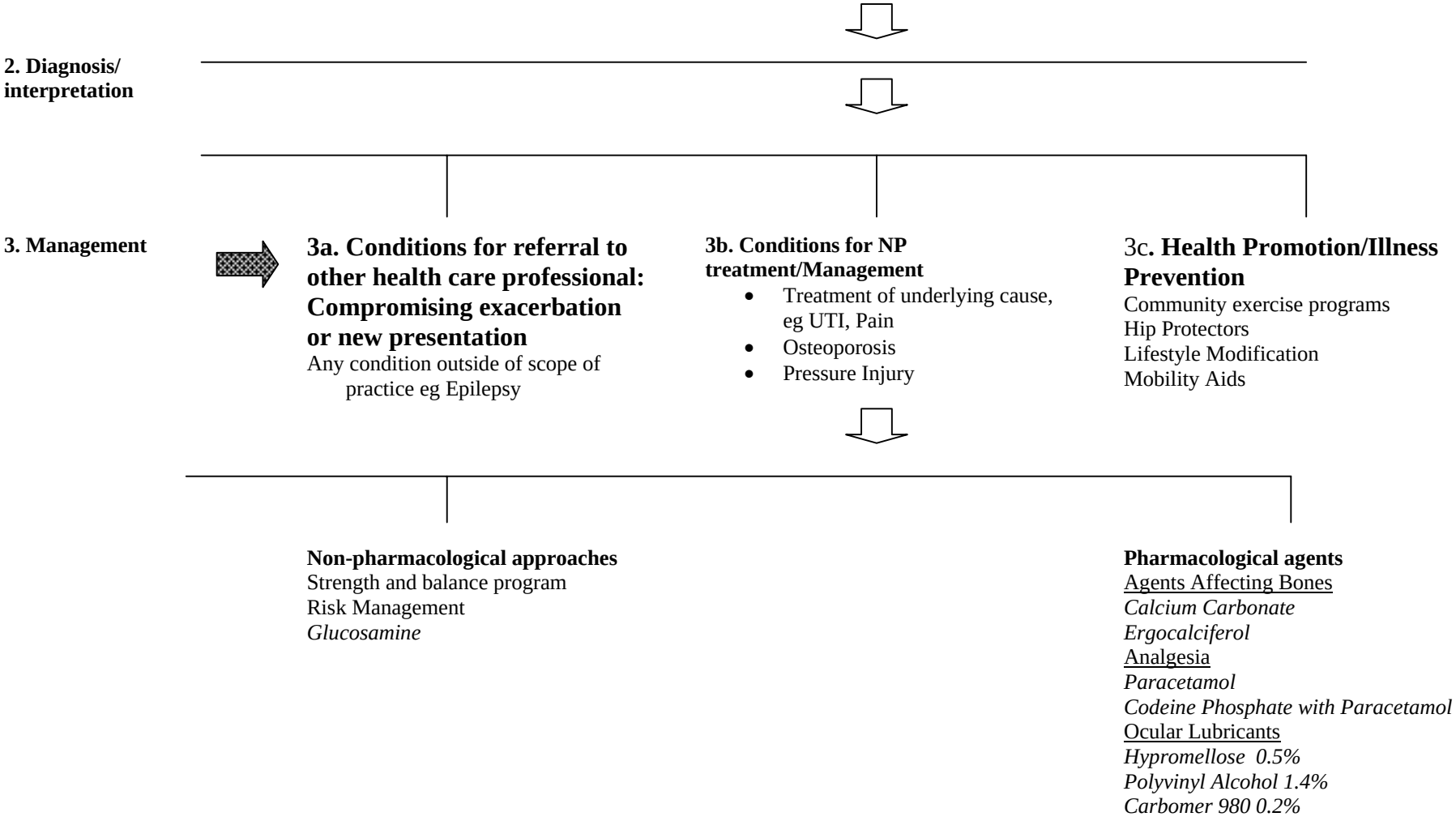

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4. Follow up

Review as clinically indicated

- Monitor test results
- Evaluate therapeutic response

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E. CLINICAL GUIDELINE FOR INFECTION: Infectious disease is widespread among elderly people and has potentially devastating consequences. Infections are major reasons of hospitalisation for the aged and old people suffer greater morbidity and mortality from infections than do younger adults.[24]

1. Assessment

Consider conditions for urgent referral to other health care professional.
Any condition outside the scope of practice eg septicaemia.

Patient history
See Comprehensive Assessment *

Examination as appropriate
See Comprehensive Assessment

Investigations for consideration
As clinically indicated eg
CRP

[24] Matteson, M.A, McConnell, E.S & Linton, A.D Gerontological Nursing: Concepts & Practise. Pg 427 (1997) Saunders Philadelphia.

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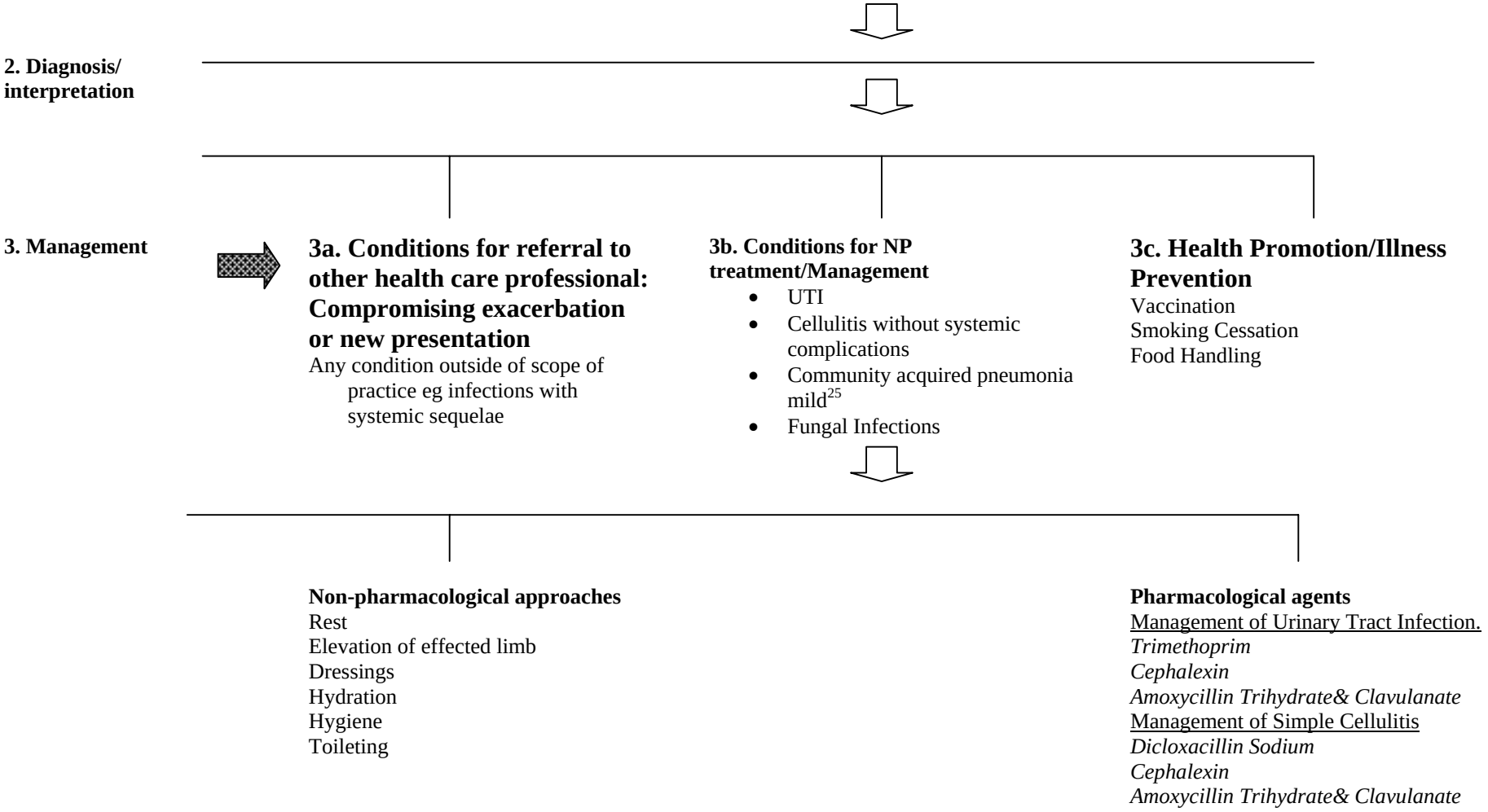

[25]Mild pneumonia as defined by CURB-65. Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. W S Lim, M M van der Eerden, R Laing, W G Boersma, N Karalus, G I Town, S A Lewis and J T Macfarlane.

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Management of Animal Bites.
Amoxycillin Trihydrate& Clavulanate
Metronidazole
Management of Community Acquired Pneumonia
Amoxycillin
Roxithromycin
Bronchodilators
Tiotropium Bromide
Salbutamol Sulphate
Immunisations
ADT
Pneumococcal Vaccine
Influenza Virus Vaccine
Management Bacterial Eye Infections
Chloromycetin Drops/ointment
Fungal Infections
Nystatin
Clotrimazole

4. Follow up

Review as clinically indicated

- Monitor test results
- Evaluate therapeutic response

Refer as appropriate.

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GLOSSARY

ACAT – Aged Care Assessment Team

BPSD – Behavioural and Psychological Symptoms of Dementia

CAM – Confusion Assessment Method

Collaborative History – A collaborative or informative history is an essential part of diagnosing moderate cognitive disorder. It involves interviewing persons well known to the individual who can report on changes over time of which the individual may not be aware.

CRP – C Reactive Protein

FBC – Full Blood Count

GCS – Glasgow Coma Scale

GDS – Geriatric Depression Scale

MMSE – Mini Mental State Examination

MSU – Mid Stream Urine

OTC – Over the Counter medications

PR – Per Rectum

UEC – Urea Electrolytes Creatinine.

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MEDICATION FORMULARY.

Vitamins and Supplements

Hydroxocobalamin Chloride
Folic Acid
Ferrous Sulphate
Thiamine
Ergocalciferol
Calcium Carbonate

Ocular

Hypromellose 0.5% eye drop
Polyvinyl Alcohol 1.4% eye drop
Carbomer 980 0.2%
Chloramphenicol

Topical

Oestriol Cream

Analagesia

Paracetamol
Codeine Phosphate with Paracetamol

Antiemetics

Domperidone
Metoclopramide hydrochloride

Antibiotics and Antifungals

Amoxycillin
Trimethoprim
Cephalexin
Dicloxacillin Sodium
Amoxycillin Trihydrate &Potassium Clavulanate
Metronidazole
Roxithromycin
Nystatin
Clotrimazole

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Bronchodilators
Salbutamol Sulphate
Tiotropium Bromide

MEDICATION FORMULARY

Laxatives
Frangula Sterculia
Psyllium Hydrophillic Mucilliod
Sorbitol
Movicol
Docusate Sodium
Sennosides A &B
Bisacodyl
Glycerine Suppositories
Sodium Magnesium Enema
Phosphate Enema

Immunisations
ADT
Pneumococcal Vaccine
Influenza Virus Vaccine

Complimentary Therapies
Cranberry tablets
Glucosamine

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Emergency Department Nurse Practitioner
Scope of Practice Statement

Position details

Local Title	Nurse Practitioner				
Classification	Registered Nurse Level 4.2				
Department/ Ward	Emergency Department				
Position number(s)		Type		Fortnightly hours	76
		Ins. No.	99/99	Cost Centre	1105

Reporting details

Supervises		Line responsibility / authority / accountability	Operational: Clinical Nurse Manager Professional: Clinical Nurse Manager Assoc Director of Nursing Director of Nursing Clinical: Clinical Nurse manager Director of Emergency Dept Legislative: Nurses Board of the ACT ACT Health Calvary Health Care ACT

Emergency Nurse Practitioner

Role	• A nurse practitioner is a Registered Nurse with advanced knowledge, skills and recognised clinical competence, authorized by the Nurses Registration Board of the ACT. • A Nurse Practitioner practices within a professional role working autonomously, with the freedom to make decisions and act on those decisions, consistent with their specific scope of practice. • The Emergency Nurse Practitioner should be a recognized specialist nurse in emergency care and have specific knowledge and education within the specialty, including; advanced life support, trauma and other specialty inputs required to perform the specifics of the role. • The Nurse Practitioner's knowledge should be supported by a Master of Nursing (Nurse Practitioner). • The Nurse Practitioner should be published and be active in education of fellow nursing staff. • The Nurse Practitioner displays a commitment to the professional development of both themselves and their departmental colleagues. • The Nurse Practitioner provides acute health care services to the community within a framework guided by professional guideline of practice through assessment, diagnosis and management of health issues in a complex, busy and unpredictable environment.
Aim	• To provide appropriate timely care to those requiring episodic acute health care services by appropriate members of a multidisciplinary health

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	professional team. • Develop the advanced nursing practice role, working autonomously, within a scope of practice, with measurable quality outcomes.
Environment	• The Emergency Nurse Practitioner works autonomously within the Emergency Department and within services providing acute health care. • The Nurse Practitioner has the expertise to support referral to other health care professionals. • Clinical consultation with persons seeking acute health care may be made autonomously and/or in collaboration with senior medical staff, primarily based in the Emergency Department. • The Nurse Practitioner works within a multidisciplinary team inclusive of medical, nursing and allied health staff as well as other health care professionals. • The Nurse practitioner works both as a colleague and in a consultant role with departmental nursing staff.
Formulary	• The Emergency Nurse Practitioner will work from a formulary based on medications required in the provision of episodic acute care. This formulary will be prescribed within a framework of clinical guidelines both specific to clinical practice within the Emergency Department and those established and accepted as best practice such as the therapeutic guidelines.
Process of Care	Assessment of Health Status • Triage • Resuscitation and Stabilisation • Obtains relevant health history • Performs an appropriate physical examination • Identifies health risks • Applies crisis intervention when indicated Diagnosis • Formulates appropriate differential diagnosis based on clinical findings • Identifies individual requirements to access health data from relevant persons • Identifies individual requirements to access health care services to support the implementation of acute care Development of a Treatment Plan • Priorities are established and a mutually acceptable plan of care is devised to maximise the health potential of the individual. This includes, though is not limited to: ➢ Ordering appropriate diagnostic tests ➢ Prescribing appropriate pharmacological agents ➢ Assessing non-pharmacological interventions

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	➢ Analysis patient education opportunities ➢ Treatment plan is based on evidence based best practice Implementation of Treatment Plan • Interventions are based upon priorities and clinical guidelines • Treatment is individual specific to the situation • Treatment is based on scientific principles, theoretical knowledge and clinical expertise Intervention Actions • Within the acute setting, providing episodic health care Including though not limited to: ➢ Accurately conducting and interpreting diagnostic tests ➢ Prescribing pharmacological agents ➢ Prescribing non-pharmacological therapies ➢ Making appropriate referrals to other health care professionals and community agencies ➢ Providing relevant patient and/or family health promotion/restoration education Follow Up • Follow up and evaluation of appropriate episodic acute health care issues • Referral for follow up appropriate community agency/LMO

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Categories of Care	The Emergency Nurse Practitioner will provide acute episodic health care intervention and education for persons presenting to the Emergency Department. This will cover a broad spectrum of both age and condition. These presenting conditions may include, though not limited to:
	
	• Abdominal Pain
	• Chest Pain
	• Respiratory Complaints
	• Resuscitation
	• Limb Injuries
	  ➢ Strains
	  ➢ Fractures
	
	• Wound Management
	  ➢ Lacerations
	  ➢ Abrasions
	  ➢ Burns
	  ➢ Ulcers
	  ➢ Cellulitis
	
	• ENT Complaints
	• Eye Complaints (With collaboration)
	• Pyrexia
	• Diabetic Emergencies
	• Foreign Body Removals
	• Sharps Injuries Acute Assessment
	• Envenomation
	• CBR/Environmental Emergencies
	• Urinary Symptoms
	• Sexual Health and STD Acute Care
	• Mental Health Acute Assessment and Referral

Role Evaluation	Regular Emergency Nurse Practitioner role effectiveness, appropriateness and productiveness will be assessed in conjunction with supervising personnel.

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Acknowledgements	Jane O'Connell EDNP North Sydney Area Health Service NSW Greater Murray Area Health Service ACT Health: Nurse Practitioners in the Australian Capital Territory – The Framework

Approved Service Director:	Heather Austin
Approved HR Department	Mary-Ann O'Sullivan

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Calvary Emergency Nurse Practitioner

Medication	Formulary
Aspirin	HB Vax II
Actrapid	Hydrocortisone
Adrenaline	Ibuprofen
Adult Diphtheria and Tetanus Vaccine	Indocid
Amoxycillin	Lasix
Amoxicillin trihydrate	Lignocaine
Atropine	Lomotil
Atrovent	Losec
Benzylpenicillin	Marcain
Carbosorb S	Maxolon
Cefalexin	Meningococcal vaccine
Cefazolin	Midazolam
Celebrex	Mylanta
Chloromycetin	Naloxone
Chlorsig	Naprosyn
Codeine aspirin	Paracetamol
Codeine paracetamol	Prednisolone
Dicloxacillin	Promethazine
Flagyl	Salbutamol
Flucloxacillin	Stemetil
Gentamicin	Tramadol
GTN	Xylocaine

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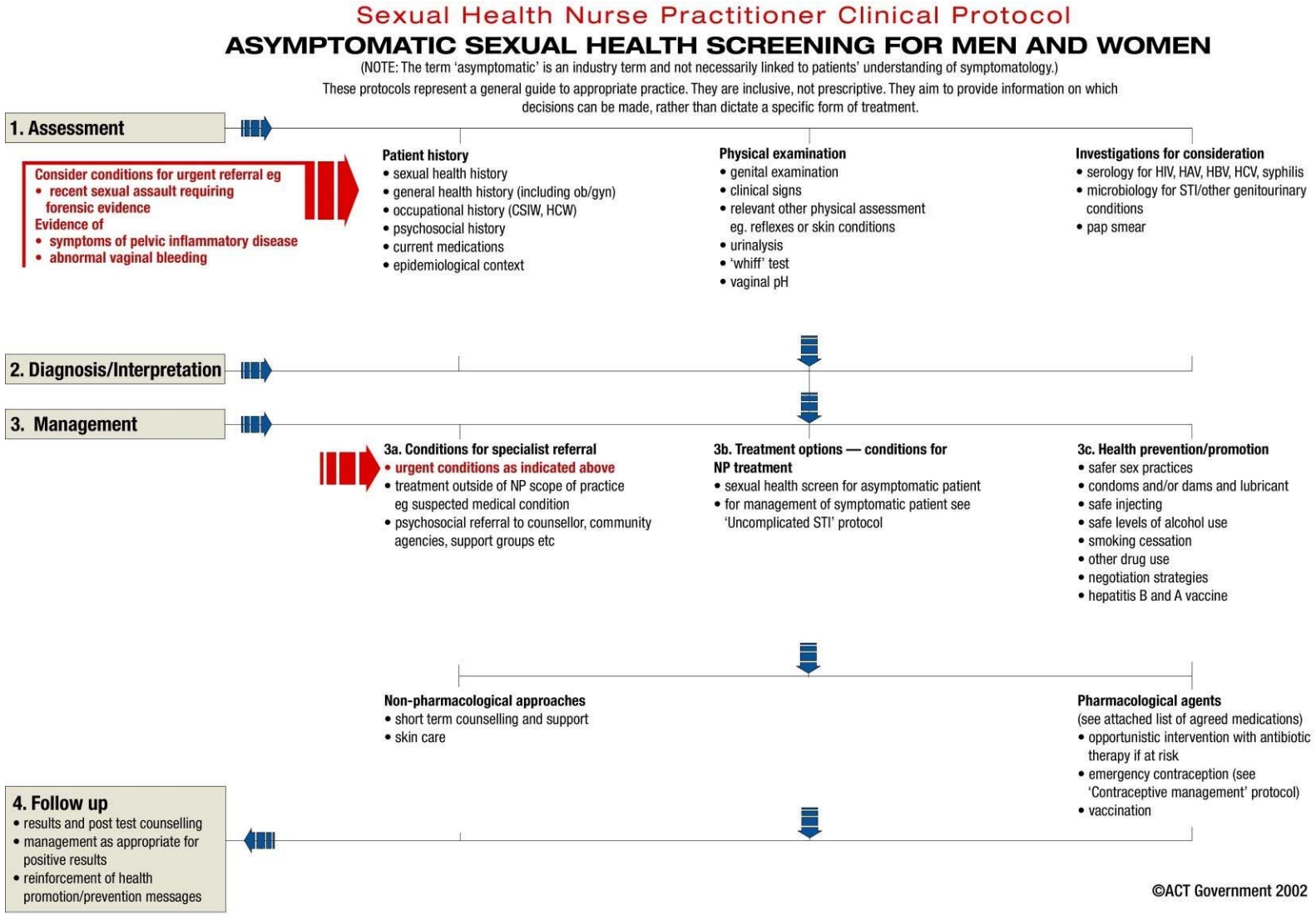
WORK IN PROGRESS



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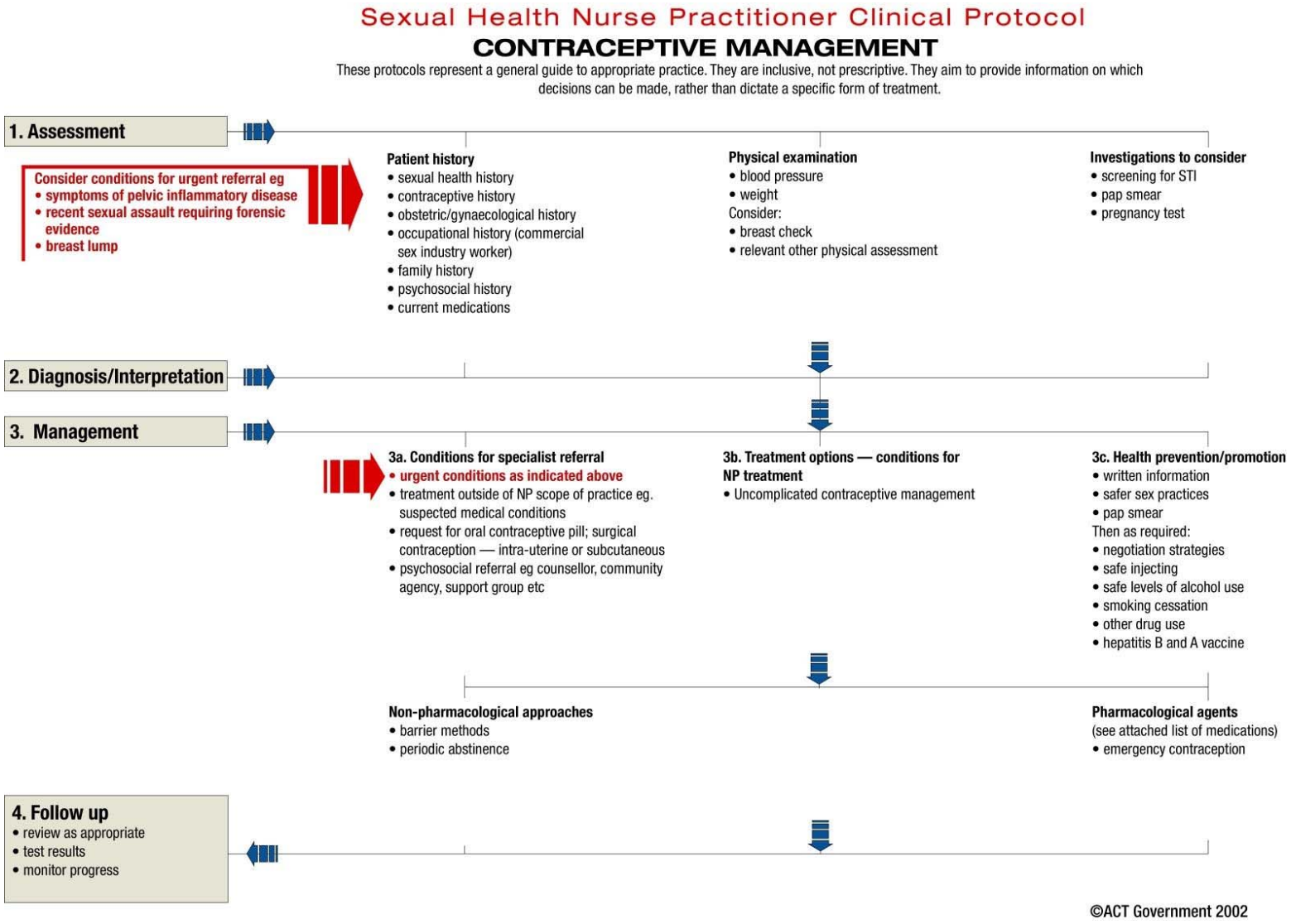

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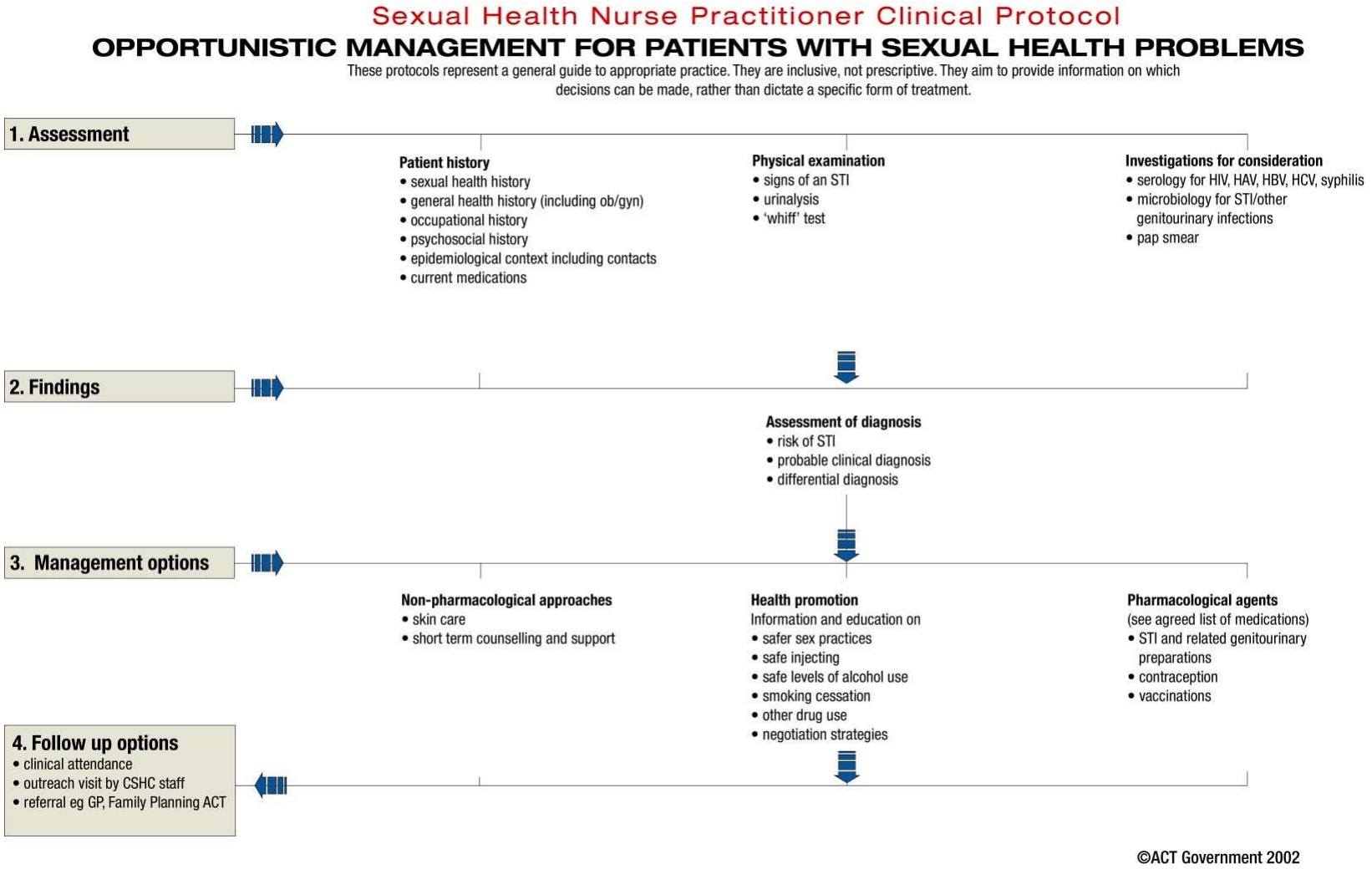

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WORK IN PROGRESS

Sexual Health Nurse Practitioner

MEDICATION FORMULARY

Agreed list of medications

STI related (antibiotic, antifungal, antiviral, antiparasitic, immunomodifier, anti-mitotic preparations)

Antibiotic:
- azithromycin
- ceftriaxone
- ciprofloxacin
- doxycycline
- tinidazole

Antifungal:
- clotrimazole (topical)

Antiviral:
- aciclovir
- famciclovir
- valaciclovir

Antiparasitic:
- permethrin (topical)

Immunomodifier:
- imiquimod (topical)

Anti-mitotic:
- podophyllotoxin (topical)

Genitourinary related (antibiotic and topical steroid)

- amoxycillin
- hydrocortisone (topical)
- metronidazole
- trimethoprim

Contraception (post coital contraception)

- levonorgestrel (progesterone only)
- ethinyloestradiol/levonorgestrel (Yuzpe method) with metoclopramide hydrochloride

Vaccinations

- hepatitis B
- hepatitis A
- combined hepatitis B and A

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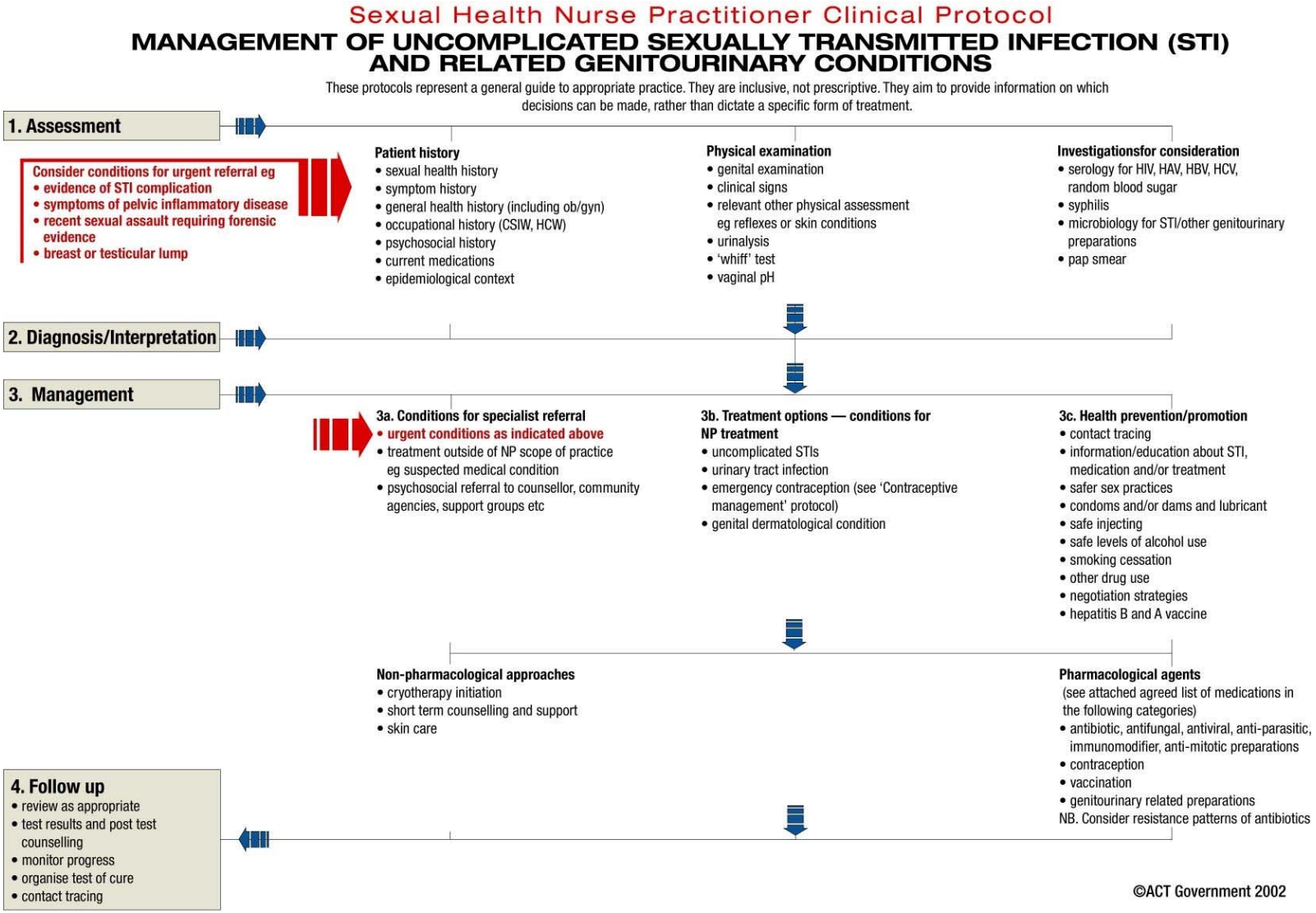
WORK IN PROGRESS



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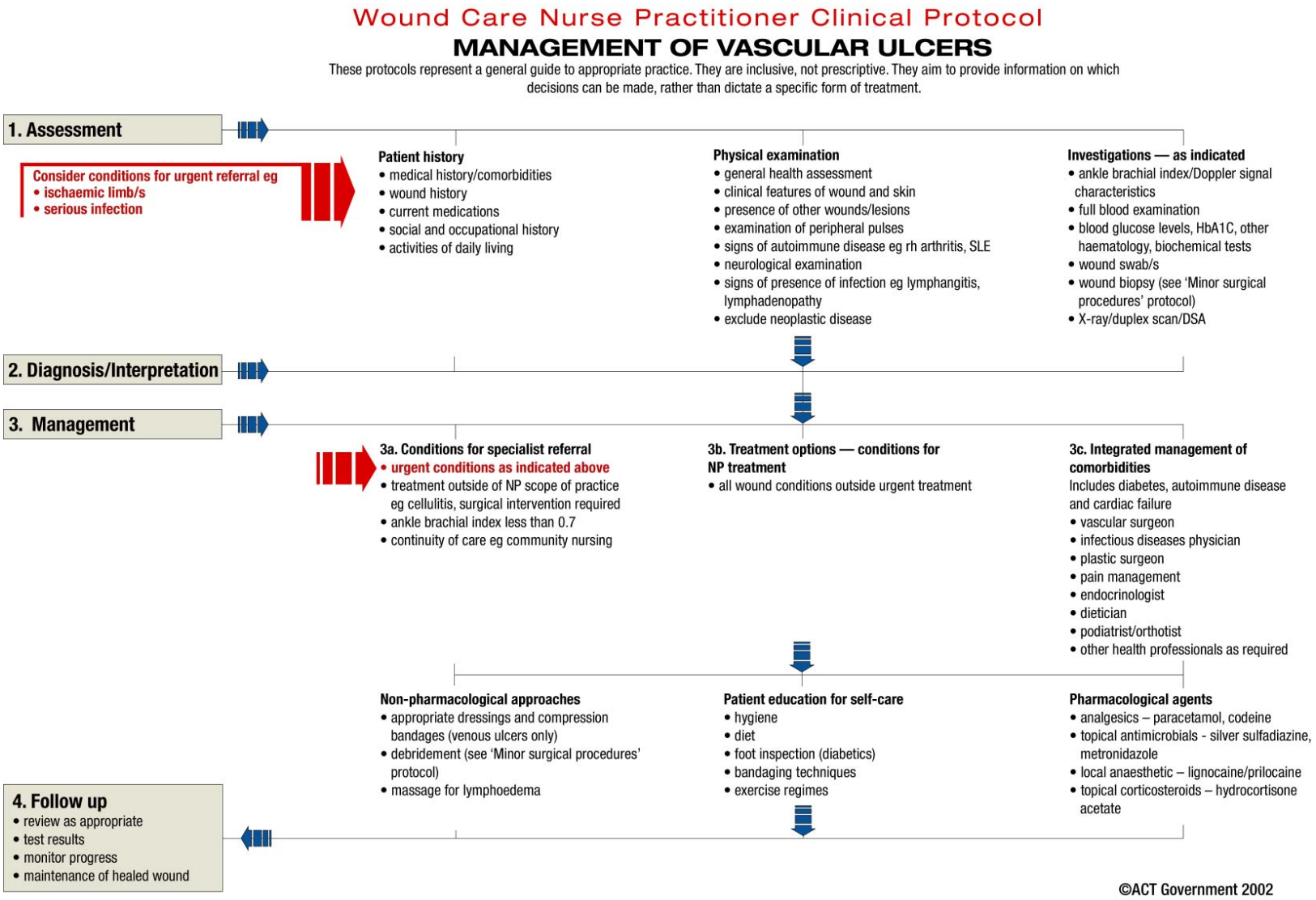

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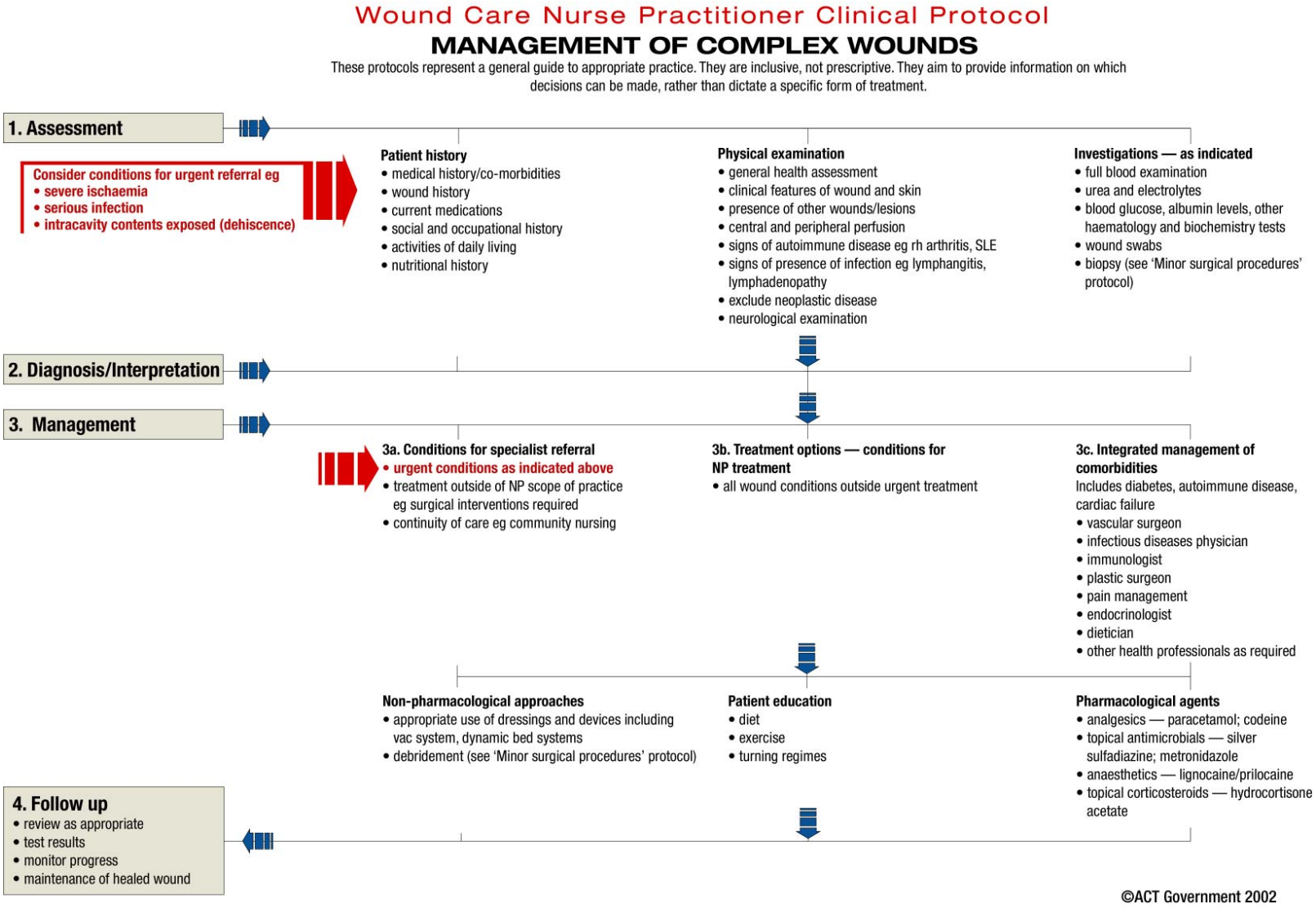

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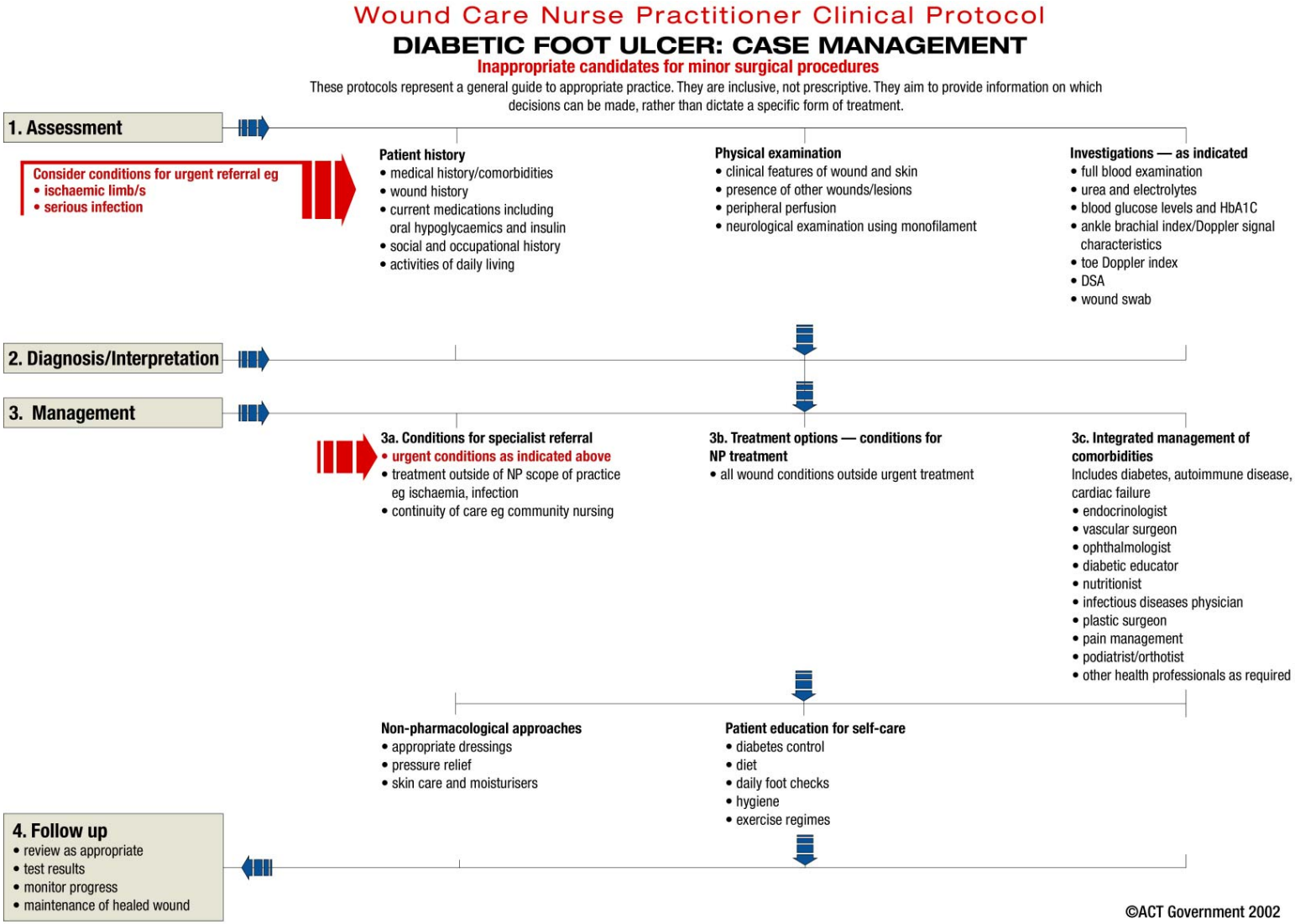

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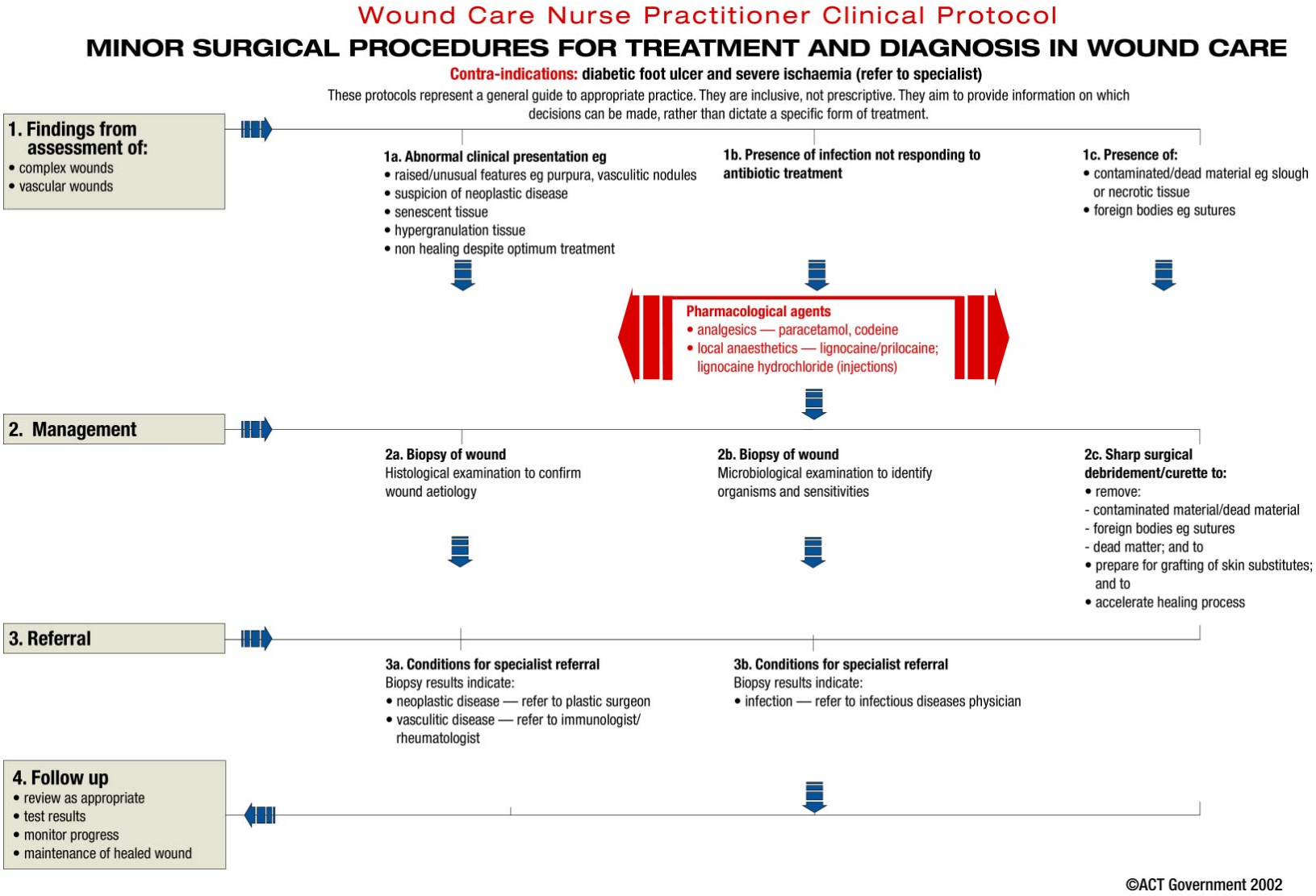

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