Patient group directions: training practitioners for competency

PATIENT group directions (PGDs) are written directions relating to the supply and/or administration of named medicines to a specified group. Their introduction in the Christie Hospital NHS Trust raised a number of issues about the most appropriate way to implement them in a specialised setting and how to put in place a robust system of competency.

The trust is a single-site regional cancer centre in Manchester, with patients attending for treatment with chemotherapy, radiotherapy and/or surgery. It is one of the largest centres of its kind in Europe, treating over 10,000 patients each year.

Expanding roles
Through the different stages of their cancer care in the trust, patients become involved with a range of health care professionals. Some of these practitioners operate autonomously, making clinical decisions about patients’ treatment. These include nurse clinicians who conduct independent patient consultations, for example, for patients with lymphoma, and for those with colorectal, breast and upper gastrointestinal cancers. In addition, a number of specialist nurses routinely perform minor procedures such as central venous line insertion, which require the administration of local anaesthetics, while others run clinics and make decisions such as selecting appropriate wound dressings.

The exclusion criteria within the PGD can be restricting at times, but this encourages the medical staff to become involved with these patients. The two-year review date will encourage continual development of the PGDs, possibly including more complex situations.

Other professionals in the trust also have roles that differ from the norm in many NHS settings. For example, the senior clinical pharmacists are key members of a multidisciplinary team leading a self-medication scheme for inpatients and supporting outpatient clinics, while radiographers advise on appropriate products for radiotherapy toxicity.

Having so many practitioners with such specialist skills meant that there was the potential to expand the role of some of these health professionals so that they would be able to use PGDs when medicines needed to be supplied or administered in a timely, structured way. Furthermore, because patients with cancer have specific treatment needs, it seemed that PGDs would be appropriate for them because anti-emetic drugs and oral and bowel care treatments following chemotherapy could be incorporated into PGDs. Some of the steps taken to ensure that staff were competent to use PGDs are outlined below.

Developing the PGDs
Health Service Circular 2000/026 (NHS Executive, 2000) specifies the legal requirements for using PGDs and contains guidance for their development. It also identifies that PGDs must be reserved solely for those occasions when there is a direct clinical benefit; thus, prescribing should always be used in preference. A team comprising a senior nurse, senior doctor and senior pharmacist

PATIENT group directions (PGDs) have enabled me as a sister working with the procedures team to administer medications to patients referred for a specific procedure. The PGDs have been particularly useful when working within specific guidelines where previously there would have been delays in obtaining a doctor’s authorisation.

The preparation for the competency assessments can be time consuming if only one or two drugs are involved, and PGDs are therefore more relevant to highly motivated staff. However, neither extended nurse prescribing nor supplementary prescribing are appropriate for my role, and would require more extensive and external training.

The competency assessment was made as appropriate to my role as possible. I was observed using the medications in a typical situation and then questioned by an appropriate clinician and the PGD pharmacist. As a specialist nurse I feel my knowledge of my role was more extensive than that of the assessors, but they were looking at my decision making, boundaries of practice, record keeping and knowledge of hospital policies, in addition to the safe use of the medicines. The involvement of the PGD pharmacist in the assessment process ensures consistency, and also provides a contact person for any subsequent problems. It also encourages multidisciplinary working and development of PGDs.

Using PGDs ensures that I take responsibility for the decision to administer medications, and for their safe use. Generally, this has not changed my practice but it gives more autonomy, and allows me to manage the patients holistically.

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ONE NURSE’S PERSPECTIVE ON USING PATIENT GROUP DIRECTIONS

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should be responsible for drawing up appropriate PGDs for a given practice area and for ensuring that qualified and trained professionals operate within them.

In order to support the development of PGDs within the trust, a pharmacist was appointed as coordinator in August 2001. The role included taking a lead in providing education and training and in ensuring documented assessment of the health professionals involved. A multidisciplinary group of specialist nurses, pharmacists, radiographers, rehabilitation professionals and professional development staff was set up to address all issues related to PGDs, extended nurse prescribing and supplementary prescribing. It was chaired by the director of nursing and operations, and met every four to six weeks.

The lists of priority medicines to be incorporated into the PGDs were collated, and a hospital template for PGDs was approved by the Drug and Therapeutics Committee (DTC). This committee acted (and continues to act) as an advisory and regulatory body with regard to PGD development, and takes a lead role in involving the medical profession. Each PGD was approved by the DTC, with signatures obtained from the DTC chair, the director of nursing and operations, the medical director (as clinical governance lead) and the chief pharmacist.

**Assessment of competency**

In order to work within a PGD, practitioners need to be assessed to ensure they have achieved a safe and effective standard of clinical practice. It was vital, therefore, to devise a means of assessing competency. To this end a competency framework was prepared by a PGD subgroup (Box 1), based on the NMC’s competencies of professional and ethical practice, care delivery, care management and personal and professional development.

The National Prescribing Centre’s (2001) competency framework for nurse prescribing was adapted to ensure that specific competency statements were set that clearly related to the use of PGDs. In addition, a Christie

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**BOX 1. THE FRAMEWORK FOR PATIENT GROUP DIRECTION COMPETENCIES**

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<tr>
<th>PROFESSIONAL AND ETHICAL PRACTICE</th>
<th>CARE MANAGEMENT</th>
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<tbody>
<tr>
<td><em>Practises as an accountable and safe practitioner within a professional, ethical, and legal framework</em></td>
<td><em>Demonstrates sound clinical judgement in the supply/administration of a specified medication</em></td>
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<tr>
<td>■ Recognises own abilities, limitations and boundaries of practice</td>
<td>■ Identifies circumstances when further advice must be sought</td>
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<tr>
<td>■ Is able to demonstrate the application of professional judgement and skills</td>
<td>■ Is able to discuss mode of action, specific potential adverse reactions, interactions and cautions</td>
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<tr>
<td>■ Understands the need for, and makes accurate, clear and timely records and clinical notes</td>
<td>■ Demonstrates an awareness of other potential underlying causes of a problem</td>
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<td>■ Accepts personal responsibility for own practice and understands the legal implications</td>
<td>■ Is able clearly to identify situations in which medications would not be given under a PGD</td>
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<td>■ Works with colleagues to ensure that continuity of care is not compromised</td>
<td>■ Is able to explain the rationale for decision-making</td>
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<tr>
<td>■ Knows limits of own knowledge and skills</td>
<td>■ Is aware of a patient’s current assessment and planned programme of care</td>
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<tr>
<td>■ Is aware of own professional code of conduct</td>
<td>■ Utilises appropriate drug information sources and applies them to clinical practice</td>
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<tr>
<th>CARE DELIVERY</th>
<th>PERSONAL AND PROFESSIONAL DEVELOPMENT</th>
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<tr>
<td><em>Applies knowledge and skills indicative of safe practice in partnership with the patient</em></td>
<td><em>Maintains the necessary knowledge and skills to practise both confidently and competently</em></td>
</tr>
<tr>
<td>■ Ensures clear understanding and informed patient consent</td>
<td>■ Before working under a PGD, each individual must reassess competency in drug administration via the learning resource within the medications policy. This must be repeated every two years</td>
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<tr>
<td>■ Assesses the effect of multiple pathologies, existing medication and contraindications of treatment options</td>
<td>■ Undertakes reassessment of both theoretical and practical competencies specific to PGDs every two years</td>
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<tr>
<td>■ Listens to and understands patient’s beliefs and expectations, dealing sensitively with any concerns</td>
<td>■ Is fully versed in hospital policies and procedures</td>
</tr>
<tr>
<td>■ Gives clear instructions to patients about medications</td>
<td>■ Demonstrates how to minimise the risk of medication errors</td>
</tr>
<tr>
<td>■ Judges suitability of time for administration</td>
<td>■ Keeps up to date with advances in practice and emerging safety concerns relating to medicines</td>
</tr>
<tr>
<td>■ Monitors the effectiveness of treatment and potential side-effects</td>
<td>■ Is able to identify individual areas requiring further development and to address needs</td>
</tr>
<tr>
<td>■ Is able to elicit all relevant information from the patient by the use of appropriate questions (including information on allergies)</td>
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Hospital framework was devised, covering both theoretical and practical learning issues that were to be used for the assessment of each individual, so ensuring consistency (Box 2).

If a practitioner does not demonstrate competency at assessment, a development plan must be completed, and a review date is then set for the assessment.

**Training and documentation**

The coordinating pharmacist established a training programme to prepare staff for assessment. Each practitioner now attends an introductory session which covers the legal requirements of PGDs and the local procedure, and receives a learning pack containing background information and essential reading, such as Health Service Circular 2000/026 (NHS Executive, 2000), The NHS Plan (Department of Health, 2000) and professional codes of conduct.

Specific clinical sessions are provided as required on subjects such as anti-emetics and bowel care, with updates on pharmacology, guidelines to good practice and evidence-based medicine. Clear documentation is vital to ensure that all practitioners are clear about which medicines they can supply, and to whom.

All practitioners have personal portfolios of PGDs for which they have been approved as being competent to use, together with the associated competency assessments and clear review dates. Practitioners’ competence is reassessed every two years.

**Limitations and uses of PGDs**

While PGDs are suitable for a range of staff and clinical situations, they should be considered only where there is direct clinical benefit to the patient without compromising safety. The requirement to develop specific in-house training and competency assessment means that practitioners can use PGDs only in the place where they are assessed as being competent.

We have concluded that PGDs are most appropriate at the Christie Hospital for nurses who are undertaking minor procedures, and for radiographers and ward-based nurses. Other trusts will need to consider the applicability of PGDs to the range of clinical conditions within their particular settings.

**Conclusion**

Patient group directions offer an alternative to prescribing in situations where there is direct clinical benefit to a patient, and they should be used only for this purpose. A multidisciplinary team approach is essential if PGDs are to be developed and to ensure that their introduction is planned.

If health care professionals are to practise safely and accountability, demonstrate sound clinical judgement, apply the knowledge and skills indicative of safe practice, and maintain the necessary knowledge to practise both confidently and competently in a consistent manner, a robust training programme and competency framework is vital.

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**REFERENCES**


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**BOX 2. CHRISTIE HOSPITAL FRAMEWORK TO ASSESS LEARNING OUTCOMES AND PRACTICAL COMPETENCY**

**LEVEL OF PRACTICAL COMPETENCY ACHIEVED**
1. Requires further supervised practice.
2. Is competent in some situations observed.
3. Is competent in all situations observed.

Staff are expected to achieve Level 3 in order to work independently under PGDs. Those achieving Levels 1 and 2 require further development, and will be reviewed at an agreed time interval. This should be documented on a development plan.

**THEORETICAL COMPETENCY**
1. Identify in what situation(s) you would supply/administer [named medicine]. Explain why, and how it should be given.
   **The trainee must be able to:**
   a. Demonstrate sound clinical judgement
   b. Apply knowledge and appropriate repertoire of skills indicative of safe practice.

2. Describe under what circumstances you would not supply [named medicine]. Explain your decision(s). Identify the circumstances that would make you more cautious.
   **The trainee must be able to:**
   a. Elicit all relevant information by the use of appropriate questions
   b. Recognise possible adverse drug reactions; evaluate risks and take action accordingly
   c. Discuss boundaries of practice.

3. Clarify when you would seek medical advice.
   **The trainee must be able to seek medical advice when necessary.**

4. Identify what information should be given to the patient.
   **The trainee must provide information and advice appropriate to the needs of the patient.**

5. Discuss what documentation is required.
   **The trainee must ensure accurate documentation in order to clarify accountability and enable safe practice, in the patient’s notes and/or drug chart as appropriate.**

6. Identify continuing education requirements.
   **The trainee should identify and prioritise his/her learning and development needs, including re-assessment every two years.**

**Theoretical competency achieved:** YES / NO
**Date:**
Successful completion can be reached only by achieving all learning outcomes. The maximum time interval between achievement of theoretical competency and practical competency is three months. If this is exceeded both areas must be reassessed.