

A COMPETENCY-BASED APPROACH TO FITNESS FOR PRACTICE

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This paper makes the case for adopting a competency-based system in order to assure fitness for practice. It highlights the need for competency assessment by taking clinical practice as an example, but also argues for the generalisability of the approach. We believe this to be a key issue for the future of the profession

Pharmacists are under pressure to meet the demand for providing quality services,¹ and improving them,² as part of the drive for clinical governance. At the same time, there is a need to respond rapidly to the opportunities offered by the Crown review of prescribing, administration and supply of medicines,³ the national service and related frameworks⁴ (for cancer, paediatric intensive care, adult mental health, coronary heart disease and older people), the NHS Plan⁵ and Pharmacy in the Future.⁶ These are exerting a powerful influence on clinical practice (Panel 1) and as a result pharmacy is facing a severe workforce shortage,⁷ junior pharmacists are expressing low job satisfaction and lack of career direction,⁸ and the full effects of extending the undergraduate pharmacy degree from three to four years have still to be determined.

Given present difficulties, sustaining the status quo may appear both a sufficient and reasonable goal. However, the absence of a national system for the development of high quality practitioners is likely to result in failure to meet the needs and expectations of both patients and the health service. Preregistration training represents an attempt to introduce the concept of competency to the profession, but this is not sustained beyond the training year. We advocate a framework for junior pharmacists based on the evaluation and accreditation of competence.

DELIVERING CLINICAL SERVICES

In the hospital sector, recruitment difficulties and competition between trusts have served only to limit the availability and mat-

uration of pharmacy practitioners. The consequence is an inability to keep pace with the increasing demand for patient-centred pharmacy services. Systems of work in many organisations therefore result in both poor use of pharmacists' expertise and an inconsistent delivery of service (Panel 2). Moreover, the persistence of traditional clinical pharmacy has meant that the techniques adopted by many practising pharmacists are based largely on prescription monitoring, and not on identifying medication-related problems from the patient's perspective.

Inconsistencies can be easily identified in the clinical services provided by different

hospitals, as well as in the capability and grading of the staff employed to perform clinical roles. Although postgraduate courses have sought to furnish practitioners with the necessary skills, attendance on these programmes is often used as a means of staff retention, rather than as an approach to developing individuals with the appropriate level of competence to meet service needs. Training is not a panacea for all problems, although our research suggests that a lack of training opportunity is linked with low job and career satisfaction among junior pharmacists.⁸

Published work has adequately defined many of the problems associated with the use of medicines and, by implication, the shortcomings of current medicines manage-

Panel 1: Key influences on clinical practice

Retention and recruitment of staff Workforce and capability related to the MPharm and the emerging taught doctorate programmes. Changes in skill mix and the role of pharmacy technicians.

Clinical governance Professional competence, clinical risk management and continuing professional development.

Primary care trusts Control of drug expenditure and the redefinition of clinical responsibilities between primary and secondary sectors. Introduction and management of new drug therapies in line with the available evidence.

New prescribers and new supply systems Training and career structure for pharmacists to become independent and supplementary prescribers. Support for the extension to nurse prescribing and patient group directions.

Information technology Decision-support prescribing programs, automation and improved information transmission between health care sectors.

Safety, concordance and compliance Reducing adverse events and helping patients to derive the maximum benefit from their medicines.

Panel 2: Limitations in the organisation of clinical services

The delivery of a clinical service will be compromised by any failure to:

- 1 Identify the priorities of the service, based on the risk associated with drug use in certain patient groups
- 1 Design a strategy for the delivery of clinical pharmacy based on knowledge of that risk, which is sustainable during periods of staff shortage
- 1 Describe the relationship between the clinical and other components of the pharmacy service
- 1 Describe the key activities that constitute an appropriate level of service
- 1 Define the competence of the practitioner required to provide the appropriate level of service
- 1 Measure the competence of the pharmacist providing the service
- 1 Provide training that is competency-based
- 1 Create a culture of responsibility for continuing professional development
- 1 Develop a career structure for clinical pharmacists that clearly describes the qualities of a leading-edge practitioner and the route to be followed to secure such a post

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ment systems.^{2,9} The incidence,¹⁰ costs (both human and financial)^{11,12} and determinants^{13,14} of adverse drug events have been well described, and non-compliance with therapy continues to be cited as a major problem.¹⁵ Political and public concern over the prevalence of adverse events has driven demands for ensuring the competence of professionals involved in patient care,¹ and this implies a training model that will produce practitioners who are “fit for purpose”.

TRAINING FOR THE FUTURE

In the United States, the Joint Commission on Accreditation of Healthcare Organisations (JACHO) describes competence as an ability equal to the requirements of the task assigned.¹⁶ Most readers will be familiar with a definition that seeks to differentiate between tasks (what a person must do) and competencies (how a person performs those functions). Competency is a comprehensive construct, encompassing skills, knowledge, behaviour and other attributes, such as personal traits, motives, values and attitudes.¹⁷

The value of a competence-based, post-registration pharmacy structure has been recognised in some settings. For Scotland, the chief administrative pharmaceutical officers' report of 1993 advocated a staged vocational training scheme to achieve this type of development, albeit with a broad focus on hospital pharmacy. Stages I and III reflect current arrangements (these are the existing preregistration and diploma/MSc training), whereas stages II and IV are intended to meet the need for basic in-service training and for post diploma/MSc progression, respectively. Stage II is competence-based and requires the trainee to collect evidence in clinical, technical, quality assurance and information domains. Stage IV is concerned with the preparation of a portfolio that demonstrates expertise within a practice or management specialty.¹⁸

Awareness of the Scottish model, coupled with recognition of the service limitations outlined in this paper, encouraged senior hospital practitioners in London and the South East to embark on the development of a competency framework for clinical

TABLE 1: COMPETENCY FRAMEWORK

Cluster	Individual competencies	Examples of specific behaviours
Personal	Organisation Communication Team work Professionalism	Prioritisation, punctuality With nurses, doctors, patients Multidisciplinary working Confidentiality, responsibility
Problem solving	Gathering information Analysing information Providing information Knowledge	Accesses, abstracts information Evaluation, decision-making Accurate, relevant and timely Pathology, pharmacology
Delivery of patient care	Need for a drug Selection of a drug Administration Provision of product Monitoring Information, education Evaluation of outcomes	Drug history Drug interactions Calculations Clarity, legality Identifies problems, refers Identifies need Contributions

cal pharmacy. This approach has been endorsed by senior pharmacy managers in both regions and is being progressed under the auspices of the Clinical Practitioner Development Group.

The task has been divided into three main phases:

1. To identify the key competencies of clinical practitioners and produce a competency grid that facilitates assessment
2. To describe the features of a training programme that would support the staged development of practitioners
3. To suggest a system by which an external body could accredit such a programme

For phase 1, components of the competency framework were derived using a recognised process¹⁷ and arranged in a hierarchy consisting of clusters (categories critical for effective performance), competencies and behavioural anchors (examples of behaviour that define competency). A full description of the development of the competencies for junior clinical pharmacists has been published by McRobbie *et al.*¹⁹ The resulting “generalist” framework provides three clusters: personal, problem-solving and delivery of patient care. Each anchor is

characterised using a four-item scale (for example, from “always” to “never”) that enables assessors to describe the observed behaviour of trainees (Table 1).¹⁹

To support the staged development of clinical pharmacists (a phase 2 objective), we propose that distinct levels of practice should be recognised, determined by the demonstration of competence in key performance domains. For example, levels I to III could represent the development of the knowledge, skills and attributes associated with a generalist practitioner; levels IV to VI, those associated with a specialist practitioner (see excerpts given in Panels 3 and 4).

For the generalist trainee, areas of practice should include general medicine and general surgery to ensure that a range of activities are undertaken, from the compilation of admission drug histories through to monitoring the effectiveness of drug treatment. Competence should be assessed at appropriate intervals and be supported by evidence of practice activities in the form of a portfolio. At the end of the generalist training period, having completed the core of clinical practice and demonstrated attainment of the level III competence, pharmacists would then be eligible to commence specialist training in a sector of their choice.

The success of a competency-based training programme will depend on an

Panel 3: Criteria for level 2 clinical pharmacist (generalist)

All criteria for stage 1, plus demonstrated ability to:

- 1 Take medication histories
- 1 Educate patients about their medication
- 1 Retrieve information from medical sources
- 1 Keep effective clinical records
- 1 Identify medication-related problems
- 1 Recommend drug dose adjustment, route selection and rate of administration
- 1 Prioritise and organise workload
- 1 Work as part of a team
- 1 Identify CPD needs and maintain a portfolio of practice
- 1 Maintain a professional approach to the patient and other health care staff
- 1 Computer literacy

Panel 4: Criteria for level 4 clinical pharmacist (specialist)

All the following criteria need to be demonstrated:

- 1 Specialist pharmaceutical knowledge as it relates to the chosen area of practice
- 1 Critical appraisal skills
- 1 Ability to assist in the production of treatment guidelines and protocols
- 1 Provision of local training and advice in specialist field to pharmacy staff and other health care professionals
- 1 Ability to organise and deliver pharmacist led clinics
- 1 Financial reporting
- 1 Negotiation skills
- 1 Undertake appropriate research
- 1 Ability to identify opportunities and develop specialist clinical pharmacy services

agreed infrastructure being put in place to allow trainees to receive the required training, even in the face of other pressures on the pharmaceutical service.

In the past, most hospitals have tried to provide training for their own staff in isolation and this has created a number of problems relating to the quality of the teaching and the efficiency of the process. In addition, during times of increased workload or staff absences, the delivery of training has been often the first casualty of a priority review. To sustain the competency-based programme, we endorse the formation of training alliances between hospitals (such as the STEP collaboration²⁰), and between hospitals and other sectors, to enable the sharing of expertise and resources. This is probably best achieved on a larger scale by moving to a "hub and spoke" arrangement.

Accreditation is an important consideration for ensuring that the quality of trainee experience is standardised. Gaining local accreditation for the scheme would be of limited value, as the competency of practitioners completing the programme may not be recognised outside the training locality. A wider accrediting body would support the movement of staff and produce a model that is sufficiently robust to be delivered on a national scale (a phase 3 objective). However, such an approach is unlikely to succeed without recognising and embracing the strengths of academia.

Pharmaceutical education in UK universities has been subjected recently to review by the Quality Assurance Agency based on six broad measures: curriculum design, content and organisation; teaching, learning and assessment; student progression and achievement; student support and guidance;

learning resources; quality management and enhancement. Adapting this approach to the quality assurance of a competency scheme will require the support of academia. Collaboration should also facilitate academic recognition, in the form of postgraduate credits, so that those individuals pursuing higher degrees (at diploma, MSc or DPharm level) will be able to use the credits gained from the competency programme as evidence of their development. Completion of the programme should, in addition, provide the practitioner with "membership" of an appropriate national body. National accreditation, based on the assurance of quality by academic centres, will ensure that training sites and those engaged in delivering the programme satisfy the necessary criteria.

PROGRESS WITH THE COMPETENCY SCHEME

The assessment grids for junior clinical pharmacists have been designed, refined¹⁹ and tested by the clinical competence pilot sites in London and South East regions. A further hospital in the South East has participated as a control site. To date, assessments have been undertaken at baseline, six weeks and 12 weeks, showing a significant improvement in performance in the active sites. This interim evaluation of the scheme's impact was reported at the Pan-Thames Pharmacy Symposium in July 2001.²¹ Consequent upon the demonstration of satisfactory outcomes, discussion with academic institutions will need to focus on processes of accreditation and the continued integration of postgraduate education with the service environment. In addition, the issues of national recognition

for different levels of competence and the derivation of specialist competencies will need to be debated.

SUMMARY

To grasp the opportunities that health care policy is starting to offer, and to satisfy the requirements of clinical governance, the profession must now embrace a credible means of assessing and accrediting practitioner competence. This paper proposes a framework for clinical competence that will be generalisable across the profession. We intend to publish the outcomes from the pilot study in full in the near future.

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