

HOW HAS THE PATIENT GROUP DIRECTIONS WEBSITE CONTRIBUTED TO PATIENT CARE?

By Peter G. W. Jones, MRPharmS

The patient group directions website at www.groupprotocols.org.uk is promoted via professional channels to members of British health care professions. This article describes how the website is used and considers its future needs

Patient group directions (PGDs) have been advocated for use in those situations where it is impractical to obtain a prescription for a named patient.^{1,2} They authorise certain health professionals to supply or administer medicines according to specified criteria and should be produced locally.

In order to minimise duplication and to provide an educational resource, a website was created at www.groupprotocols.org.uk (alternatively, <http://129.11.239.213/protocols/default1.asp>) from within Salford Royal Hospitals Trust in the North West region³ to display PGDs that had been approved by National Health Service (NHS) employers advised by professional advisory committees.

Visitors to the website are advised to view the directions online and to download them for educational purposes. However, they are advised not to copy the directions for local use but to adapt them to local circumstances because there are disadvantages to producing national PGDs.⁴ If visitors are not prepared to abide by this advice they are advised not to proceed to the site when logging on.

Since the launch of the website, the Department of Health has issued guidance on PGDs⁵ and specified a "model" status. The website now displays those model PGDs. (Model status is assigned to a PGD if it complies with HSC 2000/026,⁵ has been approved for use locally and has subsequently been reviewed by another professional.)

The website has gained both praise and constructive criticism and has been updated regularly. It strives to achieve and maintain high standards, and there is an ongoing requirement for improvement, to which health professionals are invited to contribute.

Currently the website is funded from the pharmacy practice unit in Liverpool. But with the advent of extended prescribing rights to more professions and the demise of North West region in April 2002, from which funding is also obtained, the future of the website is constantly under review.

This article reports on how the facility is being used. It provides food for thought for those who are contemplating production of PGDs by highlighting clinical conditions for

which they are used and sharing issues that have resulted in "frequently asked questions".

Aspects of website use monitored include rate of use, topics frequently viewed from the top 20 PGDs, the range of clinical conditions, issues arising from the enquiry answering service, and frequently asked questions.

USE OF THE WEBSITE

The website has been promoted over a period of two years to those health professionals who may need to use PGDs. Submissions have been made to professional journals, links have been established with numerous websites, a paper has been published relating to setting up the website,³ it has been promoted at conferences and training events, and the Department of Health has adopted the website for promoting model directions. The site has been visited over 26,000 times since 19 April 2000 at a rate exceeding 1,700 visits per month with more than 32,000 hits on PGDs currently displayed. The total number of hits is higher but includes those for PGDs that have been withdrawn, either due to expiry or failure to meet standards.

FREQUENTLY VIEWED PGDS

The top 20 most frequently used PGDs represent more than half of all the viewed PGDs on the website and cover the areas shown in Table 1. Most popular are those that enable nurses to administer medicines in the hospital service (36 per cent). In particular, a PGD for medicines that may be administered at the discretion of a nurse was visited frequently as was one for medicines supplied by emergency nurse practitioners in accident and emergency departments.

PGDs for a range of vaccines administered by nurses in primary care also feature prominently. These cover childhood and

adult immunisations and travel vaccines (22 per cent). PGDs for the treatment of anaphylaxis also feature prominently (10 per cent).

Another area of major interest is contraception both as emergency hormonal contraception (20 per cent) and family planning (7 per cent) provided from GP practices, community clinics and community pharmacy. Emergency contraception services have been exposed to national media coverage relating to services provided from community pharmacy and offer an excellent opportunity for community pharmacists to demonstrate their ability to improve access to health services for patients.

RANGE OF CLINICAL CONDITIONS

The range of clinical conditions represented on the website is diverse and, in addition to those for the Top 20, includes pain, bacterial and viral infections, angina, myocardial infarction, allergy, hypokalaemia, constipation, erectile dysfunction, asthma, haemorrhoids and reversal of opioid induced respiratory depression. Other areas covered include cannula flushing, local anaesthesia, nicotine replacement therapy, bowel evacuation, laser treatment and radiography.

ENQUIRY ANSWERING SERVICE

A service is offered whereby queries can be e-mailed to the website pharmacist manager. Responses are provided promptly and in many instances after taking advice from other sources.^{6,7} Examples of issues raised include:

Private sector police and prison authorities

The private sector poses problems for many professionals who seek advice. Although it is possible to have a PGD for NHS patients in a private hospital it is not possible at present to have one for private patients in a private hospital or for clients, even if eligible for NHS services, in the police or prison service. Medicines for travel purposes which cannot be provided on the NHS may not be included in a PGD. However the Medicines Control Agency is currently reviewing these areas and further advice may be issued shortly (see *PJ*, 19 January, p46).

Peter Jones is prescribing adviser at Salford Primary Care Trust and website manager of www.groupprotocols.org.uk. Correspondence to 151 Emmerdale Drive, Congleton, Cheshire CW12 4FL

To PGD or not to PGD Several health professionals have declared that they are unaware of when to use patient group directions. Apart from the provision of advice referring to published documentation¹⁻⁹ enquirers are referred to the website which aims to give advice on what a PGD is and when to use it. Access is provided to a flowchart entitled "To PGD or not to PGD"⁶ (by permission of colleagues from South Thames). This takes enquirers through the minefield of circumstances faced by those producing PGDs. There have been more 3,700 hits on the flowchart since January 2001, a clear indicator of the need for support.

Adjusting doses and advising patients or doctors on amended doses An area of confusion which arises frequently relates to using a PGD for adjusting doses. PGDs authorise the supply and or administration of medicines against specific guidance. They are not intended at present for the adjustment of doses. Such actions via a PGD may be considered unlawful. However, the PGD may specify a single dose or a range up to a specified maximum. The practitioner signing the PGD must be satisfied that the dose range is clinically appropriate and within the terms of the medicine's marketing authorisation. The clinical criteria for selecting a dose within a range must be specified. The person supplying or administering the medicine under the PGD must be assessed as competent to make the dosage decision.

Locum and agency staff Members of several professions have enquired regarding procedures which should be followed when employing agency or locum staff. For a service that relies upon the use of a PGD (an immunisation clinic, for example), it is essential that practitioners employed in the absence, through holiday or illness, of permanent staff are authorised to work according to the local PGD. Problems can arise because relief staff may not be trained or regularly employed. Local arrangements must therefore be made to train and recruit sufficient relief staff in the use of PGDs to ensure the continuity of service. To provide the service without a PGD would be unlawful and to expect a doctor to prescribe for each patient, impractical. There is no easy solution to this particular problem.

Audits Audit of PGDs is referred to in HSC 2000/026⁵ and specified as "a statement of the records to be kept for audit purposes" and also the additional guidance in paragraph 9 specifies: "In particular there must be a secure system for recording and monitoring medicines use from which it should be possible to reconcile incoming stock and outgoing on a patient-by-patient basis."

Many enquire whether audit has been attempted and how it was conducted. Exactly how the audits are conducted and their content are matters for local debate. As a minimum it should be possible to identify from the records which practitioner treated which patient, with which medicine, at what

TABLE 1: TOPICS FREQUENTLY VISITED, BASED ON TOP 20 MOST FREQUENTLY VIEWED

Topic	Frequency (%)
Medicines in hospitals	36
Immunisation in primary care	22
Emergency contraception	20
Anaphylaxis	10
Contraception	7
Zanamivir (Relenza)	3
Respiratory	2

TABLE 2: FREQUENTLY ASKED QUESTIONS

Subject area	Queries (%)
Eligible medicines for inclusion in a PGD	30
Labelling requirements under PGDs	12
Responsibility for ensuring competence of named practitioners	8
Content of a valid PGD	6
Indemnity insurance	4
Multiple medicines in one PGD	4
Naming of authorised practitioners	3
What is a PGD?	3

dose, by what route, and on what date, and for an immunisation the batch number of the vaccine. Equally in a clinic situation there should be reconciliation of stock to match the number of patients treated on a particular day. Further audit relating to the clinical circumstances in which the PGD has been used could usefully be considered within the local clinical audit programme.

Significant aspects to audit should include the benefits to patients as outlined in the Crown report, whether the PGDs are being followed in practice, whether patients have been involved in any adverse incidents, and assessment of other risks by using a checklist specifying all or some of the criteria in the PGD.

Controlled Drugs The inclusion of Controlled Drugs in a PGD is not allowed⁵ because the use of CDs is covered by the Misuse of Drugs Act 1971. The Home Office is currently considering the inclusion of some of the schedule 4 (benzodiazepines) and schedule 5 CDs (codeine, pholcodeine, cocaine and morphine in low strength) in the classes of medicine which may be included in a PGD.

FREQUENTLY ASKED QUESTIONS

As a result of the numerous queries which had been directed to the website managers a "frequently asked questions and answers" section was created. Many of the questions and answers included originate from guidance from the professional standards directorate of the Royal Pharmaceutical Society.^{7,8}

Analysis of 3,250 queries in the frequently asked question and answer section has identified eight key areas which represented 70 per cent of total queries (Table 2). The top three subjects, which accounted for 50 per cent of all frequently asked questions, are:

(i) **Eligible medicines for inclusion** Uncertainty exists as to which medicines can be included in a PGD (30 per cent of enquiries). Certain medicines will require special consideration before inclusion in a PGD, for example, antibiotics and "black triangle" medicines, and some are restricted by legislation, eg, Controlled Drugs, radio-pharmaceuticals, medicines without a marketing authorisation, and medicines used outside the terms of the summary of product characteristics. Further details are included in HSC 2000/026.⁵

(ii) **Labelling regulations** A small number of enquiries (20) sought confirmation that the labelling regulations for both PGDs and prescriptions are the same, although a further 260 (12 per cent) sought information on both the requirements for labelling and the provision of information leaflets when supplying medicines. The advice from the Royal Pharmaceutical Society is: "The European Union (EU) Labelling and Leaflet Directive 92/97 was incorporated into UK law in 1994 and, among other provisions, it is now a legal requirement that the manufacturer's patient information leaflet is provided each time a medicine is supplied. However, it is not a legal requirement to put a product's batch number and expiry date on a dispensed medicinal product. The particulars required are in paragraph 3 of schedule 5 of the Medicines for Human Use (Marketing Authorisations Etc) Regulations 1994 (no 3144). These requirements will apply equally to medicines supplied under PGDs. These requirements are also reproduced in 'Medicines, ethics and practice, a guide for pharmacists'¹⁰."

(iii) **Competence of named practitioners** More than 280 enquiries (8 per cent) related to determining that a senior representative of each profession should be responsible for ensuring the suitability and competence of the professionals operating within the scheme.

FUTURE OF THE WEBSITE

Based upon current levels of demand, which continue to rise, it is clear that there is sufficient interest nationally to justify the use of the website as an educational resource. The costs of maintaining the site currently amount to £4,000 annually.

Factors that might result in a reduction in use or closure of the website include developments in prescribing rights, acquisition of competence by practitioners such that they will not need to visit the site or, most drastic of all, withdrawal of funding in April 2002.

Proposed developments in nurse prescribing¹¹ include a definition of nurses eligible to prescribe. Not all nurses are eligible so there will still be many who could usefully provide improved services to patients via a PGD. In addition a three-month programme of preparation at degree level is planned. It will take time to arrange such an educational programme and time to free and

fund sufficient nurses to make an impact on the programme. Indeed, not all nurses will wish to undertake this higher level of training and should not be compelled to do so.¹² The range of medicines that nurses could prescribe will be limited initially to all GSL and P medicines which are prescribable by GPs on the NHS (with the exception of certain medicines that are subject to controls under the misuse of drugs legislation) and certain POMs to manage conditions in four treatment areas:

- 1 Minor ailments (such as hay fever or acne)
- 1 Minor injuries (such as burns, cuts or sprains)
- 1 Health promotion (such as providing vitamins for women planning pregnancy)
- 1 Palliative care

These factors coupled with the omission of many POMs, leave opportunities for PGDs to continue to be used and so there is a role for the website in the foreseeable future.

Development needs for the website include expansion of the quality assurance programme that supports the introduction and review of PGDs to model status. Further development of the promotion of the website within the NHS via an organisation such as the National Electronic Library for Health is being explored.

CONCLUSIONS

PGDs are currently a focus of interest for many practitioners nationally. The website at www.groupprotocols.org.uk continues to be used regularly and increasingly and has demonstrated a demand for educational support.

Applications for the use of PGDs span both primary and secondary care and cover a broad range of clinical situations with immunisations and medicines administered in hospitals by nurses taking the lead.

Should nurses specialise in those fields and gain prescribing rights, then the demand for PGDs and the website will fall but this is unlikely to occur rapidly. Also not all nurses are eligible for prescribing rights for a variety of practical reasons.

Enquiries to the "frequently asked questions and answers" section continue to grow demonstrating that advice is needed regarding which medicines can be included, the written advice required for patients via labelling and information leaflets and how to ensure practitioner competence, all of which contribute to quality in the delivery of health care.

There has been growth in the demand for the website as an educational resource. To justify the demand from a patient per-

spective, audit programmes are required to demonstrate the value in this method of supplying and administering medicines. In the meantime, the website will continue as long as it benefits patients and provided a source of funding can be identified.

ACKNOWLEDGEMENTS Thanks are due to Dr Victor Standing, North West regional pharmaceutical adviser secondary care, and the North West region for sponsoring the website, Jo Raffaitin of the Royal Pharmaceutical Society's professional standards directorate for her advice, and Stephen Freeborn, director of pharmacy, Salford Royal Hospital Trust, for his initiatives in respect of PGDs and his continued support and enthusiasm.

REFERENCES

1. Review of Prescribing, Supply and Administration of Medicines (Crown report). London: Department of Health; 1999.
2. Report on the supply and administration of medicines under group protocols: review of prescribing, supply and administration of medicines (HSC 1998/051). London: Department of Health; 1998.
3. Jones P, Harris A, Parker-Jones C. Using low cost internet as a quality medium for promoting PGDs *Guidelines in Practice* 2000;3:47–52.
4. Jones PGW. Call for national patient group directions *Pharm J* 2001;266:888–91.
5. Patient group directions (England only) HSC 2000/026. London: Department of Health; 2000.
6. Taylor B, Machell L. To PGD or not to PGD. Available at URL: <http://www.group-protocols.org.uk> (accessed 12 March 2002).
7. Royal Pharmaceutical Society. Patient group directions: a resource pack for pharmacists. London: The Society; 2001.
8. Raffaitin J. Patient group directions and the law. *Pharm J* 2000;265:851–2.
9. Jones PGW. How to decide when a PGD is needed. *Guidelines in Practice* 2001;4:78–84.
10. Royal Pharmaceutical Society. Medicines, ethics and practice: a guide for pharmacists (25th ed). London: The Society; 2001.
11. Extended prescribing of prescription only medicines by independent nurse prescribers; amendments to the Prescription Only Medicines (Human Use) Order 1997 (MLX 273). London: Medicines Control Agency; 2001.
12. Extension of independent nurse prescribing. London: Department of Health and Medicines Control Agency; 2001. Available at URL: <http://www.doh.gov.uk/nurse-prescribing/index.htm> (accessed 13 March 2002).

GUIDANCE FOR REPORTS ON MEETINGS AND CONFERENCES

Timing and submission *The Pharmaceutical Journal* welcomes submissions about meetings and conferences. Please contact the editorial department before sending in a report, ideally before the meeting takes place, to check that it is not already being covered and to discuss the length of the report.

Photographs are also welcome, provided they are of publishable standard.

Reports should be sent in by e-mail or on disk. If the meeting is newsworthy, the report should be sent in by the Tuesday immediately after it takes place to ensure immediate publication. All reports should be sent within two weeks of the meeting to guarantee publication within a month of the meeting. Reports submitted later than this will not always be published in full in *The Journal*. It may be necessary to publish an abbreviated version in print and post the full report on *PJ Online* (www.pharmj.com).

How to prepare a report Readers need to be encouraged to read reports, so start the report with the most interesting item, not with details of what, where and when the meeting occurred.

Concentrate throughout the report on the most newsworthy contributions to a meeting, such as valuable information that has not already been published or strongly worded opinions voiced by influ-

ential speakers. Reports that repeat what readers already know or cover old issues will not be interesting.

Write about what people actually said rather than what they talked about. Ask speakers for copies of their talks or notes. Do not submit reports that are just lists of speakers' topics; they are of no value to the reader. Instead of writing "Professor Plum gave a fascinating account of continuing professional development," readers will want to know exactly what Professor Plum said that was so fascinating.

Do not give every speaker an equal number of words. With the exception of keynote speakers if someone says nothing of interest, then do not report it, however well-known the person. If the keynote speaker says nothing of interest, consider how valuable a meeting report will be.

Advice for photographers *The Journal* is unlikely to publish more than two or three photographs from most meetings, so it is best to concentrate on the main speakers. The ideal time to take photographs is at the beginning of each address, while the speaker is still involved in introductions and is likely to be looking out at the audience rather than staring down into his or her notes. Take several shots of each speaker and always aim to be as close as possible to the podium, even if it means obstructing the view of the audience for a short time.