A comparison of demographic characteristics and workloads of independent nurse prescribers (INP) and nurses using patient group directions (PGDs) in sexual health clinics

Black, A.; Courtenay, M.; Gage, H.; Norton, C.; Franklin, B.D.

1 King’s College London; 2 Cardiff University; 3 University of Surrey; 4 Imperial College Healthcare NHS Trust

INTRODUCTION

Sexual health nurses in the United Kingdom (UK) frequently use independent nurse prescribing (INP) or patient group directions (PGDs) to independently deliver medications [1]. Both methods are supported by UK legislation [2-4]; however, training and scope of practice vary considerably. INP provides flexible prescribing authority for individual nurses who have registered their university qualification with the Nursing & Midwifery Council [5]. Whereas, PGDs allow large groups of nurses to administer or supply restricted medications for pre-determined clinical presentations [3]. While the evidence base is increasing, there is limited research specifically on sexual health nurses, and how they use INP and PGDs in practice. This study set out to explore that gap.

METHODS

INP and PGD nurses from five UK city based sexual health services completed a questionnaire, and recorded two weeks of clinical activity in a specifically designed diary, Aug 2015-Aug 2016.

RESULTS

Questionnaire response rate: 64% (61/95; INP=26/28, 93%; PGD=35/67, 52%). Participants who submitted the questionnaire, 61% (INP=17/26, 65%; PGD=20/35, 57%) also completed the diary.

INP & PGD sexual health nurses; who are they?

Respondents were mostly female, aged 35–44 years. INP were mainly Band 7 or above, educated to Masters Level, whereas PGD users were mostly Band 6, educated to Diploma Level. INP had a mean of 2.9 years more sexual health experience than PGD users (Figure 1). Both groups reported access to medications was essential (60/61, 2.9 years more sexual health experience than PGD users (Figure 2)).

How are INP & PGDs used in sexual health?

Of the total diary entries (INP=737; PGD=593), INP managed more ‘new’ care episodes than PGD users (Figure 2). There was no difference in medication delivery frequency (chi-squared test p=0.16). PGD users required additional medication delivery support from other healthcare professionals more often than INP (chi-squared p=0.01: Figure 3); however, INP spent longer with patients than PGD users (independent t-test, p=0.01: Table 1). Mean consultation support was 8 mins/consultation (both groups).

DISCUSSION

Sexual health nurses were predominantly female and of varying ages. INP nurses tended to be practising at a higher Band, be educated to a higher academic level and have more sexual health experience. Clinically, INP were more likely to manage new episodes of patient care, and less likely to require additional support from colleagues. Both INP and PGD users frequently delivered medication, and were largely able to work autonomously. PGD users, however, had shorter consultation lengths compared to INP. This aspect of the study did not measure clinical complexity of patients’ presentations, and it should be highlighted that PGD users were less represented than their INP colleagues.

References


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Table 1: Comparison in consultation times between INP & PGDs

<table>
<thead>
<tr>
<th>Group (number of entries with time recorded)</th>
<th>Consultation times (minutes)</th>
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<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>INP (n=591)</td>
<td>14,701</td>
</tr>
<tr>
<td>PGD (n=563)</td>
<td>12,859</td>
</tr>
<tr>
<td>Total (n=1,154)</td>
<td>27,560</td>
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</tbody>
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*One INP prescriber for another nurse, so recorded ‘0’ minutes with patient.