CoDEG

Competency Development & Evaluation Group

GLF

General Level Framework

A Framework for Pharmacist Development in General Pharmacy Practice

GLF Second Edition
October 2007

About CoDEG

The Competency Development and Evaluation Group (CoDEG) is a collaborative network of developers and researchers, practitioners, specialist and academic pharmacists.

Further information and implementation resources and guidance are available from www.codeg.org

CoDEG is supported by the following organisations:

NHS

East & South East England Specialist Pharmacy Services

East of England, London, South Central & South East Coast

Clinical Pharmacy

School of Pharmacy and Biomolecular Sciences, University of Brighton

The School of Pharmacy
University of London

Organisational Endorsement

The following Pharmacy organisations have endorsed the framework:

The Guild of Healthcare Pharmacists

United Kingdom Clinical Pharmacy Association

Pharmaceutical Services Negotiating Committee

Centre for Postgraduate Pharmacy Education

FACULTY OF PRESCRIBING AND MEDICINES MANAGEMENT

THE COLLEGE OF PHARMACY PRACTICE

JOINT PROGRAMMES BOARD LONDON, EAST AND SOUTH EAST ENGLAND

Support from other Pharmacy Organisations:

The Royal Pharmaceutical Society welcomes the contribution that the GLF could make to supporting continuing professional development within the profession. The GLF has been added, for selection by pharmacists, to the Society's Plan and Record CPD website (**www.uptodate.org**)

The NPA see this framework as a valuable aid to CPD, helping pharmacists develop beyond the acceptable standards of competence a pharmacist will demonstrate at registration to make a wider contribution in their role in healthcare.

Preface to the General Level Competency Framework

The CoDEG General Level Framework (GLF) supports post-registration development for pharmacists delivering general pharmacy services. The framework can be used by pharmacists working in hospital, community pharmacy and primary care.

A controlled trial of the first edition GLF has demonstrated that its use accelerates and sustains pharmacists' development (Antoniou *et al*. *Pharmacy Education* 2005: **5**: 201-7).

The second edition GLF (Mills *et al*. *Pharmaceutical Journal* 2005; **275**: 48-52) has been successfully evaluated in primary care and community pharmacy. This version is suitable for use in hospital, primary care and community pharmacy.

The GLF has been adopted by the College of Pharmacy Practice and its Faculty of Prescribing and Medicines Management for full membership. Further information about this is available at www.collpharm.org.uk

The GLF and the KSF

A guidance document describing how the GLF links with the KSF outline for a Band 6 pharmacist has been produced and is available from the CoDEG website.

The guide was developed in partnership with Cambridge University Hospitals NHS Foundation Trust, with support from the Guild of Healthcare Pharmacists

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Previously, pharmacists using the GLF have been able to add the GLF behaviours to the Plan and Record website manually using guidance from CoDEG. The GLF behaviours have now been added to the Plan and Record website as part of an overall revision of the site. This development facilitates the use of the GLF with the Society's CPD requirements.

Correspondence and enquiries, please e-mail: **info@codeg.org**
An electronic version is available to download from **www.codeg.org**

Foreword to the Second Edition: What's changed?

Overview

The main drivers for revising the successful first edition (October 2003) of the General Level Framework (GLF) were the need to:

- Incorporate developments in NHS and Pharmacy Policy and Practice since the development of the first edition.

- Take account of other relevant competencies and competency frameworks published since 2000

- Generalise the content and terminology for use in hospital, primary care and community pharmacy

The result of this revision and the ensuing successful evaluation in primary care and community pharmacy has resulted in the 2nd Edition that is available for use across all three areas of pharmacy practice.

Summary of main changes

Users familiar with the first edition will immediately notice two key changes:

1. The generalisation of the terminology in the handbook and framework (grids). The grids have been adapted to allow for four assessment phases to monitor performance as used initially by pharmacists at the Chelsea and Westminster hospital.
2. The addition of a Management and Organisational Cluster. This cluster incorporates:
    - Clinical Governance: Risk Management, Standard Operating Procedures
    - Service Provision: Quality and Improvement
    - Budgets and Reimbursement: Financial flows; Prescribing expenditure; formularies etc.
    - Organisations: Local and national linked (e.g. UKCPA, NPA)
    - Training and staff management: Personal Development Plans
    - Procurement: Stock management and cost effectiveness

Minor changes have been made to the remaining clusters. The Delivery of Patient Care cluster has a change in the order that the competencies appear. This was to align the shift in focus of practice from the prescription to the patient.

Other Resources

The CoDEG website (**www.codeg.org**) has several resources to support the use of the GLF. These include how to use the GLF for CPD and guidance on how it links with the KSF.

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Publications

An article by Dr Mills et al describes the development of the General Level Framework for primary care and community pharmacy:
Mills et al (2005) Pharmaceutical Journal, 275: 48-52

The following articles describe early pilots and evaluations of the General Level Framework:
Antoniou et al. Pharmacy Education 2005; 3/4: 201-7
Webb et al. Int J Pharm Pract 2003: 11(suppl): R91
Goldsmith et al. Pharmacy Education 2003; 2: 127-134
McRobbie et al. Pharmacy Education 2001; 2: 67-76

An article by Alison Eggleton describes how the GLF can be used with the NHS Knowledge and Skills Framework for Band 6 hospital pharmacists:
Eggleton et al. Hospital Pharmacist 2007; 14: 163-165

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Introduction

The purpose of this document is to provide guidance on a competency framework that supports the development of pharmacists as safe, effective general level practitioners. In hospital general level usually relates to the services delivered by a Band 6 pharmacist. In primary care this framework is aimed at pharmacists working either full time, part time or on a sessional basis for PCTs, or GP practices providing audit support and/or medication review services, and pharmacists working full or part time in a registered pharmacy premises in the community. PCT pharmacist working at a strategic level may find it useful to consider the Advanced and Consultant Level Competency Framework (ACLF) as this may be more suitable.

The framework will:

- Facilitate continuing professional development;
- Help individuals and their tutors define gaps in knowledge and skills, and identify training and development needs;
- Provide documentary support for appraisals and service delivery.

As well as individual pharmacists, the framework can be used by education and training providers, employers and commissioners.

A portfolio based on this framework can be used to demonstrate a pharmacist's ability to work at a general level. This provides a platform for further development to higher level practice. For NHS employed pharmacists this may be the ACLF and for community pharmacists this may be the Pharmacist with a Special Interest (PhwSI) framework.

Competencies and their uses

What is a competency framework?

Competence is the ability to carry out a job or task. A competency is a quality or characteristic of a person related to effective or superior performance. It is made up of many things such as motives, traits and skills. A behavioural competency describes typical behaviour observed when effective performers apply motives, traits or skill to job relevant tasks.

Different organisations define competency in different ways. The NHS identifies three main models of competence.

Outcome (standards) model: essentially expectations of an individual undertaking a particular area of work or work role. This model has its origins in national occupational standards, which form the basis of vocational qualifications (S/NVQs). A task-based competency is often referred to as a competence, and its assessment is criterion referenced.

Educational model: focuses on what an individual needs to know or be able to do by the end of a period of learning, usually in the form of stated learning outcomes. Assessment is usually norm-referenced or grade-related.

Personal model: deals with the underlying characteristics of an individual that result in effective performance. These qualities often relate to knowledge, skills, motives and personal traits. Most commonly applied to management, the model relies on behavioural indicators and is useful in self-assessment and individual development.

The NHS Knowledge and Skills Framework and Development Review Guidance (NHS Exec, 2003)

This general level competency framework has been developed using a *hybrid approach.* While behavioural competencies help individuals (and their managers) look at how they do their job, the outcome model identifies whether someone is effective in a particular area of work.

A *competency framework* is a collection of competencies that are thought to be central to effective performance.

What can competency frameworks be used for?

Competency frameworks can be used to support a range of different things. Typically, they are used to help with:

- Training and development
- Recruitment
- Performance review

What can this framework be used for?

We envisage that this framework will be used to help with training and development activities (see below). However, as the pharmacist develops, the framework also has the potential to be used as an aid to recruitment and as a tool to help in appraisal and to demonstrate performance.

Who can use this framework?

The framework can be used by:

The individual practitioner

- To facilitate continuing professional development
- To help individuals identify gaps in knowledge and skills and identify training and development needs
- To demonstrate requirements for service delivery

Employers

- As an aid to appraisals and setting personal development plans
- To provide opportunities for individual employers in a geographical area to work collaboratively to deliver training for their staff
- To provide support for the recruitment and induction process

Commissioners

- To set standards and monitor service delivery
- To provide a framework for accreditation of pharmacists for service delivery
- To identify and remedy poor performance

Education and training providers

- To provide training linked to service provision
- To provide the link between training and practice
- To underpin competency led postgraduate training programmes

Links to other frameworks

Competency Frameworks used to develop this framework

The development of this framework included full mapping against general level elements of key pharmacy competency lists and frameworks. The frameworks/lists mapped were:

- Previous editions of the General Level Framework 2003 and 2004;
- RPSGB 2003. Plan and Record. Continuing Professional Development. Appendix 4: Key areas of competence for all pharmacists. RPSGB London.;
- National Prescribing Centre and NHS Executive, 2003. Competencies for pharmacists working in primary care;
- RPSGB. Competencies of the future pharmacy workforce. Phase 1 report. April 2003. RPSGB, London
- A Competency Framework for Community Health Pharmacy Services June 2003
- A Competency Framework for Medicines Information: UKMI Services Sept 2001. As the MI training workbook used in many hospital trusts, a detailed mapping of this GLF and the MI competences is available on (www.codeg.org);
- National Prescribing Centre, 2003. Maintaining competence in prescribing – an outline framework to help pharmacist supplementary prescribing;
- College of Mental Health Pharmacists, 2001. Outline competencies for mental health pharmacists.

Links to the Competency Framework for the Assessment of Pharmacists providing the Medicines Use Review (MUR) and Prescription Intervention Service

The General Level Framework was used as a basis for the development of the MUR framework. A mapping document demonstrating how the two frameworks link can be found on the CoDEG website (www.codeg.org).

The GLF and the NHS Knowledge and Skills Framework

The GLF maps fully onto the KSF Profile for Band 6 pharmacists recommended by the Guild of Healthcare Pharmacists (GHP). Guidance of the mapping for this version of the GLF and prior GF versions is available on the CoDEG web-site (www.codeg.org).

The GLF can be used as evidence for the KSF as detailed in the DH KSF document[11]: The KSF states that:

"Qualifications and other competences, for example, may be used as evidence towards the achievement of the dimensions and levels if this is agreed and applicable but they cannot replace the NHS KSF"

Hence pharmacists and managers alike can be reassured that by using the GLF and meeting the agreed standards for the competences will meet the requirements of the KSF for Band 6 pharmacists.

Pharmacy Practice Framework

The Practice framework being developed by the RPSGB will define what members of the pharmacy team do and what they therefore need to know, what skills they must acquire and how they need to behave. The Practice framework will involve the definition of:

- Key roles pharmacist and members of the pharmacy team perform
- Broad functions that enable pharmacists and members of the team to fulfil each role
- Daily activities that contribute to each function
- Specifications of the knowledge, skills and attitudes pharmacists and pharmacy team members need

The general level competency framework will be a tool that will support pharmacists delivering core services in fulfilling the requirements of the pharmacy practice framework.

Introducing the Framework

The structure of the framework

This framework is made up of the following components:

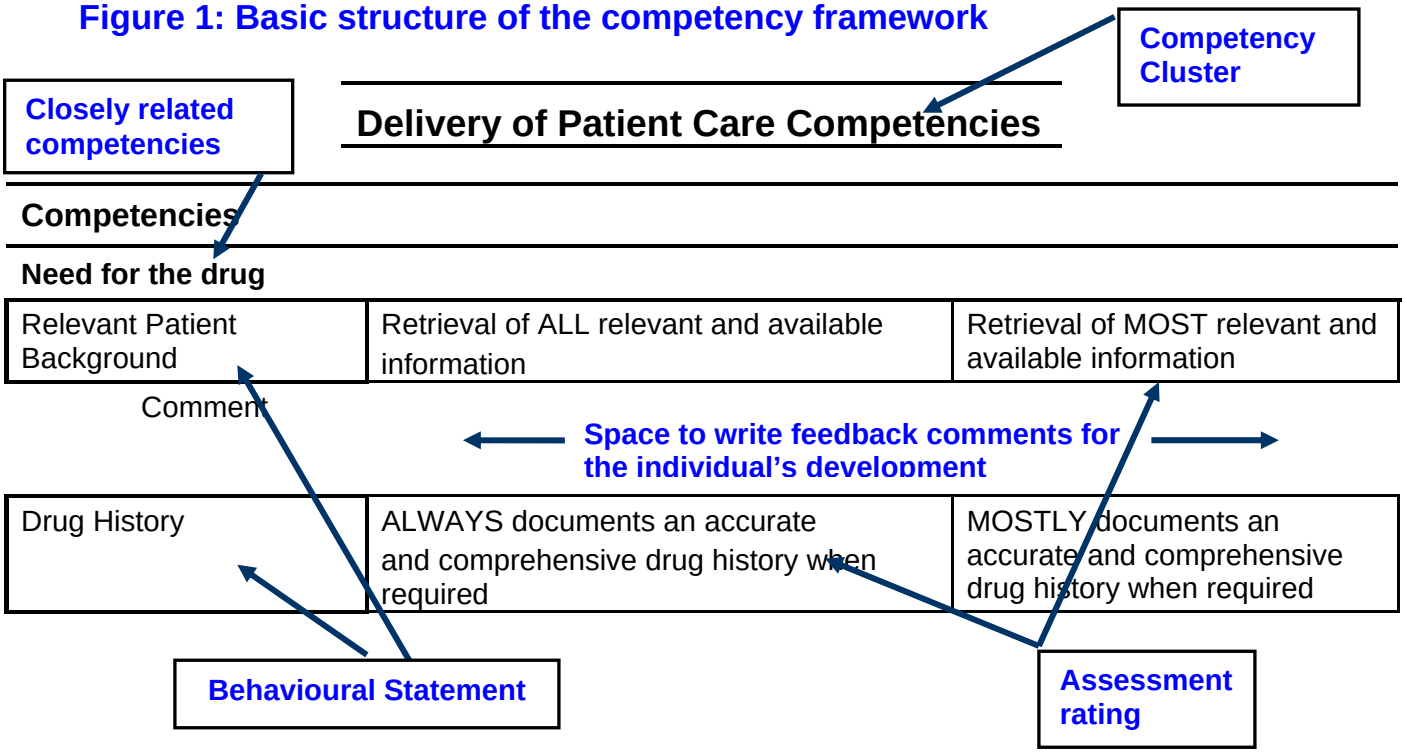
- The main areas of competency (competency cluster), which are:
  - Delivery of patient care
  - Problem solving
  - Personal
  - Management and Organisation

- Each of these clusters contains closely related competencies. Using the *Delivery of patient care* competency cluster as an example, the competencies in this area pertain to:
  - Patient consultation
  - Need for the drug
  - Selection of drug
  - Drug specific issues
  - Provision of drug product
  - Medicines information and patient education
  - Monitoring drug therapy
  - Evaluation of outcomes

- Each of these competencies has:
  - A number of statements, known as behavioural statements that define how that competency would be recognised.
  - An assessment rating ranging from always, usually, sometimes or never.

The basic structure is illustrated in Figure 1.

Figure 1: Basic structure of the competency framework



Assessment Rating

The assessment rating is on a four-point scale of Never, Sometimes, Usually and Always.

Feedback from the evaluation in secondary care suggested the definitions below for the assessment ratings. Assessment should be referenced to the *desired performance level* that would be expected at a general level. This may vary between areas, trusts or organisations.

Rating	Definitions	Percentage expression
Always	Demonstrates the expected standard practice with very rare lapses	85-100 %
Mostly	Implies standard practice with occasional lapses	51-84 %
Sometimes	Much more haphazard than "mostly"	21-50 %
Never	Very rarely meets the standard expected. No logical thought process appears to apply	0-20 %

Guidance notes on assessment

There are various acceptable methods of assessment using the framework. This includes assessment by another individual and self assessment. In the secondary care evaluation where there are several pharmacists both senior and junior, professional development was facilitated by structured assessment alongside annual appraisal. This included day to day observations; accompanied visits; using other staff to assess; and unusual clinical situations.

Day to day observations

In the secondary care evaluation this method of assessment was used in sites where junior pharmacists are supervised day-to-day by a more experienced member of staff; for example, ward based teams or a senior pharmacy manager. In community pharmacy this option might be useful in pharmacies with more than one pharmacist.

Accompanied visits

This option could be used if the assessor or facilitator do not have the opportunity to observe the pharmacist's daily practice and hence need to make arrangements to accompany the pharmacist in their work. Assessment can be based on a number of briefer accompanied visits or during a period at work.

Two different types of accompanied visits were used successfully in the secondary care evaluation.

1. *Assessment with learning*

An interactive accompanied visit, which included an assessment component and a training component. In this situation, the assessor asked questions for clarification and to identify learning points.

2. *Assessment only*

This has been described as shadowing. Here the interaction between the assessor and practitioner was more limited (unless there was an issue of patient care to resolve). Feedback was reserved until the assessment was completed.

Using other staff to assess

The use of staff, other than the assessor, to assess competencies was found useful in the secondary care trial. This included other pharmacists, technicians, nurses, medical staff or other relevant personnel. The opinion of other staff may be particularly helpful in relation to problem solving and personal competencies. However, assessment should not be based solely on the reports of staff other than the designated assessors. The assessment should at least include some direct observation.

Unusual clinical situations

There were occasions during the assessments in secondary care when there were no patients to demonstrate a particular competency. In these circumstances, the assessor constructed a hypothetical scenario. For example for drug/patient interactions they might ask how the patient management would change if the patient was pregnant. The assessment is then based on their response.

Assessment in Primary Care

In primary care pharmacists generally work in professional isolation and thus direct assessment is less appropriate. In the primary care evaluation the pharmacists

completed a self assessment and identified their individual learning needs from this. A portfolio of evidence was used to demonstrate performance against the competencies. They received two visits during the evaluation from a facilitator who helped them in this process.

The sources of evidence collected to support self assessment form part of the pharmacists CPD. These can include:

- Plan and record documentation from the RPSGB's CPD folder;
- Case scenarios;
- Intervention records;
- Anonymised pharmaceutical care records;
- Any written documentation or procedures used in their practice;
- Records relating to any continuing education undertaken;
- Documentation required by commissioners, employers or education and training providers.

Using the rating scale

The following is an example of how to assess an individual against the four-point scale.

Following an accompanied visit, it was seen that the individual sometimes identifies a drug-drug interaction, prioritises them appropriately and takes appropriate action when they discover it.

This would be assessed by:
Sometimes identify drug interaction
Always prioritises appropriately
Always appropriate action.

This highlights that they follow through appropriately but need further development on identifying the interactions.

Assessment Tools

The main assessment tool using this framework is the development of a portfolio of evidence linked to the behaviours.

As a result of ongoing implementation of the framework various other assessment tools have been developed (see Appendix 1). These are based on the tools used by junior doctors during their foundation training but are applicable for pharmacists in all sectors. They include:

- Self mini-PAT (Peer Assessment Tool) for general level pharmacists
- Mini-CEX (Clinical Evaluation Exercise) for general level pharmacists
- Case Based Discussions for general level pharmacists

The Medication Related Consultation Framework (MRCF) has been developed to support pharmacists in developing consultation skills[1]. The summary tool is available in Appendix 2.

All of the tools mentioned above are available on the CoDEG website (www.codeg.org).

Setting a performance standard

In the secondary care evaluation the individual hospital trusts set the desired performance levels that the general level pharmacist could be compared to. Wider implementation has led to groups of hospitals setting area/regional levels to encourage consistency. This has been possible because the service delivered by Band 6 pharmacists tends to be very similar between different hospital trusts.

[1] **Abdel Tawab, R**.; Davies, J.G.; Horne, R. & James, D.H. Evaluating pharmaceutical consultations: a validation of the "Medication-related Consultation Framework (MRCF)". *The International Journal of Pharmacy Practice*, Supplement 2005, 13: R27.

Although some competencies will have an obvious minimum performance level such as legal requirements, the diversity of roles of pharmacists in primary care (many pharmacists have PCT/GP practice-based roles as well as community pharmacy roles) means it is not possible to set fixed levels for all the behaviours in the GLF. However, as a result of the primary care evaluation a consensus of performance levels for the Delivery of Patient Care and Management and Organisation clusters was achieved.

In order to support users of this framework to consider desired performance levels, the levels used in the primary care evaluation were subsequently reviewed to ensure their suitability for secondary care. These are available on the CoDEG website (www.codeg.org).

Using the Competency Framework to support CPD

The Framework can be used to support CPD (including linking the use of the GLF with RPSGB Plan and Record). It is recommended that a portfolio of evidence is used to demonstrate competence against the behaviours in the framework that are relevant to an individual pharmacist's role. The section before each cluster in this handbook describes the interpretation of the competency and related behavioural statements. These will assist in completing the steps below. The steps were successfully used to support users of the GLF who took part in the primary care evaluation and have been adapted to ensure relevance for both sectors.

STEP 1 ***Set the Scene***

- Familiarise yourself with the relevant competencies and behavioural statements (including their general interpretation) in the GLF
- Review the recording of CPD using the RPSGB Plan and Record process

STEP 2 ***Determine the a)desired and b)current level of performance***

For **each of the behavioural statements** in Step 1 consider the following questions:

a
- What do I understand by this behavioural statement?
- How does this behaviour relate to my job?
- What is the desired performance level reasonable for my area of practice?

For some behaviours this may be defined by Regulatory, Professional or Organisational standards.
(If you are not sure about this for specific behaviours, you may wish to discuss this with colleagues, mentors or your manager as appropriate).

b
- What method(s) might I use to determine where my current performance lies?
- Who might I involve in this process?
- What evidence can I collect and document to support my current performance?
- Am I achieving the desired performance level?

Be specific and think through these questions for each of the behavioural

statements. Don't worry if you don't complete all the behavioural statements at once. It is far better to think through a few behaviours through in detail than glossing over many.

STEP 3 ***Identify your learning and development needs:***

1. Consider the **behavioural statements** where your current performance is **to the right of** (therefore below) the desired performance level.
2. These determine your learning and development needs for these competency areas.
3. To start with, choose a behaviour that
   - You would be most comfortable with, and
   - will be straightforward to determine your learning and development need within your working environment
   - Each behaviour could result in a **separate entry** for your CPD or alternatively you may find that one learning objective covers more than one behaviour/competency**.**
   - You can add competencies to the RPSGB list if necessary

Record each learning need in the Reflection section of Plan and Record.

STEP 4 ***Planning and action: Filling the Gap***

1. Once you have determined the learning and development need **plan how you might meet that need.** This forms your **action plan**.
   - Write SMART objectives: Specific, Measurable, Achievable, Realistic, Timely.
   - Determine an appropriate learning method that is realistic within the likely resource constraints in your workplace and your preferred learning style.
   - You may find it easier to split them into short (1-4 months), medium (4-8 months) or long term entries (8-12 months). This will help you build your CPD record over a year (or time period that suits your CPD) and allow entries to coincide with planned events such as formal appraisals or CPD submission deadlines.

2. Complete the action you have decided on for each learning need.

Complete the Planning and Action sections of Plan and Record for each learning need.

STEP 5 ***Evaluate and Demonstrate***

1. Complete the Evaluation section of Plan and Record for each CPD entry.
2. You will need to provide written evidence to demonstrate your achievement of, or movement towards, the desired performance level for the relevant competency/behavioural statements in your CPD plan. Examples of evidence include:
   - Case studies (i.e. prescription interventions, advice to patients or other heath professionals) that relate to specific competencies and behavioural statements. Use the record of evidence form to record these;
   - Protocols, procedures, and other examples of systems you have put in place as a result of a learning action;
   - Audits and surveys completed;
   - Formal Postgraduate training assessments;
   - Evidence required by commissioners or employers (e.g. evidence required by PCTs for delivering the Community Pharmacy Contract);
   - Certificates of attendance at training events can be included but

are **insufficient** as evidence **alone** as they do not describe the application of the knowledge/skills gained

For each source of evidence, you will find it easier to state the competency and behavioural statements the example relates to. One source of evidence can cover more than one behaviour across more than one competency area. If this is the case you will need to be able to explain this to your facilitator.

There is no set style or length required for the evidence for your record. Simple summaries that provide a focus for further discussion with your facilitator are fine.

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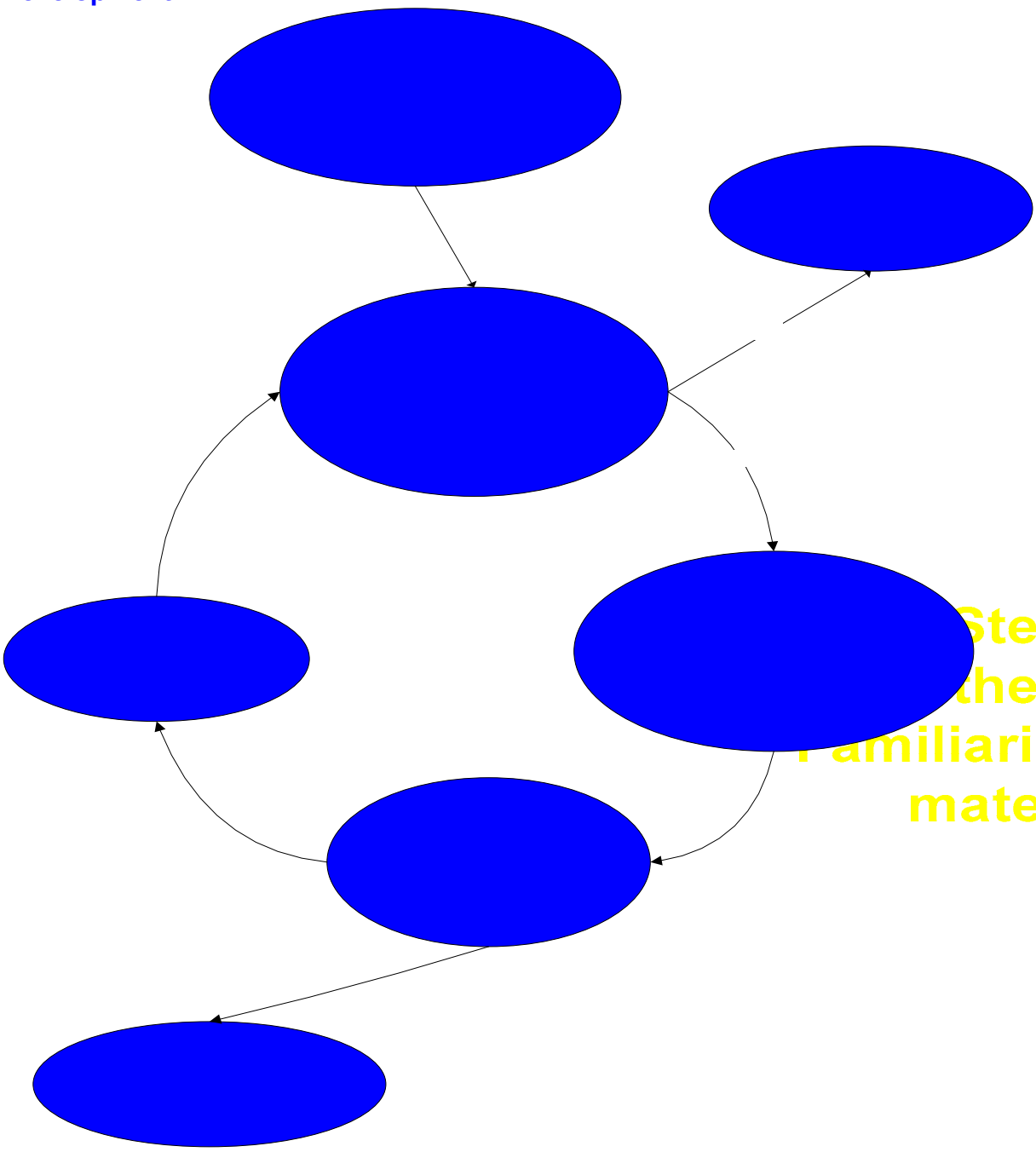
Using the Competency Framework to support Continuing Professional Development



Competency Framework

Delivery of Patient Care Competencies

Delivery of Patient Care Competencies

Patient Consultation

This competency incorporates the structure and processes needed to provide a patient with advice. This advice may be part of a request for the treatment of symptoms, whether coming from an in-patient or an out-patient in hospital or in the community. The personal skills needed for effective communication in this process are described in the personal competencies cluster. The Society has produced guidance on the process of responding to symptoms[2]. This approach is relevant irrespective of the sector of practice. There must be a system in place to support quality and consistency whilst allowing the user to bring in their own knowledge and experience. An appropriate system could also aid data collection and audit.

The delivery of a patient consultation is linked to the communication skills and behaviours in the Personal Cluster of this framework. Consultations should embrace the concept of concordance. The National Prescribing Centre have produced a framework to support achieving shared decision-making with patients about their medicines[3].

The pharmacist should demonstrate a structured, patient-centered process of consultation with patients and carers.

Assessment of the patient consultation competency could be facilitated using the Medicines Consultation Framework. Appendix 2 includes a summary assessment tool. The full tool is available on the CoDEG website (www.codeg.org).

Patient Assessment

The pharmacist should:

- Recognise and interpret the condition. This includes exploring the following:
  - The identity of the patient;
  - The nature and duration of the symptoms;

[2] Guidance on Counter Prescribing. *Pharm J* 2000; **265**: 359
[3] National Prescribing Centre, January 2007. A competency framework for shared decision-making with patients.

- ❖ Other symptoms that may be associated with the condition (where appropriate observe other signs, visible or otherwise;
- ❖ Concurrent or recent medication to exclude adverse drug reactions.

- The following should always be referred:
  - ❖ Symptoms that are potentially serious;
  - ❖ Persistent symptoms;
  - ❖ Patients at increased risk;

- Take particular care when dealing with:
  - ❖ Babies;
  - ❖ Infants and children;
  - ❖ Pregnant women;
  - ❖ Breast feeding mothers;
  - ❖ Older people;

The pharmacist should:

- Determine the goal of treatment which might be one of the following:
  - ❖ Curing a disease or disorder;
  - ❖ Reducing or eliminating a symptom;
  - ❖ Arresting or slowing disease progression;
  - ❖ Preventing a disease;
  - ❖ A combination of any of the above;

- Recommend a treatment, taking into account the patient's own health beliefs and preferences. The action taken might be one of the following:
  - ❖ Give self-care advice and/or reassurance without recommending a medicine or other treatment;
  - ❖ Recommend a medicine or treatment;
  - ❖ Refer to someone else;
  - ❖ A combination of any of the above;

- Provide advice. The following information should be provided where appropriate:
  - Information on why a particular course of action is being suggested and how to achieve the intended outcomes;
  - Information on the condition as assessed during the consultation and any changes that need to be monitored;
  - Information on the medicine or treatment recommended and how to use it;
  - Advice on when it would be appropriate to seek further advice from either the pharmacist or someone else if the condition does not improve;
  - A combination of any of the above.

Consultation or referral

The general level pharmacist should be aware of their own limitations and always consult a colleague if necessary or refer the patient appropriately. During a specific episode of care the decision to continue with the consultation or to refer may occur at anytime. For example at the outset as the health need is inappropriate for pharmacist management, or at the end once identified medicines problems have been prioritised and referral is the appropriate action. Referral could be to another health professional or to a more senior colleague. Referral may also involve signposting patients to other services or organisations.

The referral and consultation process should form part of continuing professional development and it is expected that during the course of an individuals work, repeated exposure to similar pharmaceutical problems will result in development of the general level pharmacist's experience and competence.

Recording Consultations

In order to allow monitoring of the treatment that has been recommended and allow audit of care, a record of the consultation should be made in appropriate cases in the patient's records. Many community pharmacy IT systems now allow pharmacists to record these electronically.

Patient Consent

As pharmacists develop new roles and provide additional services they will require a greater understanding of the issues surrounding consent. This has an increasing focus

for NHS services[4]. There are already key areas of practice where consent is obtained e.g. sharing of patient information, recording of patient information in patient medication records (PMR). Additional services such as screening or monitoring for chronic diseases, medication review, and prescribing and patient group directions (PGD) usage all require patient consent.

Need for the drug

Relevant patient background

In providing pharmaceutical care for a patient it is essential that background information about the patient's health and social status is identified. Without this information it is difficult to establish the existence of, or potential for, medication related problems. Review of prescriptions without this information risks flawed judgements on the appropriateness of therapy for that individual. The detail required will vary depending on the circumstances. Sources of patient information include medical, nursing and electronic records, as well as directly from the patient or carer themselves.

Details required may include:

- *Age* – the very young and the very old are most at risk of medication related problems. A patient's age will indicate their likely ability to metabolise and excrete medicines and therefore have implications for appropriate selection of drug dosage.
- *Gender* – may impact on the choice of therapy for certain conditions.
- *Ethnic background/religion* – pharmaceutical implications of this information include racial pre-dispositions to intolerance or ineffectiveness of drug classes. For example ACE-inhibitors in Afro-Caribbean individuals, or, the unsuitability of drug formulations such as blood products in Jehovah's Witness patients or porcine derived products for Jewish patients.
- *Social background* – this may impact on their ability to manage their medicines and may influence their pharmaceutical care needs. For example what are their home circumstances? Do they live in their own home or in residential accommodation? Do they have a visiting district nurse or carer?

[4] 12 Key points on consent: The law in England. London; Department of Health, 2001

- *Presenting condition* - need to establish what symptoms the patient described and the signs identified by the doctor on examination. Could they be attributed to the side-effects of prescribed or purchased medicines?
- *Working diagnosis* - of the medical team treating the patient. How would you expect this condition to be managed? What drug therapy would be considered appropriate and evidenced based? This will give you an indication as to the classes of medications you expect to see on the prescription (this could be in the form of a drug chart in hospital or a prescription in the community).
- *Previous medical history* - establishing concurrent medical conditions will help you to ensure that management of the acute newly diagnosed problem does not compromise a prior condition, and guide the selection of appropriate therapy by identifying potential contraindications.
- *Relevant laboratory or other physical findings of the medical examination*? (If available) - focus on findings that will affect drug therapy, including:
    - Renal function
    - Liver function
    - Full blood count
    - Blood pressure
    - Cardiac rhythm

Consider not only the impact that these findings could have on the ongoing management of drug therapy, e.g. need for dose adjustments, but also whether these results could have been caused by an unwanted drug effect.

Establishing this background information will allow you to make more accurate assessment of the appropriateness of recommendations.

Obtaining relevant information will depend on your sector of practice. Routine review of medical notes (if available) may be inappropriate and unnecessary for the retrieval of basic information, and the most concise information source should be used. Possible sources of information include:

- *Patients* – patients are often able to provide information, particularly in relation to medicine taking, although some skill is required in terms of managing the

consultation to avoid becoming sidetracked. However, there are times when they are the only accurate source for the information you require.

- *Medical notes* – will provide the most detailed description of the patient's care to date, although they are often lengthy and repetitive and should therefore be used to confirm findings rather than as a first source of reference. Increasingly medical notes will be available electronically and routinely accessible by pharmacists. Previous hospital admissions and subsequent discharge summaries are often useful to clarify medication histories.

- *Pharmacy based information – e.g. Patient Medication Records (PMR).* In community pharmacy an up to date PMR is the most accessible and relevant source of information about the patient's medication history.

- *Nursing 'Kardex'* – In a hospital setting, this is usually an excellent basic summary of the patient's admission details and should be used as the first source of information. It is concise and accessible and will provide all of the key features identified above, with the possible exception of laboratory findings, although abnormal results are often commented upon. In primary care, if pharmacists provide domiciliary visits, then nursing care plans are normally found in the patient's home if they are being treated by community nurses.

- *Nurses (including practice and district nurses)* – are the frontline care providers for the patients in hospital and increasingly in primary care. Hence, developing a good working relationship with the nurses is a valuable exercise. In hospital a daily handover from the nursing team can prove to be an excellent source on information about the patient's current condition.

- *Allied health care professionals* - e.g. physiotherapists, social services care workers or occupational therapists maybe involved in the patient's medicines management e.g. assessing compliance and recommending compliance aids.

- *Laboratory results systems*

If laboratory results are readily available, the general level pharmacist should ensure that they have personal access and have been trained in retrieving correct patient information from the database.

Finally, remember that all patient information that comes to your attention is CONFIDENTIAL and should not be discussed with anyone not involved in that patient's care.

Drug history

Taking a complete drug history may not always form part of the service the pharmacist is delivering. However, pharmacists need to be aware of the patient's medications. This process is included in the patient assessment behaviour in the patient consultation competency above.

It is important to distinguish between a complete drug history and reconciliation of medicines. Medicines reconciliation is defined by the Institute of Healthcare Improvement as 'the process of identifying the most accurate list of a patient's current medicines – including name, dosage, frequency and route – and comparing it to the current list in use, recognising any discrepancies and documenting any changes, thus resulting in a complete list of medicines, accurately communicated.'

Complete Drug History: a clinical process that includes identification of drug allergies or serious ADRs; information gathering from the patient; and documentation of information. It forms part of medication review and admission into hospital.

Taking accurate and complete drug histories has been shown to have a beneficial effect on patient care[5,6]. Pharmacists have demonstrated that they can accurately and reliably take drug histories[7]. The benefit to the patient is that errors of omission or transcription are identified and corrected early, reducing the risk of harm and improving care[2].

[5] Beers MH, Munekata M, Storrie M. The accuracy of medication histories in the hospital medical records of elderly person. J Am Geriatr Soc. 1990;38:1183-7.
[6] Nester TM, Hale LS. Effectiveness of a pharmacist-acquired medication history in promoting patient safety. Am J Health-Syst Pharm 2002;59(22):2221-5.
[7] Gurwich EL. Comparison of medication histories acquired by pharmacists and physicians. Am J Hosp Pharm. 1983;40:1541-2.

Queries regarding drug therapy should be clarified with the prescriber, or referred to a more senior pharmacist. Table 1 describes the core components of a drug history, although individual organisations may have additional components they wish to routinely include (refer to local guidelines).

Table 1. Core components of a complete drug history

1. Introduce yourself to the patient and explain the purpose of the visit/consultation.
2. Identify any drug allergies or serious ADRs - record these in the appropriate box on the drug chart, PMR or care notes[8].
3. Ascertain any information the patient is able to provide about their drug therapy from (in order of priority):
    - their own knowledge;
    - the drugs they brought in;
    - a GP referral letter;
    - a copy of a recent FP10/repeat prescription list;
    - information from medical notes;
    - phoning the GP;
4. Ensure the following are recorded;
    - generic name of the medicine (brand name to be recorded where appropriate);
    - dose;
    - frequency;
    - length of therapy if appropriate (e.g. antibiotics);
5. Ensure that items such as inhalers, eye drops & topical agents are included and are used correctly, as patients often do not consider these to be 'medicines'.
6. Ascertain their adherence to the prescribed medication regimen.
7. Consider practical issues such as swallowing difficulties, ability to read labels and written information, container preferences, ordering or supply problems.
8. Identify any self-treatment that the patient may be using e.g. OTC, herbal, homeopathic remedies;
9. Document the drug therapy in an appropriate format.
10. Note any discrepancies between your drug history and that recorded by other medical staff;
11. Ascertain if these discrepancies are intentional (from patient, nursing staff, medical staff, medical notes).
12. Non-intentional discrepancies should be communicated to the medical staff including nursing staff as appropriate.
13. Document any other important drug related information in an appropriate manner e.g. Chronic Renal Failure, dialysis, steroid dependent etc.

Selection of Drug

This relates to the principles of evidence-based medicine, clinical and cost-effectiveness in the selection of the most appropriate drug, dose and formulation for an individual patient. General level pharmacists are not expected to know the full breadth of clinical evidence for all conditions, but should familiarise themselves with and be able to demonstrate appreciation of key literature relevant to their current field of practice. For example for respiratory conditions they should know the BTS/SIGN guidelines on the management of asthma, COPD etc. Pharmacists should also be

aware of local trust formularies. Postgraduate education and continuing professional development should be guided by learning needs identified in practice.

Drug-drug interactions

General level pharmacists are expected to:

- Identify common, well-documented, *actual* drug interactions.
- Be able to recognise those drugs with increased risk of *potential* interactions such as
  - drugs with narrow therapeutic indices
  - drugs metabolised by the CYP450 system
  - drugs which are inducers or inhibitors of the CYP450 system
- Assess the actual or potential interaction for clinical significance, management options and refer appropriately.

Drug-patient interactions

This refers to *individual, patient specific* reactions and *contra-indications/cautions* to medicines in certain patient groups such as children and pregnancy. A general level pharmacist should:

- Understand the *potential* for unwanted effects of medicines e.g. allergies and other adverse drug reactions (ADR's).
- Ensure that any allergy or ADR is identified and documented;
- Review the prescription to ensure that no culprit medicines have been prescribed;
- Take appropriate action to ensure that no harm comes to the patient.

Drug-disease interactions

This refers to the *contra-indications/cautions* that should be applied to the use of individual drugs in a range of pathophysiological conditions. A general level pharmacist should be able to:

- Understand the mode of action and pharmacokinetics of medicines;
- Understand how these mechanisms may be altered by the *disease* e.g. renal impairment;
- Understand how these mechanisms may be altered by genetic determinants e.g. beta blockers in patients of Afro-Caribbean origins;
- Take appropriate action to ensure that the patient comes to no harm.

Drug specific issues

The pharmacist should ensure that the medicine as prescribed can be administered safely and effectively to the individual patient. The pharmacist should:

- Assess the prescription to ensure that the dose is appropriate. This includes adjustments for route and formulation prescribed. For example IV versus PO metronidazole, IM versus PO anti-psychotics, liquid versus solid dosage forms.
- Consider whether the prescribed route is *available* (is the patient nil by mouth? Are they able to take medicines orally?) and *appropriate* for that patient (e.g. unnecessary prescription of IV medication when the patient can swallow, or a solid dosage form when the patient has dysphagia);
- Consider whether the medicine is available in a suitable form for administration via the prescribed route?
- Consider whether the nurses or care staff require any specific information in order to administer the medicine safely. For example appropriateness of crushing tablets, dilution requirements for parenteral medication, rate of administration, iv compatibilities including syringe drivers;
- Consider whether aids are required to ensure safe and effective administration e.g. volumatics for inhalers;
- Complete documentation to ensure the safe and effective administration of the medicine.

Particular attention should be paid to the monitoring of parenteral therapy, which carries the additional risk of extravasation, infection and administration errors.

Provision of drug product

The pharmacist is responsible for the efficient supply of medicines to patients. When supplying a medicine for an individual patient the pharmacist should:

- Ensure the prescription is clear, unambiguous and legal in the country it is being dispensed in. Pharmacists may need to take into account the different rules in England, Scotland and Wales (e.g. drug tariff and exemptions);
- Consider the availability of the drug within the hospital or community (i.e. formulary, drug tariff and local shared care policy);

- Consider whether the prescribed indication is within the medicine's license (unlicensed drugs procedure);
- Follow local guidelines to obtain unlicensed and non-formulary medicines and ensure that appropriate documentation is completed;
- Communicate clearly with the relevant people to ensure the efficient and safe supply of medicines;
- Ensure continuity of supply for in-patient use, discharge and in the community;
- Document supply issues clearly on the drug chart or prescription and ensure that all instructions are clear. In secondary care endorsement of drug chart should follow local trust guidelines;
- Ensure medicines are labelled accurately e.g. with clear dosage instructions. Consider products with similar names or packaging, patients with similar names, and dispensing for many family members at the same time;
- Ensure medicines are labelled appropriately for the patient e.g. the visually impaired, non English speakers.

Patient information and education

It is expected that the pharmacist will provide medicine and health information and advice, both to patients, carers and medical staff. This may be in response to information requested by an individual, but the pharmacist should also seek actively, opportunities to provide this aspect of the pharmacy service.

Public Health

Pharmacists should actively explore the patient's need for lifestyle advice such as diet, smoking and exercise. The contribution that pharmacists can make to public health are detailed in 'Choosing Health Through Pharmacy' (Department of Health 2005). This includes brief opportunistic advice. A wide range of resources to support pharmacists' involvement in public health are available at http://www.pharmacymeetspublichealth.org/. An awareness of local services and initiatives and the referral process in primary care or discharge planning is essential.

Health Needs

The pharmacist must take into account the patient's cultural, language and social background when assessing their health need. This will influence their health beliefs and may affect the style of communication adopted.

Need for information is identified

It is important that the pharmacist is aware of differing individual needs for information and facilitates its provision in an appropriate format. Pharmacists should be cautious about providing information to patients in a 'blanket' format. This may not be appropriate for patients who have been on a medicine long term and require specific information relevant to their situation – this will not be established unless the pharmacist allows the patient an opportunity early in the consultation to ask their own questions.

Medicines Information

The pharmacist should ensure the accuracy of the medicine information they provide, utilise appropriate resources and consult with appropriate colleagues if unsure. The information should then be delivered in a manner appropriate to the recipient. Jargon should be avoided when speaking to patients, but caution is required not to cause confusion by trying to over simplify information – some warfarin patients will have no more idea about the state of their blood if it is described as 'too thin' or 'too thick' or the implications for their health, than if given a list of the clotting factors that warfarin inhibits.

Provision of written information

Where necessary the pharmacist may provide written medicine information.

- A product information leaflet must be provided with dispensed medicines. This is now a legal requirement and all manufacturers produce them.
- Health information leaflets are produced by many national organisations such as Diabetes UK and the British Heart Foundation. Pharmacists should be aware of and provide these valuable resources.
- Patients may need specific information such as a medicines reminder chart. The individual preparing the information should ensure that the print is legible, of an appropriately sized font, and that the information is accurate. Written

information should be signed and dated to facilitate the response to any subsequent queries.

Monitoring drug therapy

Once a drug has been appropriately selected for a patient, supplied and administered, ongoing use of the drug should be assessed, both for the desired therapeutic effect and the appearance of adverse reactions. Therapeutic drug monitoring (TDM) is an essential duty for hospital pharmacists. Pharmacists in primary care will increasingly have access to this information electronically and will need to be aware of its importance, how to interpret it and take appropriate action.

Identification and prioritisation of medicines management problems

The pharmacist should be able to identify patients for whom ongoing monitoring of therapy is required. They should be able to identify monitoring parameters for effectiveness of treatment and potential adverse effects of drug therapy and establish and maintain a plan for reviewing the therapeutic objective/end point of treatment. This may be necessary due to characteristics of the medicine or particular patient needs.

Drug characteristics

1. The pharmacist should Identify patients prescribed drugs with narrow therapeutic indices and be familiar with the monitoring parameters for these drugs. These include:

- Warfarin (there are recent NPSA recommendations on the management of patients on warfarin. Further information is available at www.npsa.nhs.uk;
- Digoxin;
- Phenytoin;
- Carbamazepine;
- Vancomycin;
- Gentamicin;
- Theophylline;
- Lithium ;
- Unfractionated heparin.

NB This list is not exhaustive (refer to local guidelines)

2. For drugs amenable to TDM and where the information is available, calculate predicted levels if no patient serum concentrations are available;
3. Identify monitoring parameters for ongoing disease management such as BP and cholesterol;
4. Evaluate the patient against these parameters;
5. Recommend appropriate monitoring to medical staff;
6. Discuss with a colleague if necessary;
7. Discuss changes to medication with medical staff if required.

Patient characteristics

The pharmacist should be able to recognise those patients who will require ongoing pharmaceutical input because of their clinical condition. For example, concomitant:

- Renal impairment;
- Hepatic impairment; or,
- An unstable clinical condition.

The pharmacist should be able to prioritise the medicines management problems of both individual patients and the group of patients for whom they are responsible.

Use of guidelines

A general level pharmacist should be able to demonstrate an awareness of guidelines available for the clinical field in which they are practicing. Pharmacists should also know the practical implications of these guidelines. Guidelines may be local policies or national guidelines from established groups (e.g. British Thoracic Society guidelines for respiratory diseases, National Service Frameworks, NICE guidance, Trust nil by mouth policy or peri-operative sliding scales guidelines on surgical wards).

The pharmacist should be able to utilise guidelines and be aware of both the advantages and disadvantages of their use, and show regard for individual patient need when using guidelines.

Resolution of medicines management problems

Having identified and prioritised medicines management problems, the pharmacist should ensure that an appropriate action to this problem is identified and implemented. If resolution requires the input of a number of staff, the action required and the urgency of that action must be accurately communicated to the relevant personnel. At all times, the pharmacist must ensure that no harm comes to the patient.

Record of Contributions

In order to allow monitoring of the treatment that has been recommended and allow audit of care, a record of the consultation should be made in appropriate cases in the patient's records. These can be manual or electronic.

Where relevant, the general level pharmacist should document information to support their contribution to patient care and ensure information is available to other members of staff.

Evaluation of outcomes

Reflection and evaluation of practice is essential if an individual pharmacist is going to undertake effective work based learning. Contributions to care should be recorded and followed up where possible to establish the outcomes of individual actions. It may not be appropriate or possible for a general level pharmacist to follow the care of an individual patient every time, but effective communication with colleagues will often establish outcomes.

There are different mechanisms for assuring evaluation of contributions:

- Actual feedback from patient, carer, or health professional on a specific issue/service
- Reflecting on service delivery or patient encounter and as a result identifying a service improvement need or a learning need from it.

The pharmacist should be able to demonstrate that they reflect on their contributions and learn from the outcomes.

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Patient Consultation

Patient Assessment	ALWAYS uses appropriate questioning to obtain relevant information from the patient	**a**	**b**	USUALLY uses appropriate questioning to obtain all relevant information from the patient	**a**	**b**	SOMETIMES uses appropriate questioning to obtain all relevant information from the patient	**a**	**b**	Does NOT use appropriate questioning to obtain all relevant information from the patient	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Consultation or referral	Pharmaceutical or health problems are ALWAYS appropriately referred	**a**	**b**	Pharmaceutical or health problems are USUALLY appropriately referred	**a**	**b**	Pharmaceutical or health problems are SOMETIMES appropriately referred	**a**	**b**	Does NOT appropriately refer pharmaceutical or health problems	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Recording Consultations	ALWAYS documents consultation where appropriate in the patient's records	**a**	**b**	USUALLY documents consultation where appropriate in the patient's records	**a**	**b**	SOMETIMES documents consultation where appropriate in the patient's records	**a**	**b**	Does NOT document consultation where appropriate in the patient's records	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Patient consent	ALWAYS satisfactorily obtains patient consent if appropriate	**a**	**b**	USUALLY satisfactorily obtains patient consent if appropriate	**a**	**b**	SOMETIMES satisfactorily obtains patient consent if appropriate	**a**	**b**	NEVER satisfactorily obtains patient consent	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Need for the drug

Relevant Patient Background	Retrieval of ALL relevant and available information	**a**	**b**	Retrieval of MOST relevant and available information	**a**	**b**	Retrieval of SOME relevant and available information	**a**	**b**	Does NOT retrieve relevant or available information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Drug History	ALWAYS documents an accurate and comprehensive drug history when required	**a**	**b**	MOSTLY documents an accurate and comprehensive drug history when required	**a**	**b**	SOMETIMES documents an accurate and comprehensive drug history when required	**a**	**b**	Does NOT document a drug history for any patient	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Selection of drug

Drug – drug interactions	Drug-drug interactions are ALWAYS identified	**a**	**b**	Drug-drug interactions are USUALLY identified	**a**	**b**	Drug-drug interactions are SOMETIMES identified	**a**	**b**	Does NOT identify any drug-drug interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Drug-drug interactions are ALWAYS appropriately prioritised	**a**	**b**	Drug-drug interactions are USUALLY appropriately prioritised	**a**	**b**	Drug-drug interactions are SOMETIMES appropriately prioritised	**a**	**b**	Does NOT prioritise any drug-drug interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Appropriate action is ALWAYS taken	**a**	**b**	Appropriate action is USUALLY taken	**a**	**b**	Appropriate action is SOMETIMES taken	**a**	**b**	Does NOT take any appropriate action	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Selection of Drug

Drug – patient interactions	Drug-patient interactions are ALWAYS identified	**a**	**b**	Drug-patient interactions are USUALLY identified	**a**	**b**	Drug-patient interactions are SOMETIMES identified	**a**	**b**	Does NOT identify any drug-patient interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Drug-patient interactions are ALWAYS appropriately prioritised	**a**	**b**	Drug-patient interactions are USUALLY appropriately prioritised	**a**	**b**	Drug-patient interactions are SOMETIMES appropriately prioritised	**a**	**b**	Does NOT prioritise any drug-patient interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Appropriate action is ALWAYS taken	**a**	**b**	Appropriate action is USUALLY taken	**a**	**b**	Appropriate action is SOMETIMES taken	**a**	**b**	Does NOT take any appropriate action	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Drug – disease interactions	Drug-disease interactions are ALWAYS identified	**a**	**b**	Drug-disease interactions are USUALLY identified	**a**	**b**	Drug-disease interactions are SOMETIMES identified	**a**	**b**	Does NOT identify any drug-disease interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Drug-disease interactions are ALWAYS appropriately prioritised	**a**	**b**	Drug-disease interactions are USUALLY appropriately prioritised	**a**	**b**	Drug-disease interactions are SOMETIMES appropriately prioritised	**a**	**b**	Does NOT prioritise any drug-disease interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Appropriate action is ALWAYS taken	**a**	**b**	Appropriate action is USUALLY taken	**a**	**b**	Appropriate action is SOMETIMES taken	**a**	**b**	Does NOT take any appropriate action	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Drug Specific Issues

Ensures appropriate dose	Appropriate dose is ALWAYS ensured	**a** / **c**	**b** / **d**	Appropriate dose is USUALLY ensured	**a** / **c**	**b** / **d**	Appropriate dose is SOMETIMES ensured	**a** / **c**	**b** / **d**	Does NOT ensure appropriate doses for any patient	**a** / **c**	**b** / **d**

Comment

Selection of dosing regimen	Appropriate route is ALWAYS ensured	**a** / **c**	**b** / **d**	Appropriate route is USUALLY ensured	**a** / **c**	**b** / **d**	Appropriate route is SOMETIMES ensured	**a** / **c**	**b** / **d**	Does NOT ensure appropriate route for any patient	**a** / **c**	**b** / **d**
	Appropriate timing of dose is ALWAYS ensured	**a** / **c**	**b** / **d**	Appropriate timing of dose is USALLY ensured	**a** / **c**	**b** / **d**	Appropriate timing of dose is SOMETIMES ensured	**a** / **c**	**b** / **d**	Does NOT ensure appropriate timing of dose	**a** / **c**	**b** / **d**

Comment

Selection of formulation and concentration	Appropriate formulation is ALWAYS ensured	**a** / **c**	**b** / **d**	Appropriate formulation is USUALLY ensured	**a** / **c**	**b** / **d**	Appropriate formulation is SOMETIMES ensured	**a** / **c**	**b** / **d**	Does NOT ensure appropriate formulation for any patient	**a** / **c**	**b** / **d**
	Appropriate concentration is ALWAYS ensured	**a** / **c**	**b** / **d**	Appropriate concentration is USUALLY ensured	**a** / **c**	**b** / **d**	Appropriate concentration is SOMETIMES ensured	**a** / **c**	**b** / **d**	Does NOT ensure appropriate concentration for any patient	**a** / **c**	**b** / **d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Provision of drug product

The prescription is clear	ALWAYS ensures the prescriber's intentions are clear	**a**	**b**	USUALLY ensures the prescriber's intentions are clear	**a**	**b**	SOMETIMES ensures the prescriber's intentions are clear	**a**	**b**	Does NOT ensure the prescriber's intentions are clear for any patient	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

The prescription is legal	Legality of prescription is ALWAYS ensured	**a**	**b**	Legality of prescription is USUALLY ensured	**a**	**b**	Legality of prescription is SOMETIMES ensured	**a**	**b**	Does NOT ensure appropriate regimen for any patient	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Labelling of the medicine	The label on the dispensed medicine ALWAYS includes required information	**a**	**b**	The label on the dispensed medicine USUALLY includes required information	**a**	**b**	The label on the dispensed medicine SOMETIMES includes required information	**a**	**b**	The label on the dispensed medicine NEVER includes required information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	The dispensed medicine is ALWAYS labelled appropriately for the patient	**a**	**b**	The dispensed medicine is USUALLY labelled appropriately for the patient	**a**	**b**	The dispensed medicine is SOMETIMES labelled appropriately for the patient	**a**	**b**	The dispensed medicine is NEVER labelled appropriately for the patient	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Medicines Information and patient education

Public Health	ALWAYS provides lifestyle advice appropriately	**a**	**b**	USUALLY provides lifestyle advice appropriately	**a**	**b**	SOMETIMES provides lifestyle advice appropriately	**a**	**b**	Does NOT provide lifestyle advice appropriately	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Health Needs	ALWAYS takes into account the patient's individual circumstances	**a**	**b**	USUALLY takes into account the patient's individual circumstances	**a**	**b**	SOMETIMES takes into account the patient's individual circumstances	**a**	**b**	Does NOT take into account the patient's individual circumstances	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Need for information is identified	Patient need for information is ALWAYS accurately identified	**a**	**b**	Patient need for information is USUALLY accurately identified	**a**	**b**	Patient need for information is SOMETIMES accurately identified	**a**	**b**	Did NOT identify the need for information in any patient	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Medicines Information	Accurate and appropriate medicines information is ALWAYS communicated	**a**	**b**	Accurate and appropriate medicines information is USUALLY communicated	**a**	**b**	Accurate and appropriate medicines information is SOMETIMES communicated	**a**	**b**	Did NOT communicate accurate and appropriate ,medicines information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Medicines Information and patient education

Provision of written information	Appropriate information is ALWAYS provided	**a**	**b**	Appropriate information is USUALLY provided	**a**	**b**	Appropriate information is SOMETIMES provided	**a**	**b**	Did NOT provide appropriate information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Monitoring drug therapy

Identification of medicines management problems	Medicines management problems are ALWAYS identified	**a**	**b**	Medicines management problems are USUALLY identified	**a**	**b**	Medicines management problems are SOMETIMES identified	**a**	**b**	Does NOT identify any medicines management problems	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Prioritisation of medicines management problems	Medicines management problems are ALWAYS accurately prioritised	**a**	**b**	Medicines management problems are USUALLY accurately prioritised	**a**	**b**	Medicines management problems are SOMETIMES accurately prioritised	**a**	**b**	Does NOT accurately prioritise any medicines management problems	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Use of Guidelines	Current clinical guidelines are ALWAYS applied as appropriate	**a**	**b**	Current clinical guidelines are USUALLY applied as appropriate	**a**	**b**	Current clinical guidelines are SOMETIMES applied as appropriate	**a**	**b**	Does NOT apply recent clinical guidelines	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Delivery of Patient Care

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Monitoring drug therapy

Resolution of medicines management problems	Appropriate action is ALWAYS taken to resolve or refer medicines management problems	**a**	**b**	Appropriate action is USUALLY taken to resolve or refer medicines management problems	**a**	**b**	Appropriate action is SOMETIMES taken to resolve or refer medicines management problems	**a**	**b**	Does NOT appropriately resolve or refer any medicines management problems	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Record of contributions	Appropriate documentation of the intervention is ALWAYS completed	**a**	**b**	Appropriate documentation of the intervention is USUALLY completed	**a**	**b**	Appropriate documentation of the intervention is SOMETIMES completed	**a**	**b**	Does NOT complete appropriate documentation of the intervention	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comments

Evaluation of outcomes

Assessing outcomes of contributions	Outcomes of contributions are ALWAYS appropriately assessed	**a**	**b**	Outcomes of contributions are USUALLY appropriately assessed	**a**	**b**	Outcomes of contributions are SOMETIMES appropriately assessed	**a**	**b**	Did NOT appropriately assess outcomes of contributions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

General comments

Personal Competencies

Personal Competencies

Organisation

Prioritisation

The general level pharmacist should be able to prioritise their own work and adjust priorities in response to changing circumstances; for example, knowing which patients/tasks take priority. We recognise that it is not possible or necessary to review the pharmaceutical care of every patient, every day. Guidance for prioritisation of workload in the clinical tasks of the pharmacist is as follows:

- In hospital, identifying all new patients that have arrived since the last pharmacy visit;
- In hospital, identifying patients approaching discharge and establishing their need for discharge medicines;
- Obtaining and recording an complete drug history for new patients;
- Ensuring that all medicines are appropriate and that the patient is informed about their medicines;
- Ensuring newly prescribed medicines are safe for the patients and sufficient supplies are available;
- Monitoring narrow therapeutic index drugs;
- In hospital, monitoring parenteral therapy;
- Evaluating current medicines for safety and effectiveness.

In community practice prioritisation will depend on the setting and circumstances and may vary on a day to day basis.

Punctuality

The pharmacist should ensure satisfactory completion of tasks with appropriate handover and recognise the importance of punctuality and attention to detail.

Initiative

The pharmacist should demonstrate initiative in solving a problem or taking on a new opportunity/task without the prompting from others, and demonstrate the ability to work independently within their limitations.

Efficiency

The general level pharmacist should demonstrate efficient use of their time. This will involve demonstrating a process of care using their time productively with minimum waste or effort. An example could be reviewing the allocated patients in the given time to an appropriate standard.

Effective Communication Skills

Good communication is essential if pharmaceutical care is to be provided for patients. This involves communicating effectively in verbal, electronic and written form, using the language appropriate to the recipient; for example, use of open questions initially followed by appropriate closed questions and supporting any recommendations with evidence.

Effective communication skills are particularly important during a patient consultation. The communication style should enable a shared decision between the pharmacist and the patient to be made.

Effective communication encompasses the following skills:

- Questioning and exploring;
- Listening – active listening demonstrates genuine respect and concern for the individual. It involves both verbal and non verbal aspects;
- Feedback – to ensure that the message is understood. It can take the form of appropriate questions and asking the individual to demonstrate that they understand or can now do what you have explained;
- Empathy – seeking to understand where other people are coming from – what their wants and needs are;
- Explaining;
- Non verbal communication;
- Over coming physical and emotional barriers to effective communication e.g. speech difficulties, fear and aggression;
- Negotiating;
- Influencing.

The desired outcome of using effective communication skills should be a concordant relationship[9]. There are three aspects of concordance with medicines:

1. Patients as partners: the patient and the healthcare team participate as partners to reach an agreement on the illness and its treatment;
2. Patient's beliefs: the agreement on treatment draws on the experiences beliefs and wishes of the patient to decide when, how and why to use medicines;
3. Professional partnerships: healthcare staff treat one another as partners and recognise each other's skills to improve the patient's participation.

Patient and carer

The 'patient' in this context means any person the pharmacist provides any pharmaceutical service to. This includes the 'walking well'. The 'carer' may be a friend or relative as well as a social services or private agency care worker.

Medical Staff

Doctors and dentists, and in some cases veterinary surgeons.

Nurses

This includes nurses providing services in primary and secondary care, for example health visitors, community psychiatric nurses and ward nursing staff etc.

Other healthcare professionals

This includes physiotherapists, occupational therapists, dieticians, opticians and paramedics.

Other Health Staff

This includes the ward clerk, practice manager, GP receptionist, prescription clerk, and medical secretaries.

[9] National Prescribing Centre, January 2007. A competency framework for shared decision-making with patients.

Immediate pharmacy team

This includes the transfer of information to temporary staff such as locum relief pharmacists, as well as other permanent members of the pharmacy team.

Mentor/tutor

Ensure time is allocated for discussion of progress, including strengths and weaknesses.

Employing Organisation

This includes non clinical staff within the organisation such as administrators, pay roll, human resources and area managers. The organisation might be the hospital trust, the primary care trust or the community pharmacy company.

Linked Organisations

This relates to any communication with other organisations that affect the delivery of patient care, especially involving the transfer of care.

Team work

It is important for the general level pharmacist to be a team player. This includes understanding the roles and responsibilities of team members and how the team works. Respecting the skills and contributions of colleagues and directly managed staff as well as recognizing one's own limitations within the team.

Pharmacy team

Within the pharmacy team, the general level pharmacists should be expected to:

- Be a committed member of the team;
- Establish good working relationships with all colleagues;
- Accept responsibility for own work (and for those in training where appropriate);
- Give and receive constructive criticism;
- Work efficiently in a team;
- Share learning experiences with colleagues;
- Know when to ask for help;
- Understand the roles of all other team members
- Identify when team members need support and provide it;
- Understand individuals' strengths and weaknesses.

Multi-disciplinary teams

The pharmacist should recognise the roles and skills of other healthcare professionals and seek to establish co-operative working relationships with colleagues, based on understanding of, and respect for, each other's roles.

Organisational team

The pharmacist should recognise the roles and skills of other non-clinical staff within the organisation.

Professionalism

Confidentiality

As for all health care professionals, pharmacists must respect an individual's right to confidentiality, maintain confidentiality and understand the circumstances when information about the patient's condition can be shared with colleagues. This includes an awareness of local trust policies and relevant legislation such as the Data Protection Act 1998, Caldicott guidance, Code of Ethics and Article 8 of the Human Rights Act 1998. As this behaviour is essential there are no assessment ratings in the competency grid. Confidentiality must always be maintained.

Recognition of limitation

The individual should know their own professional and personal limitations and seek advice or refer when necessary. The individual must continue to work within the professional code of ethics.

Quality and Accuracy of Documentation

General documentation is covered in the Delivery of Patient Care. Within a professional context, pharmacists should ensure that legally required documentation is completed in a timely manner, for example CD register entries.

Legislation

Pharmacists must be aware of and appropriately implement legislation that directly impinges on the delivery of a service to the individual patient. This includes the Disability Discrimination Act, Child Protection, Human Rights, Working with Vulnerable Adults. Important changes are occurring relating to controlled drugs and pharmacy supervision legislation (i.e. the introduction of the 'responsible pharmacist') and pharmacists need to take account of these as they happen.

Responsibility for own action

To be responsible is to be prepared to give an account of your professional judgements, acts and omissions in relation to your professional role. Accountability flows from such responsibility. Hence anyone who is responsible is also accountable. In professional ethics accountability is of paramount importance. The code of ethics states that "pharmacists assuming responsibility for any pharmacy functions whether as an employee, locum, advisor or otherwise are professionally accountable for all decisions to supply a medicine or offer advice."

Confidence

All pharmacists must inspire confidence in patients and other healthcare professionals.

Responsibility for patient care

The pharmacist should adopt a non-discriminatory attitude to all patients and recognise their needs as individuals. As part of their responsibility, pharmacists should recognise when to ask for advice and be willing to consult, and to identify and act upon errors.

CPD

The general level pharmacist should understand the need for, and take personal responsibility for, Continuing Professional Development. This involves:

- Reflecting on own practice, such as using critical incident review;
- Maintaining current awareness of professional, pharmaceutical and clinical issues (e.g. attends clinical pharmacy meetings, CPPE or NPC workshops);
- Maintaining a broad background of clinical knowledge;
- Recognising and using learning opportunities;
- Evaluating learning;
- Being self-motivated and eager to learn;
- Show willingness to learn from colleagues;
- Willingness to accept criticism for the benefit of their own development.

Demonstration of the above may be facilitated by review of a CPD record. It is now a requirement of registration for pharmacists to formally document their CPD via the RPSGB Plan and Record process. For more information see www.uptodate.org.uk

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Organisation

Prioritisation	ALWAYS prioritises work well	**a**	**b**	USUALLY prioritises work well	**a**	**b**	Does NOT prioritises work well	**a**	**b**	POOR prioritisation results in work not being completed	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Punctuality	ALWAYS punctual	**a**	**b**	USUALLY punctual	**a**	**b**	SELDOM punctual	**a**	**b**	NEVER punctual	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Initiative	ALWAYS demonstrates appropriate initiative	**a**	**b**	USUALLY demonstrates appropriate initiative	**a**	**b**	SOMETIMES demonstrates appropriate initiative	**a**	**b**	Does NOT demonstrate initiative	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Efficiency	ALWAYS uses time efficiently	**a**	**b**	USUALLY uses time efficiently	**a**	**b**	Inefficient use of time SOMETIMES results in tasks not being satisfactorily completed	**a**	**b**	Inefficient use of time results in tasks NEVER being completed	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Effective Communication Skills

Patient and Carer	Communication is ALWAYS clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise but NOT appropriate	**a** **c**	**b** **d**	Communication is unclear and inappropriate	**a** **c**	**b** **d**

Comment

Medical Staff	Communication is ALWAYS clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise but NOT appropriate	**a** **c**	**b** **d**	Communication is unclear and inappropriate	**a** **c**	**b** **d**

Comment

Nurses	Communication is ALWAYS clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise but NOT appropriate	**a** **c**	**b** **d**	Communication is unclear and inappropriate	**a** **c**	**b** **d**

Comment

Other Healthcare Professionals	Communication is ALWAYS clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise and appropriate	**a** **c**	**b** **d**	Communication is USUALLY clear, precise but NOT appropriate	**a** **c**	**b** **d**	Communication is unclear and inappropriate	**a** **c**	**b** **d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Effective Communication skills

Other Health Staff	Communication is ALWAYS clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise but NOT appropriate	**a**	**b**	Communication is unclear and inappropriate	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Immediate Pharmacy Team	Communication is ALWAYS clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise but NOT appropriate	**a**	**b**	Communication is unclear and inappropriate	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Mentor/tutor	Communication is ALWAYS clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise but NOT appropriate	**a**	**b**	Communication is unclear and inappropriate	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Employing Organisation	Communication is ALWAYS clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise but NOT appropriate	**a**	**b**	Communication is unclear and inappropriate	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Effective Communication Skills

Linked Organisations	Communication is ALWAYS clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise and appropriate	**a**	**b**	Communication is USUALLY clear, precise but NOT appropriate	**a**	**b**	Communication is unclear and inappropriate	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Team work

Pharmacy Team	ALWAYS recognises value of other staff	**a**	**b**	USUALLY recognises value of other staff	**a**	**b**	SOMETIMES unaware of value of other staff	**a**	**b**	Does NOT value other members of staff	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS works effectively as part of a team	**a**	**b**	USUALLY works effectively as part of a team	**a**	**b**	SOMETIMES an ineffective member of team	**a**	**b**	Disruptive in team	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Team work

Multi-disciplinary team	ALWAYS recognises value of other members of the healthcare team	**a**	**b**	USUALLY recognises value of other members of the healthcare team	**a**	**b**	SOMETIMES unaware of value of other members of the healthcare team	**a**	**b**	Does NOT value other members of the healthcare team	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS uses appropriate channels to refer patients to other members of the healthcare team	**a**	**b**	USUALLY uses appropriate channels to refer patients to other members of the healthcare team	**a**	**b**	SOMETIMES uses appropriate channels to refer patients to other members of the healthcare team	**a**	**b**	NEVER uses appropriate channels to refer patients to other members of the healthcare team	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Organisational Team	ALWAYS recognises the roles of non-clinical staff within the organisation	**a**	**b**	USUALLY recognises the roles of non-clinical staff within the organisation	**a**	**b**	SOMETIMES recognises the roles of non-clinical staff within the organisation	**a**	**b**	Does NOT recognise the roles of non-clinical staff within the organisation	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Professionalism

Confidentiality	ALWAYS maintains confidentiality	**a**	**b**	(ALWAYS maintains confidentiality)	**a**	**b**	(ALWAYS maintains confidentiality)	**a**	**b**	Does NOT always maintain confidentiality	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Recognition of limitation	ALWAYS recognises limitations	**a**	**b**	USUALLY recognises limitations	**a**	**b**	SELDOM Recognises limitations	**a**	**b**	UNABLE to recognises limitations	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Quality and accuracy of documentation	Legally required information is ALWAYS documented	**a**	**b**	Legally required information is USUALLY documented	**a**	**b**	Legally required information is SOMETIMES documented	**a**	**b**	Does NOT document legally required information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Professionalism

Legislation	Can describe ALL the legislation that affects patient care	**a**	**b**	Can describe MOST of the legislation that affects patient care	**a**	**b**	Can describe SOME of the legislation that affects patient care	**a**	**b**	Can NOT describe any legislation that affects patient care	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Responsibility for own action	ALWAYS takes responsibility for own action	**a**	**b**	USUALLY takes responsibility for own action	**a**	**b**	FAILS to accept responsibility for own action	**a**	**b**	Fails to recognises personal responsibility	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Confidence	ALWAYS inspires confidence	**a**	**b**	USUALLY inspires confidence	**a**	**b**	SOMETIMES inspires confidence	**a**	**b**	FAILS to inspire confidence	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Personal Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Professionalism

Responsibility for patient care	ALWAYS takes responsibility for patient care	**a**	**b**	USUALLY takes responsibility for patient care	**a**	**b**	SOMETIMES fails to accept responsibility for patient care	**a**	**b**	FAILS to recognise responsibility for patient care	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

CPD	ALWAYS maintains a CPD record	**a**	**b**	USUALLY records some evidence	**a**	**b**	SOMETIMES records come evidence	**a**	**b**	Does NOT maintain a CPD record	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS reflects on performance	**a**	**b**	USUALLY reflects on performance	**a**	**b**	SOMETIMES reflects on performance	**a**	**b**	NEVER reflects on performance	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS identifies CPD learning needs	**a**	**b**	USUALLY identifies CPD learning needs	**a**	**b**	SOMETIMES identifies CPD learning needs	**a**	**b**	NEVER identifies CPD learning needs	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS evaluates learning	**a**	**b**	USUALLY evaluates learning	**a**	**b**	SOMETIMES evaluates learning	**a**	**b**	NEVER evaluates learning	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

General comments

Problem Solving Competencies

Problem Solving Competencies

Gathering information

Accesses information

The general level pharmacist should be able to demonstrate that they can access all the information necessary in order to undertake a review of the appropriateness, safety and efficacy of the medicines prescribed for a patient. They should be able to access this information from a variety of sources and in the most time-efficient manner.

Summarises information

Following review of the information, the pharmacist should demonstrate the ability to précis the information, to extract the key points that influence drug therapy and if necessary, be able to relay concisely this information to another colleague.

Up to date information

Information needed on a day to day basis should be kept up to date. This will include clinical aspects of the patient's care and up to date texts and guidelines.

Knowledge

Pathophysiology

An understanding of normal organ function and the effect on this of disease state, is relevant to the effects of, and the effects on, drug therapy. The general level pharmacist should be able to clearly describe the pathophysiology relevant to the therapeutic areas in which they are currently working.

Pharmacology

The general level pharmacist should be able to clearly discuss the mode of action of medicines that they routinely review in the course of their daily practice. An appreciation of the distribution, metabolism and elimination of these medicines and the influence of disease states (e.g. renal failure) and patient factors (e.g. age) should also be demonstrated.

Side effects

Knowledge of the common and major side effect profile of routinely used medicines must be demonstrated. Pharmacists should be able to both discuss the potential for these with patients and recognise and describe any appropriate monitoring parameters.

Interactions

The general level pharmacists should be able to describe the different mechanisms of drug interactions and be able to identify which type of interaction applies.

Analysing information

Evaluates information

The general level pharmacist should demonstrate the ability to effectively evaluate information they have retrieved. This could be for a variety of purposes including designing a local patient information leaflet or critically appraising information about new products. The pharmacist should be able to assess information for the following aspects:

- Reliability of source – depending on the nature of information retrieved, the pharmacist should be able to evaluate the likely accuracy of information and any likelihood of bias (drug company sponsored information);
- Relevance to patient care – the impact or potential impact that the information will have on the pharmaceutical care the patient requires.

Required response : the pharmacist should demonstrate the ability to identify an appropriate response, both in the nature of the action required and the priority that it should be assigned.

Problem identification

After gathering and evaluating the information, and applying their knowledge, the pharmacist should be able to identify problems where they occur.

Appraises options

The general level pharmacist should demonstrate that they have considered the various options available to them to resolve a problem. They should consider the possible outcomes of any action and recognise the pros and cons of the various options.

Decision making

Having appraised a selection of options, the pharmacist should be able to identify the most appropriate solution and be able to justify the decision taken. However, general level pharmacists should recognise their limitations and seek advice from another colleague wherever necessary.

Logical approach

The pharmacist must develop a logical approach to their work. The competency framework is intended to guide the activities that should be undertaken for each patient or task, to ensure that points are not overlooked. The pharmacist should be able to demonstrate that they use a logical process when reviewing a prescription and that this process identifies the key action points that need to be addressed for that patient. It is recognized, however, that individuals will use different approaches to problem solving and still achieve the required outcome.

Providing information

Provides accurate information

Whenever information is requested, or a need for information is identified, it is the pharmacist's responsibility to ensure that the response they give is accurate. Information should be accessed from a reliable source and, if necessary, reference should be made to appropriate literature or to colleagues.

Provides relevant information

The content and style of presentation should be appropriate to the recipient's needs. Establishing the reason for the request, and appreciating what action will be taken on receipt of the information, should be a first priority. The general level pharmacist should demonstrate that they have considered these aspects and responded appropriately by tailoring the information that they provide.

Provides timely information

When information is requested, or the need for information is identified, the pharmacist should provide it in a timely manner. It may be that the information is immediately required for patient care and it will take priority over other activities such as management of drug alerts. Conversely, other duties may take precedence over a considered review of the literature.

Follow up

Ensures resolution of problems

If a problem is identified by, or reported to a general level pharmacist, it is their responsibility to ensure that it is appropriately resolved. This may not require their direct action, but they must ensure that the appropriate person is alerted to the situation and that accurate information is given to them. As a minimum they must ensure that no harm comes to the patient.

For development purposes the pharmacist should seek to follow up problems, both those that they had dealt with directly and those that were referred to another party, and reflect on the outcomes.

Problem Solving Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Gathering Information

Accesses Information	ALWAYS able to access information from appropriate information sources	**a**	**b**	USUALLY able to access information from appropriate information sources	**a**	**b**	SOMETIMES able to access information from appropriate information sources	**a**	**b**	NEVER able to access information from appropriate information sources	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Summarises information	ALWAYS able to summarise key points from information gathered	**a**	**b**	USUALLY able to summarise key points from information gathered	**a**	**b**	SOMETIMES able to summarise key points from information gathered	**a**	**b**	NEVER able to summarise key points from information gathered	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Up to date information	ALWAYS keeps information needed on a day to day basis up to date	**a**	**b**	USUALLY keeps information needed on a day to day basis up to date	**a**	**b**	SOMETIMES keeps information needed on a day to day basis up to date	**a**	**b**	NEVER keeps information needed on a day to day basis up to date	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Problem Solving Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Knowledge

Pathophysiology	Knowledge of pathophysiology is EXCELLENT	**a**	**b**	Knowledge of pathophysiology is GOOD	**a**	**b**	Knowledge of pathophysiology is REASONABLE	**a**	**b**	Knowledge of pathophysiology is POOR	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Pharmacology	ALWAYS able to discuss how drugs work	**a**	**b**	USUALLY able to discuss how drugs work	**a**	**b**	SOMETIMES able to discuss how drugs work	**a**	**b**	NEVER able to discuss how drugs work	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Side effects	ALWAYS able to describe the major side effects of drugs	**a**	**b**	USUALLY able to describe the major side effects of drugs	**a**	**b**	SOMETIMES able to describe the major side effects of drugs	**a**	**b**	NEVER able to describe the major side effects of drugs	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Interactions	ALWAYS able to describe mechanisms of interactions	**a**	**b**	USUALLY able to describe mechanisms of interactions	**a**	**b**	SOMETIMES able to describe mechanisms of interactions	**a**	**b**	NEVER able to describe mechanisms of interactions	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Problem Solving Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Analysing information

Evaluates information	Is ALWAYS able to evaluate information gathered	**a**	**b**	Is USUALLY able to evaluate information gathered	**a**	**b**	Is SOMETIMES able to evaluate information gathered	**a**	**b**	Is NEVER able to evaluate information gathered	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Problem identification	ALWAYS able to identify problems	**a**	**b**	USUALLY able to identify problems	**a**	**b**	SOMETIMES able to identify problems	**a**	**b**	NEVER identifies problems	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Appraises options	ALWAYS appraises options	**a**	**b**	USUALLY appraises options	**a**	**b**	SOMETIMES appraises options	**a**	**b**	NEVER appraises options	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Decision making	ALWAYS demonstrates clear decisions making	**a**	**b**	USUALLY demonstrates clear decision making	**a**	**b**	SOMETIMES demonstrates clear decision making	**a**	**b**	NEVER demonstrates clear decision making	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Problem Solving Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Analysing information

Logical Approach	ALWAYS demonstrates a logical process to problem solving	**a**	**b**	USUALLY demonstrates a logical process to problem solving	**a**	**b**	SOMETIMES demonstrates a logical process to problem solving	**a**	**b**	NEVER demonstrates a logical process to problem solving	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comments

Providing information

Provides accurate information	ALWAYS provides accurate information	**a**	**b**	USUALLY provides accurate information	**a**	**b**	SOMETIMES provides accurate information	**a**	**b**	NEVER able to provide accurate information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Provides relevant information	Always provides relevant information	**a**	**b**	USUALLY provides relevant information	**a**	**b**	SOMETIMES provides relevant information	**a**	**b**	NEVER able to provide relevant information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Problem Solving Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Providing information

Provides timely information	ALWAYS provides timely information	**a**	**b**	USUALLY provides timely information	**a**	**b**	SOMETIMES provides timely information	**a**	**b**	NEVER able to provide timely information	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Follow up

Ensures resolution of problem	ALWAYS ensures resolution of problem	**a**	**b**	USUALLY ensures resolution of problem	**a**	**b**	SOMETIMES ensures resolution of problem	**a**	**b**	NEVER able to ensure resolution of problem	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

General comments on the assessment of problem-solving competencies

Management and Organisation Competencies

Management and Organisation Competencies

Clinical Governance

Clinical governance has been defined as:

> "*A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish.*"[10]

It requires an understanding of why incidents and errors happen. This encompasses the knowledge and skills to undertake the roles required and an ability to keep up to date with developments. It is about evaluating one's own practice, considering how it might be improved, and then changing practice, implementing the changes and finding out if the changes worked.

Clinical governance issues

Clinical governance consists of a series of processes for improving quality and ensuring that professionals are accountable for their practice. These processes have been identified as continuing professional development, evidence-based practice, audit, dealing with poor performance, managing risk, monitoring clinical care and patient involvement.

These processes underpin all areas of practice. General level pharmacists should understand issues surrounding clinical governance and continuous quality improvement. These should be applied in their area of practice and also consider applicability in the wider context of patient care. In community pharmacy there is now a specific requirement in the contract for all pharmacies to have an identifiable clinical governance lead responsible for applying clinical governance principles to the delivery of services.

[10] Clinical Governance: Quality in the new NHS. (HSC 1999/065) Department of Health, London, 1999.

Standard Operating Procedures

Standard operating procedures (SOPs) are part of risk management and harm minimisation strategies. They are part of a process of assuring clinical governance. The Society requires that all pharmacists have written standard operating procedures in place. The SOPs should cover the dispensing process within individual pharmacies (hospital and community), but SOPs may also be required for other elements of a pharmacy service. It is now a legal requirement for specific SOPs to be in place for the management and use of controlled drugs. SOPs will examine current practice and ensure that systems of operating within pharmacies are safe. They should allow for continual improvement of standards of service and provide evidence of commitment to protecting patients.

The areas of the dispensing process to be covered by standard operating procedures include:

- Prescription handling
- Assessment of the prescription for validity, safety and clinical appropriateness
- Interventions and problem solving
- Assembly and labelling of required medicine or product
- Accuracy checking procedure
- Transfer of medicine or product to the patient
- Disposal of waste medicines

General level pharmacists should be aware of, and follow, all the procedures in place in their organisation.

Use of procedures includes the ability to identify the need for a procedure, and to develop, implement and review them.

Working Environment

The Code of Ethics describes the requirements for a suitable working environment that facilitates a safe system of work. There are also other national policies relevant to the work place such as Health and Safety, Control of Substances Hazardous to Health (COSHH), Hygiene, Infection Control, Duthie Report 2005[9], and consultation area requirements.

Risk Management

Pharmacists should record patient safety incidents such as dispensing and prescribing errors and patient complaints in line with national and local policy. These documents may need to be forwarded to the appropriate organisation in the spirit of a fair blame culture, for example, the National Patient Safety Agency (NPSA) and/or the primary care organisation. The NPSA also publish specific recommendations for key risk areas. General level pharmacists should be familiar with these and take account of them in their practice.

Medication errors occur in all health care systems. Serious errors harm patients and expose health professionals to civil liability and sometimes criminal prosecution. They occur too frequently and they are preventable. Prescribing, dispensing and administration of medicines are complex and skilled tasks and errors can occur at any stage. General Level pharmacists need to be aware of and be able to identify the causes and risks of medication errors and implement strategies for their prevention. This applies to the identification, prioritisation and action to resolve the risk of errors both in services they deliver themselves and services delivered by pharmacy colleagues and other health professionals.

The DH report 'Building a Safer NHS for Patients- Improving Medication Safety'[10] report explores the causes and frequency of medication errors, highlights drugs and clinical settings that carry particular risks, and identifies models of good practice to reduce risks.

Service Provision

Pharmacists should be advocates of the services available from their pharmacy team and pharmacy services available outside their sector of practice. For example hospital pharmacists should be able to advise patients/healthcare professionals of pharmacy services available in Community Pharmacy and their local Primary Care Organisations and vice versa.

Quality of Service

Ensuring a high quality service is central to the NHS Plan[11] and clinical governance. All healthcare professionals are expected to regularly review the quality of their services and make improvements where necessary. This can be achieved by carrying out formal patient surveys, audits and service reviews (either internal or external in origin) against key aspects of the service. General level pharmacists should review their services to ensure they meet local and national standards and specifications such as service specifications as described in the Medicines, Ethics & Practice, A Guide for Pharmacists, key performance indicators, Service Level Agreements.

Service Development

General level pharmacists should have knowledge of national drivers for service development for example modernisation and practice based commissioning, as well as knowledge of local health delivery plans. New services or new ways of working should be identified in relation to local plans. Primary care organisations and Hospital Trusts will be looking to develop services to meet their local needs. New ideas should be referred to and discussed with the line manager with a view to implementation. When developing a new service, the sustainability and availability of the service must be ensured. Failure to do this will reduce the quality of patient care.

Budgeting and Reimbursement

Service Reimbursement

General level pharmacists are expected to have adequate knowledge to ensure appropriate and accurate reimbursement for services offered and items dispensed. The process by which reimbursement is claimed and services paid for will vary in the different sectors. For example, in the community, reimbursement for dispensed medicines is laid out in the drug tariff and reimbursed by the NHS Business Services

[11] Department of Health. The NHS Plan: A plan for investment, a plan for reform. London: HM Stationery Office; 2000
[9] RPSGB March 2005. The Safe and Secure Handling of Medicines (Duthie 2005)
[10] Department of Health. Building a Safer NHS for Patients- Improving Medication Safety. Jan 2004

Authority Prescription Pricing Division (NHS BSA PPD) formerly known as the Prescription Pricing Authority (PPA).

Other Essential and Advanced services are also reimbursed nationally. Reimbursement for other services, e.g. Enhanced Services, is likely to come from the PCT or Practice-based Commissioners.

Hospitals receive their funding from PCTs and hospital pharmacies receive funding from a proportion of the overall amount their trust receives. The local formulary (including red/green prescribing policies) and medicines that form a significant contribution to the National Tariff/Payment by Results are key elements that have an impact on service costs. General level pharmacists should incorporate this into the services they provide (e.g. discourage the use of non-formulary medicines).

Prescribing Budget

Prescribing can greatly influence prescribing budget expenditure. General level pharmacists in both sectors are expected to have an awareness of the overall allocation of funds for healthcare and its components (including prescribing expenditure). They should be able to describe where the prescribing budget fits in to the overall budget for healthcare (nationally and locally), how prescribing affects the prescribing budget both in general medical services (via PCTs, PACT Data) and hospital services (e.g. formularies, specials) and the financial flow for prescribed medicines.

General level pharmacists should also be able to describe how the services they provide impact on the prescribing expenditure in primary and/or secondary care. For example initiatives have been introduced across primary and secondary care to reduce expenditure by using the most cost effective medicines such as statins. All pharmacists can support these initiatives by ensuring they are aware of them and can therefore provide patients and other healthcare professionals with relevant information.

Organisations

Organisational Structure

General level pharmacists should have an awareness of the general structure that drives organisational policy (i.e. PCT, hospital trust, company). They are not expected to communicate daily with people but they need to know the organisational hierarchy. They should be able to refer queries appropriately.

Linked Organisations

There are many organisations that are linked to the different sectors of pharmacy. These organisations often influence policy and affect service delivery. General level pharmacists should be able to describe the roles of the key linked organisations appropriate to their sector. For example organisations linked to hospital pharmacy might include UKCPA or the Guild of Healthcare Pharmacists. Community pharmacy might include the LPC, NPA or PSNC, and primary care pharmacy might include the LPC, PCPA and the NPC.

In addition, general level pharmacists should be able to describe the key organisations involved in continuing professional development, e.g. CPPE, CPP.

Pharmaceutical Industry

General level pharmacists should work within national and local policies on working with the pharmaceutical industry. This includes NHS policy, Association of the British Pharmaceutical Industry policies, and local organisation or trust policies.

Training

Staff

Pharmacists need to ensure that all staff for which they are responsible are competent and working within national and employing organisational requirements. The Royal Pharmaceutical Society has introduced minimum competence requirements for dispensing and pharmacy assistants involved in providing pharmacy services. The policy covers dispensing/pharmacy assistants working under the supervision of a pharmacist in the community, hospital or other pharmacy sector. In hospital pharmacy it may also include other staff who may not necessarily

be based in the dispensary such as assistant technical officers working in a manufacturing unit, or staff who put stock away. In addition, the Code of Ethics states that all staff whose work regularly includes the sale of pharmacy medicines must be competent. They should have undertaken, or be undertaking an accredited medicines counter assistant course.

Pharmacy technicians will soon have to be registered with a regulatory body (currently voluntary via the RPSGB). They have their own code of ethics, currently published in the Medicines, Ethics and Practice 2006.

Pharmacy techncians and pharmacy assistants are working under the supervision of the pharmacist when undertaking the tasks associated with their job. If staff are working under the supervision of a general level pharmacist, the pharmacists must ensure they are competent, and make arrangements for training where necessary.

General level pharmacists may also be involved in training pre-registration pharmacist trainees.

Other healthcare professionals

Other healthcare professionals or health/social care staff may need training in the provision of medicines to the public. A general level pharmacist may identify training needs in the course of their interactions with such staff. For example ward staff and appropriate storage of medicines; staff working in care homes and domiciliary care workers administering medicines or prescription clerks issuing repeat prescriptions. These training needs could be met by the general level pharmacist. This does not necessarily entail organising a training event; it could be an opportunistic chat or provision of an aide memoir such as how to write prescriptions for controlled drugs.

Where General level pharmacists are involved in delivering formal training sessions, coaching or mentoring this can be done for individual learners or group learning.

The delivery of an effective learning session can be achieved using these 12 steps :

Table 2: Delivering an effective training session:

1. Identify the task and learning needs of the learner(s).
2. Who is the target population? This will help you set the level and content of the session.
3. Research the topic you are going to deliver- make sure you know the topic well enough for the target population.
4. Write aims and objectives for the session (if not provided for you)- this can be learning outcomes such as what you expect the learner(s) to be able to as a result of the session.
5. Select the sequence and content of the session as needed.
6. Consider appropriate methods and strategies. e.g. video/IT tools; didactic/interactive content.
7. Write a lesson plan- make sure you include estimated timing and strategies for dealing with too little or too much time left.
8. Prepare the teaching aids.
9. Prepare the room/venue.
10. Give the lesson- use effective communication as detailed in the professional cluster.
11. Evaluate your teaching- use evaluation forms for sessions or other feedback mechanisms.
12. Keep a record of the session.

(Adapted from Postgraduate Certificate in Clinical Teaching West Suffolk College accredited by UEA 2001)

Some learning activities will require an assessment and the general level pharmacist may be asked to participate as assessors. The assessments may be either formative (an assessment that supports learning by giving feedback) or summative (an assessment completed at the end of a period of learning which may provide the learner with achievement grades or marks towards a formal qualification).

The general level pharmacist should support assessments effectively to ensure reliability and validity of the outcomes for learners and tutors.

Either as a result of assessments, delivering training sessions or acting as a facilitator, general level pharmacists will provide feedback to learners and/or their tutors. This feedback can be written or oral and should include certain elements (see Table 3):

Table 3: Giving Feedback

1. Make the feedback specific. 2. Say **why** as well as **what**- this will help the learner understand what to improve and why. 3. Clarify the basis of feedback- is it your view, the view of others or a fact (stating the source)? 4. Relate the feedback to the learner's progress. 5. Show respect. 6. Provide feedback that the learner will understand- pace and vocabulary used for feedback is also as important as content and style. 7. Give feedback that will help the learner to increase their understanding of the discipline- knowledge, skills and attitudes, and actions and implications of actions. 8. Confirm the learner's understanding- allow them to ask questions and ask them questions to confirm understanding.

(Adapted from Practice Guide 4- Marking and Giving Feedback, H851 Teaching in Higher Education Technology, Open University, 2001)

It is also considered good practice to provide feedback using the 'sandwich model':

- Start with positive comments;
- Describe any problems or errors in the work, alongside ideas about how to avoid them next time. Relate this to Table 3 above;
- End with an encouraging summary.

Staff Management

This competency is only relevant if the pharmacist has direct managerial responsibility for other staff.

Performance management

The purpose of the staff appraisal is to discuss achievements, expectations and outcomes related to work content, contribution, development and aspirations. This is in relation to the individual's own role and the strategic plans of the organisations. The appraisal process should realise potential, monitor performance and recognise contribution.

The key to appraisal is the opportunity to discuss openly issues that are important to both parties.

The appraisal can be carried out against last year's objectives, using work activities, knowledge, skills and experience or against the job description. The outcomes of

the appraisal will relate directly to the expected level of performance, responsibility and competence for the job.

The appraisal should be carried out in a fair and equitable way with due consideration paid to the individual's needs in relation to the process and outcomes of appraisal. Appraisals should be carried out at least annually and in line with local and national NHS policy.

Staff development

Staff should be supported to realise their potential in relation to organisational strategy and personal development. Development objectives and aspirations should be identified and reassessed during regular appraisals.

Employment Issues

General level pharmacists are expected to have awareness of employment issues, including employment legislation, whether directly involved in employing staff or not. Such issues include interviewing skills, statutory rights (e.g. annual leave, maternity leave, minimum wage, sick pay), and disciplinary procedures. Such issues must be considered when managing staff as well as part of the pharmacists's own employment.

Procurement

Not all general level pharmacists will be sourcing pharmaceuticals themselves, but they will still need to understand how products are sourced.

Pharmaceutical

Most medicines are readily available from the wholesaler. However there may be occasions when special products need to be sourced. This may include specially manufactured products such as griseofulvin suspension, unlicensed products, foreign products, products only available from the manufacturer (e.g. NeoRecormon), hospital only products (e.g. Roaccutane), or products only available in the community. Pharmacists should be aware of such products and where to source them, or be able to suggest suitable alternatives.

Supply problems

Pharmacists need to ensure patients in their care are able to receive medicines in a timely fashion. Resolution of supply problems does not just include obtaining the product. In some cases this is not possible. In this situation resolution of the supply problem would entail arranging a suitable alternative product for the patient.

Stock Management

Well managed stock levels reduce the possibility of owing the patient part of a prescription, yet minimise excess stock and the risk of products on the shelf reaching their expiry date. Stock management is important within dispensaries as well as other sites where a pharmacy service is delivered (e.g. wards, treatment rooms etc).

Cost effectiveness

When purchasing and dispensing stock and advising on prescribing choices, consideration must be given to cost effectiveness (e.g. dispensing generics, buying in bulk, selecting a product from several therapeutic equivalents). This is usually reflected in local hospital or PCT formularies. However, patient care must not be compromised. Brand substitution for those therapeutic agents for which variations in bioavailability may affect clinical outcome should be carefully considered. These agents include:

- Carbamazepine;
- Phenytoin;
- Sodium valproate;
- Theophylline;
- Aminophylline;
- Diltiazem (long acting);
- Nifedipine;
- Lithium;
- Cyclosporin.

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Clinical Governance

Clinical Governance Issues	Can ALWAYS demonstrate the application of clinical governance issues	**a** **c**	**b** **d**	Can USUALLY demonstrate the application of clinical governance issues	**a** **c**	**b** **d**	Can SOMETIMES demonstrate the application of clinical governance issues	**a** **c**	**b** **d**	NEVER demonstrates the application of clinical governance issues	**a** **c**	**b** **d**

Comment

Standard Operating Procedures	ALWAYS uses relevant and up to date procedures for practice	**a** **c**	**b** **d**	USUALLY uses relevant and up to date procedures for practice	**a** **c**	**b** **d**	SOMETIMES uses relevant and up to date procedures for practice	**a** **c**	**b** **d**	NEVER uses relevant and up to date procedures for practice	**a** **c**	**b** **d**

Comment

Working Environment	ALWAYS implements legal and professional requirements for a safe system of work	**a** **c**	**b** **d**	USUALLY implements legal and professional requirements for a safe system of work	**a** **c**	**b** **d**	SOMETIMES implements legal and professional requirements for a safe system of work	**a** **c**	**b** **d**	NEVER implements legal and professional requirements for a safe system of work	**a** **c**	**b** **d**

Comment

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Clinical Governance

Risk Management	ALWAYS documents critical incidents	**a**	**b**	USUALLY documents critical incidents	**a**	**b**	SOMETIMES documents critical incidents	**a**	**b**	NEVER documents critical incidents	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS forwards critical incident reports to the appropriate organisations	**a**	**b**	USUALLY forwards critical incident reports to the appropriate organisations	**a**	**b**	SOMETIMES forwards critical incident reports to the appropriate organisations	**a**	**b**	NEVER forwards critical incident reports to the appropriate organisations	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Service Provision

Quality of Service	ALWAYS looks to improve the quality if the services offered	**a**	**b**	USUALLY looks to improve the quality if the services offered	**a**	**b**	SOMETIMES looks to improve the quality if the services offered	**a**	**b**	NEVER looks to improve the quality if the services offered	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b =** Four month facilitation **c =** Eight month facilitation **d =** Twelve month self assessment

Service Provision

Service Development	Can ALWAYS describe the key drivers for national and local service development	**a**	**b**	Can USUALLY describe the key drivers for national and local service development	**a**	**b**	Can SOMETIMES describe the key drivers for national and local service development	**a**	**b**	Can NEVER describe the key drivers for national and local service development	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS identifies and refers the need for new services	**a**	**b**	USUALLY identifies and refers the need for new services	**a**	**b**	SOMETIMES identifies and refers the need for new services	**a**	**b**	NEVER identifies or refers the need for new services	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Budget setting and reimbursement

Service Reimbursement	ALWAYS uses relevant reference sources to ensure appropriate and accurate reimbursement	**a**	**b**	USUALLY uses relevant reference sources to ensure appropriate and accurate reimbursement	**a**	**b**	SOMETIMES uses relevant reference sources to ensure appropriate and accurate reimbursement	**a**	**b**	NEVER uses relevant reference sources to ensure appropriate and accurate reimbursement	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	ALWAYS claims reimbursement appropriately for services provided	**a**	**b**	USUALLY claims reimbursement appropriately for services provided	**a**	**b**	SOMETIMES claims reimbursement appropriately for services provided	**a**	**b**	NEVER claims reimbursement appropriately for services provided	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

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Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Budget setting and reimbursement

Prescribing budgets	Can ALWAYS interpret how prescribing affects prescribing budgets	**a**	**b**	Can USUALLY interpret how prescribing affects prescribing budgets	**a**	**b**	Can SOMETIMES interpret how prescribing affects prescribing budgets	**a**	**b**	CANNOT interpret how prescribing affects prescribing budgets	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Organisations

Organisational structure	Can ALWAYS describe the structure of employing organisation	**a**	**b**	Can USUALLY describe the structure of employing organisation	**a**	**b**	Can SOMETIMES describe the structure of employing organisation	**a**	**b**	CANNOT describe the structure of employing organisation	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Linked Organisation	Can ALWAYS describe the key organisations that affect service delivery	**a**	**b**	Can USUALLY describe the key organisations that affect service delivery	**a**	**b**	Can SOMETIMES describe the key organisations that affect service delivery	**a**	**b**	CANNOT describe the key organisations that affect service delivery	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Organisations

Pharmaceutical Industry	ALWAYS follows local and national guidance when working with the pharmaceutical industry	**a**	**b**	USUALLY follows local and national guidance when working with the pharmaceutical industry	**a**	**b**	SOMETIMES follows local and national guidance when working with the pharmaceutical industry	**a**	**b**	NEVER follows local and national guidance when working with the pharmaceutical industry	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Training

Staff	ALWAYS ensures staff are competent to undertake the tasks allocated to them	**a**	**b**	USUALLY ensures staff are competent to undertake the tasks allocated to them	**a**	**b**	SOMETIMES ensures staff are competent to undertake the tasks allocated to them	**a**	**b**	NEVER ensures staff are competent to undertake the tasks allocated to them	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Other healthcare professionals	Is ALWAYS active in training other healthcare professionals	**a**	**b**	Is USUALLY active in training other healthcare professionals	**a**	**b**	Is SOMETIMES active in training other healthcare professionals	**a**	**b**	Is NEVER active in training other healthcare professionals	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment b = Four month facilitation c = Eight month facilitation d = Twelve month self assessment

Staff Management

Performance management	ALWAYS carries out staff appraisals on a regular basis	**a**	**b**	USUALLY carries out staff appraisals on a regular basis	**a**	**b**	SOMETIMES carries out staff appraisals on a regular basis	**a**	**b**	NEVER carries out staff appraisals	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Staff development	ALWAYS supports staff in their development	**a**	**b**	USUALLY supports staff in their development	**a**	**b**	SOMETIMES supports staff in their development	**a**	**b**	NEVER supports staff in their development	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Employment issues	ALWAYS correctly applies employment issues	**a**	**b**	USUALLY correctly applies employment issues	**a**	**b**	SOMETIMES correctly applies employment issues	**a**	**b**	NEVER correctly applies employment issues	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Procurement

Pharmaceutical	Can ALWAYS describe how pharmaceuticals can be sourced	**a**	**b**	Can USUALLY describe how pharmaceuticals can be sourced	**a**	**b**	Can SOMETIMES describe how pharmaceuticals can be sourced	**a**	**b**	Can NEVER describe how pharmaceuticals can be sourced	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**
	Can ALWAYS source pharmaceuticals in a timely manner	**a**	**b**	Can USUALLY source pharmaceuticals in a timely manner	**a**	**b**	Can SOMTIMES source pharmaceuticals in a timely manner	**a**	**b**	Can NEVER source pharmaceuticals in a timely manner	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Supply problems	Supply problems are ALWAYS resolved promptly	**a**	**b**	Supply problems are USUALLY resolved promptly	**a**	**b**	Supply problems are SOMETIMES resolved promptly	**a**	**b**	Supply problems are NEVER resolved promptly	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Stock management	ALWAYS ensures stock is managed	**a**	**b**	USUALLY ensures stock is managed	**a**	**b**	SOMETIMES ensures stock is managed	**a**	**b**	NEVER manages stock	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

Comment

Management and Organisation Competencies

Competencies **Rating**

a = Initial self assessment **b = Four month facilitation** **c = Eight month facilitation** **d = Twelve month self assessment**

Procurement

Cost effectiveness	ALWAYS ensures stock purchased maximises cost effectiveness	**a**	**b**	USUALLY ensures stock purchased maximises cost effectiveness	**a**	**b**	SOMETIMES ensures stock purchased maximises cost effectiveness	**a**	**b**	NEVER ensures stock purchased maximises cost effectiveness	**a**	**b**
		c	**d**		**c**	**d**		**c**	**d**		**c**	**d**

General comments

Appendices

Information on how to use these tools is available on www.codeg.org. Some will need to be adapted for use in Primary Care and Community Pharmacy

Self mini-PAT (Peer Assessment Tool)

Please complete the questions using a cross: ☒ Please use black ink and CAPITAL LETTERS

Surname

Forename

User Number:

Please grade the following areas using the scale:**	Below expectations for GLF completion		Borderline for GLF completion	Meets expectations for GLF completion	Above expectations for GLF completion		U/C*
Delivery of Patient Care							
1 Patient consultation	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
2 Need for drug	☐	☐	☐	☐	☐	☐	☐
3 Selection of drug	☐	☐	☐	☐	☐	☐	☐
4 Drug specific issues	☐	☐	☐	☐	☐	☐	☐
5 Provision of drug product	☐	☐	☐	☐	☐	☐	☐
6 Medicines information and patient education	☐	☐	☐	☐	☐	☐	☐
7 Monitoring drug therapy	☐	☐	☐	☐	☐	☐	☐
Personal Attributes							
8 Organisation	☐	☐	☐	☐	☐	☐	☐
9 Effective Communication Skills	☐	☐	☐	☐	☐	☐	☐
10 Teamwork	☐	☐	☐	☐	☐	☐	☐
11 Professionalism	☐	☐	☐	☐	☐	☐	☐

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Problem-solving							
12 Gathering Information	☐	☐	☐	☐	☐	☐	☐
13 Knowledge	☐	☐	☐	☐	☐	☐	☐
14 Analysing information	☐	☐	☐	☐	☐	☐	☐
15 Providing information	☐	☐	☐	☐	☐	☐	☐
15 Overall, how do you compare yourself to a pharmacist ready to complete GLF training?	☐	☐	☐	☐	☐	☐	☐

*U/C Please mark this if you feel unable to comment. ** Guidance on ratings are on page 95

Assessors Name: **Assessors Position:** **Date:** **Assessors Signature:** Anything going especially well?	Please describe any areas that you think you should particularly focus on for development:

Your Signature:…….. Date: ☐☐ / ☐☐ / ☐☐

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Mini-Clinical Evaluation Exercise (CEX)

Please complete the questions using a cross: ☒ Please use black ink and CAPITAL LETTERS

Pharmacist Surname

Forename

User Number:

Clinical setting: A&E ☐ OPD ☐ In-patient ☐ Acute Admission ☐ GP Surgery ☐

Patient Type: CoE Care ☐ Medical ☐ Surgery ☐ Orthopaedic ☐ Paediatric ☐ Critical ☐

New or FU: New ☐ FU ☐ Focus of clinical encounter: History ☐ Pharm. Management ☐ Discharge Planning ☐

Complexity of PT. case: Low ☐ Average ☐ High ☐ Assessor's position: Consultant ☐ Specialist ☐

Number of previous mini-CEXs observed by assessor with any trainee: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5-9 ☐ >9 ☐

Please grade the following areas using the scale:**	Below expectations for GLF completion		Borderline for GLF completion	Meets expectations for GLF completion	Above expectations for JGLF completion		U/C*
Delivery of Patient Care							
	1	2	3	4	5	6	7
1 Patient consultation	☐	☐	☐	☐	☐	☐	☐
2 Need for drug	☐	☐	☐	☐	☐	☐	☐
3 Selection of the drug	☐	☐	☐	☐	☐	☐	☐
4 Drug specific issues	☐	☐	☐	☐	☐	☐	☐
5 Provision of drug product	☐	☐	☐	☐	☐	☐	☐
6 Medicines information and patient education	☐	☐	☐	☐	☐	☐	☐
7 Professionalism	☐	☐	☐	☐	☐	☐	☐
Problem Solving							
8 Gathering information	☐	☐	☐	☐	☐	☐	☐
9 Knowledge	☐	☐	☐	☐	☐	☐	☐
10 Analysing information	☐	☐	☐	☐	☐	☐	☐

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11 Overall clinical care	☐	☐	☐	☐	☐	☐

*U/C Please mark this if you have not observed the behaviour and therefore feel unable to comment.
** Guidance on ratings are on page 95

Anything especially good?	**Suggestions for development**

Agreed action:

Trainee satisfaction with mini-CEX (Highly) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ (Not at all)

Assessor satisfaction with mini-CEX 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Have you had training in the use of this assessment tool?:
☐ No ☐ Yes: Face-to-Face ☐ Yes: Written Training ☐ Yes: Web/CD rom

Time taken for discussion: (in minutes) ☐☐

Assessor's Signature:
.....

Date: ☐☐ / ☐☐ / ☐☐

Assessor's Surname

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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Case-based Discussion (CbD)

Please complete the questions using a cross: ☒ Please use black ink and CAPITAL LETTERS

Pharmacist Surname

Forename

User Number:

Clinical setting: A&E ☐ OPD ☐ In-patient ☐ Acute Admission ☐ GP ☐ Surgery

Patient Type Care: CoE ☐ Medical ☐ Surgical ☐ Orthopaedic ☐ Paediatrics ☐ Critical ☐

Focus of clinical Professionalism encounter: Assessment of Drug therapy ☐ Management of Pharmaceutical Issues ☐

Complexity of case: Low ☐ Average ☐ High ☐ Assessor's position: Consultant ☐ Specialist ☐ PT ☐

Please grade the following areas using the scale:**	Below expectations for GLF completion	Borderline for GLF completion	Meets expectations for GLF completion	Above expectations for GLF completions	U/C*
1 Pharmaceutical Needs Assessment	☐ ☐	☐	☐	☐ ☐	☐
2 Treatment Recommendations	☐ ☐	☐	☐	☐ ☐	☐
3 Follow-up / monitoring	☐ ☐	☐	☐	☐ ☐	☐
4 Professionalism	☐ ☐	☐	☐	☐ ☐	☐
5 Overall clinical judgement	☐ ☐	☐	☐	☐ ☐	☐

*U/C Please mark this if you have not observed the behaviour and thus feel unable to comment. ** Guidance on ratings are on page 95

Anything especially good?

Suggestions for development

Agreed action:

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Highly Not at all

Trainee satisfaction with CbD 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Assessor satisfaction with CbD 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Have you had training in the use of this assessment tool?: ☐ No ☐ Yes: Have Read Guidelines ☐ Yes: Face-to-Face ☐ Yes: Web/CD rom

Time taken for discussion: (in minutes) ☐☐

Assessor's Signature:

.....

Date: ☐☐ / ☐☐ / ☐☐

Assessor's Surname

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

The rating scale for the Mini-CEX, Mini-PAT and CBD

The rating scale should be viewed as a continuum, from 1-6.

1 is the worst and 6 is the best. When choosing a point on the scale for each descriptor, decide how well the pharmacist is performing compared to a pharmacist of similar experience who is ***"meeting your expectations"*** .

Significantly below
Performs poorly; very rarely meets the standard expected

Below
Performs poorly; meets standard required occasionally

Borderline
Performs satisfactorily; with appropriate support and direction should *meet expectations*

Meets expectations
Performs well and to the standard expected of a pharmacist with a similar level of experience

Above
Performs to a standard higher than what you would expect from a pharmacist with a similar level of experience

Significantly above
Performs to an excellent standard; student is ahead of his/her peer group

U/C
Unable to comment, as performance not observed whilst s/he was here

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MEDICATION-RELATED CONSULTATION FRAMEWORK (MRCF - Summative)

Student name: ……..…… Date: ……

Assessor name: …… Signature: ……

How well did the student undertake the following activities when consulting with the patient?

1) INTRODUCTION

- Introduces self
- Invites patient to discuss medication or health related issue
- Discusses purpose and structure of the consultation
- Negotiates shared agenda

The practitioner was **not** able to build a therapeutic relationship with the patient	0	1	2	3	4	The practitioner was **fully** able to build a therapeutic relationship with the patient

Comments:

2) DATA COLLECTION & PROBLEM IDENTIFICATION

- Medication history, social history
- How often patient misses dose(s) of treatment
- Patient's understanding of the rationale for prescribed treatment
- Reasons for missed dose(s) (*unintentional* or *intentional)*
- Patient's (lay) understanding of his/her illness
- Identifies and prioritises patient's pharmaceutical problems (summarising)

The practitioner was **not** able to identify the patient's pharmaceutical needs	0	1	2	3	4	The practitioner was **fully** able to identify the patient's pharmaceutical needs

Comments

3) ACTIONS & SOLUTIONS

- Relates information to patient's illness & treatment beliefs (risk – benefit discussion)
- Checks patient's ability to follow plan (are any problems anticipated?)
- Involves patient in designing a management plan
- Checks patient's understanding
- Gives advice on how & when to take medication, length of treatment & negotiates follow up
- Refers appropriately to other healthcare professional(s)

The practitioner was **not** able to establish an acceptable management plan with the patient	0	1	2	3	4	The practitioner was **fully** able to establish an acceptable management plan with the patient

Comments

4) CLOSING

- Explains what to do if patient has difficulties to follow plan and whom to contact
- Provides further appointment or contact point
- Offers opportunity to ask further questions

The practitioner was **not** able to negotiate 'safety netting' strategies with the patient	0	1	2	3	4	The practitioner was **fully** able to negotiate 'safety netting' strategies with the patient

Comments

5) CONSULTATION BEHAVIOURS - *Did the pharmacist demonstrate the following consultation behaviours?*

- Listens actively & allows patient to complete statements
- Demonstrates empathy & supports patient
- Uses open & closed questions appropriately
- Adopts a structured & logical approach to the consultation
- Accepts patient (i.e. respects patient, is not judgemental or patronising)
- Manages time effectively (works well within the time available)

The practitioner was **not** able to demonstrate any of these consultation behaviours	0	1	2	3	4	The practitioner was fully able to demonstrate these consultation behaviours

Comments

Total number of marks for each section: ……/20

6) OVERALL IMPRESSION:

Overall the practitioner's ability to consult was…	Not competent- Poor	Not competent - Borderline	Competent - Satisfactory	Competent - Good	Competent -Very good

Additional comments

Abdel Tawab R, James DH, Horne R & Davies JG. Reproduced with the authors' permission r.abdel-tawab@brighton.ac.uk; jamesdh@cf.ac.uk ; j.g.davies@brighton.ac.uk

Acknowledgements

Competency Project Group

David Webb	Director of London Clinical Pharmacy, London Eastern and South East Specialist Pharmacy Services
Dr Graham Davies	Associate Director of Clinical Pharmacy and Academic Director of Clinical Studies, School of Pharmacy & Biomolecular Sciences, University of Brighton
Duncan McRobbie	Principal Pharmacist, Guy's and St Thomas' Hospital NHS Trust and Pharmacy CHD Advisor, London Eastern and South East Specialist Pharmacy Services
Ian Bates	Head of Educational Development, School of Pharmacy, University of London
Sotiris Antoniou	Competency Project Manager, London Clinical Pharmacy / Barts and the London NHS Trust
Julia Wright	Clinical Pharmacy Manager, Southampton University Hospitals NHS Trust
John Quinn	Chief Pharmacist, South Bucks NHS Trust
Lizzie Mills	Primary Care Competency Project Manager, School of Pharmacy, University of London
Denise Farmer	Associate Director of Clinical Pharmacy Services, Eastern Region

Contributors to the Secondary Care Framework

Ruth Bednall	Lead Pharmacist, General Medicine, Guy's and St Thomas' Hospital NHS Trust.
Grainne Goldsmith	MSc student, pilot project. UKCPA/Wyeth Education and Training Award 2002.
Andrew Caunce	Control site assessor
Jane Hough	Control site assessor
Jane Nicholls	Control site assessor
Devina Khambhaita	Former researcher assistant
Naomi Meadows	MSc student, Advanced Practice Competency Framework / Barts and the London NHS Trust
Stuart Semple	Clinical Services Manager, Lewisham Hospital NHS Trust

Study Participants

Central Middlesex Hospital NHS Trust

Hammersmith Hospitals NHS Trust

Chelsea & Westminster Healthcare NHS Trust

Mayday Healthcare NHS Trust

Northwick Park Hospital NHS Trust

Oxford Radcliffe Hospitals NHS Trust

Royal Free Hampstead NHS Trust

St George's Healthcare NHS Trust

Southampton University Hospitals NHS Trust

Kings College Hospital NHS Trust

Southend Hospital NHS Trust

Brighton and Sussex University Hospitals NHS Trust

Guys and St Thomas' Hospital NHS Trust

Epsom & St Helier NHS Trust

Homerton University Hospital NHS Trust

Kingston Hospital NHS Trust

Northampton General Hospital NHS Trust

North Middlesex University Hospital NHS Trust

St Mary's NHS Trust

West Middlesex University Hospital NHS Trust

Great Ormond Street Hospital for Children NHS Trust

We would like to thank the members of the former London and South East Clinical Practitioner Development group for their contribution:

Peter Sharott	Director, London, Eastern and South East Specialist Pharmacy Services
Robert Lea	Pharmaceutical Advisor, Kent and Medway Strategic Health Authority
Tony West	Chief Pharmacist, Guy's and St Thomas' Hospital NHS Trust
Susan Sanders	Director of London Pharmacy Education and Training
Gail Fleming	Director of South East (South Coast) Pharmacy Education and Training
Cathy Mooney	Chief Pharmacist, St Mary's Hospital NHS Trust
Martin Stephens	Chief Pharmacist, Southampton University Hospitals NHS Trust
Sue Ashwell	Director of Pharmacy Services, Kettering General Hospital

We are also grateful to the following for their support:

Michael Cross	Director of Pharmacy, Barts and The London NHS Trust
Dr Norman Langan	Chief Pharmacist, Lothian University Hospitals NHS Trust
Marion Bennie	Specialist in Pharmaceutical Public Health, Lothian and Fife Health Boards
Chris Barrett	Former Chief Pharmacist, The Royal Hospitals NHS Trust
Christine Masterson	Administrator, Clinical Pharmacy Unit, London Eastern and South East Specialist Pharmacy Services
Josie Mansell	STEP Programme Coordinator, Public Health Directorate, Lambeth PCT
Helen Middleton	CPD Manager & Training Specialist London Pharmacy Education & Training

Contributors to the development and evaluation of the primary care edition

Ian Charles	Co-ordinator for Norfolk Medicines Support Services
Norman Dean	Norfolk Local Pharmaceutical Comittee Secretary
Tony Crook	Regional Practice Pharmacist, Moss Pharmacy
Paula Wilkinson	Pharmaceutical Advisor for Chelmsford PCT and Whitton, Braintree and Housted Care Trust, Assistant Chief Pharmacist for Mid Essex Hospital Services Trust.
Esther Johnson	Prescribing Advisor for Ipswich PCT
Jennifer Peel	Prescribing Advisor for South Cambridgeshire PCT
Barry Shooter	Community pharmacist – owns four branches Part time lecturer in Pharmacy Practice & Pharmacy Management at School of Pharmacy Member of ALLIANCE UNICHEM EUROPEAN PHARMACISTS' FORUM
Barbara Parsons	Head of Pharmacy Practice, PSNC
Sue Smith	Regional Professional Development Manager, Lloyds Pharmacy
Nick Weatherburn	Regional HR Manager, Lloyds Pharmacy
Margaret Cutler	Medicines Management Facilitator, Maldon and South Chelmsford PCT
Rasila Shah	Chief Pharmacist, Watford and Three Rivers PCT
Helen Rhodes	National Project Manager, Community Pharmacists Medicines Management Project
Jennifer Archer	Assistant Director Direct Learning CPPE
Jane Edmonds	Training Pharmacist, National Pharmaceutical Association
Karen Rosenbloom	Hertfordshire LPC Secretary, CPPE tutor for Essex
Priya Smith	Community Pharmacist, Essex Community Pharmacy Practice Development Unit
Simon Williams	Prescribing Advisor, Castle Point and Rochford PCT
Liz Bere	PCT Pharmacist for E&T, Southampton City PCT
John Stanley	Chief Executive Essex LPC
Graham Fletcher	PCT Pharmacist and Pharmacy Consultant
Martin Freedman	Community Pharmacy Clinical Governance Facilitator – Ipswich PCT Community Pharmacist; Vocational Trainer/Assessor/ Verifier
Katherine Delargy	Community Pharmacist
Brian Conn	Community Pharmacist
Mary Weatherstone	PCT Pharmacist and Practice Pharmacist