Comment

# Developing group protocols: problems and pitfalls

The last issue of the journal presented guidelines on implementing the Crown 2 (i) Report for diabetes specialist nurses (Vol 3 No 3: pp. 85–89). These may have made the development of local documents sound like a relatively straightforward process. For some DSNs this may be the case but I have to admit that my experience has been different.

I would like to be able to quote our own trust's protocols as shining examples to be followed. The reality is that myself and my colleagues have as yet been unable to get them anywhere near the drugs and therapeutics committee (DTC). Our third draft of the Supply and Administration of Insulin Under Group Protocol has almost assumed the weight of a Masters dissertation as a result of requests for more specificity and detail, but it is still firmly stuck in the system. As facilitator of the Working Party Group on Nurse Prescribing this is frustrating, particularly when colleagues from other trusts phone to say thanks for the help in getting their protocols through their DTCs.

Why are we having such problems? Are we alone or are there others out there sharing our experiences? If so, then an analysis of what is happening in our situation might provide consolation and insight. It would seem that for us the following factors are operating against progress:

## Political

We have been attempting to develop group protocols against the seismic upheaval of two large acute trusts and half a dozen peripheral hospitals merging to become the largest trust in the UK. Over the last 15 months services have been reconfigured leading to a saving of £2.5 million from management restructuring alone. The resulting culture of competitiveness and insecurity has not so far been conducive to moving initiatives forward.

## Organisational

One of the agendas of the newly formed trust is uniformity of service on different sites. When my first draft protocol was

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submitted to managers and pharmacists it was returned with a directive to work together with the other diabetes multidisciplinary teams. The trust has three diabetes centres geographically situated over a spread of 15 miles and we were all working in different ways. Getting together to work on a group protocol for insulin seemed to be a useful starting point but progress has understandably been slow and there are still areas such as recording practices and types of insulins used which vary from site to site. This raises the question of whether it is either possible or desirable for three multidisciplinary diabetes teams working on entirely different sites and serving diverse socio-ethnic populations to standardise working practice.

## Cultural

Traditionally, the cultures of the various sites have been individual and the merger has inevitably resulted in some clashes, with peripheral hospitals like the one in which I work losing out in all kinds of ways. Also, the loss of acute services to the site resulted in the disappearance of most of the medical teams, leaving medical cover on site much depleted. But in a climate of increasing clinical need for DSNs to help patients make decisions regarding insulin regimens and doses, my working practice has been severely curtailed since the insulin protocol agreed by the old trust less than 2 years ago has now been declared invalid. The spiralling incidence of litigation in the city centre trust sites may have been a factor in this situation even though litigation is uncommon in the peripheral sites.

## Crown 2 interpretation

The major stumbling block to the development of our cross-trust group protocol has been over the interpretation of the Crown 2 Report. There seems of be a school of thought that regards diabetes as an unsuitable condition for the group protocol treatment because patients are being offered individualised care. This refers to the final Crown 2 Report (March 1999) Annex C, page 88, section 1. Other trusts would seem to be more liberal in their interpretation by taking the view that the preliminary Crown 2 Report (April 1998) was published early as an interim measure to try to dispel the confusion surrounding group protocols by providing very specific guidelines for best and safest practice. It was intended as a holding measure in an attempt to support existing extended practice until out of date legislation could be changed.

## Conclusion

Unfortunately, or perhaps with deliberate perspicacity, Crown does not identify by name which clinical situations are suitable for group protocols or which should be excluded. In its conclusions to Annex C the Report does state that group protocols should be 'reserved for those limited situations where this offers an advantage for patient care, and where it is consistent with appropriate professional relationships and accountability'. That sounds like a good basis for group protocols in diabetes to me.

DSNs would seem to be destined to become dependent or independent prescribers but it is likely to be several years before this happens. In the meantime the Royal College of Nursing has advised its members to bring existing protocols into line with the Crown 2 Report's recommendations. ■

Department of Health (1998) *Review of Supply and Administration of Medicines Under Group Protocol. Preliminary report; Crown 2(i). (April 1998, as implemented by HSC 1998/051)*

Department of Health (1999) *Review of Supply and Administration of Medicines. Final report, Crown 2(ii). (March 99)*