Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Bronllys Hospital, Bronllys, Brecon, Powys, LD3 0LU

This Patient Group Direction (PGD) must only be used by registered healthcare professionals who have been named and authorised by their organisation to practice under it. The most recent and in date final signed version of the PGD should be used. Healthcare professionals should always access the PGD via the PTHB internet to ensure that they are always working to the most up to date version.

Patient Group Direction

for the administration of

Intramuscular (IM) Medroxyprogesterone Acetate (DMPA) injection as Hormonal Contraception

by Registered Nurses or Midwives

in Powys Teaching Health Board (PTHB)

Version number: PGD 0157F

Reference Number: PGD 0157F
Valid from: 01/05/2026
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hange History		
Version number	**Change details**	**Date**
0157	Initial issue	06/12/2019
0157A	Review issue in line with updated Powys PGD template and SPS template 'Administration of IM medroxyprogesterone acetate (DMPA) injection' version number 1.1. 1st August 2020	28/09/2022
0157B	Updated according to SPS template version 2.0: Updated template	01/08/2023
0157C	Updated according to SPS template version 2.1: Reworded section on cervical and breast cancer risk, in line with updated FSRH guidance. Updated references. Safeguarding level amended, as per SPS template. Format change to Appendix A.	12/12/2023
0157D	Updated according to SPS template version 2.2: Statement added regarding a suggested link between the prolonged use of medroxyprogesterone acetate and a small increased risk of intracranial meningioma in line with FSRH statement. Added exclusion of meningioma as per SPC. Updated references. Updated SLWG. Removal of Appendix B: The Patient Group Direction **Record Sheet** for the Administration of Medroxyprogesterone Acetate (Depo-Provera®) from this PGD. Minor updates to PTHB PGD template.	26/09/2024
0157E	Updated according to SPS template version number 2.3: Updated contraindications and cautions in line with Sayana Press ® SmPC. Reworded to align SPS DMPA PGDs by both routes. Minor updates to PTHB PGD template.	21/07/2025

0157F	Updated according to SPS template version number 3.0: Planned end of life review. Reflects changes in UKMEC (2025). Updated reference from FSRH to CoSRH. Minor rewording to align the RH PGDs content, and update terminology. Update SLWG and references.	01/05/2026

This Powys Teaching Health Board (PTHB) PGD is based on template v3.0 developed on behalf of the Specialist Pharmacy Service (SPS), which had been peer reviewed by the Reproductive Health PGDs Short Life Working Group (SLWG) in accordance with their Terms of Reference. It had been approved by the College of Sexual and Reproductive Health (CoSRH) in January 2026. The template has been adapted for use in Powys Teaching Health Board.

Note the working group and approving organisation(s) agreement to the content only applies to the national template and does not extend to any local adaptations made to any of the content which are solely the responsibility of the organisation authorising the PGD. The most up to date version of the template is available from the SPS national PGD, protocol and written instructions templates webpage.

Acknowledgements:

Name or Role	Position
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Sandra Wolper	Out of Hospital Care Lead, Medicines Use and Safety, Specialist Pharmacy Service

PGD authorisation

Name	Job title and organisation	Signature	Date
Senior doctor **Dr Kate Wright**	Lead doctor for PTHB	DocuSigned by: Kate Wright 1F267952823F473...	4/22/2026
Chief Pharmacist **Jonathan Boyd**	Chief Pharmacist for PTHB	Signed by: Jon Boyd 6D8ECFE8C9EB423...	4/24/2026
Clinical Governance Lead **Lucie Cornish**	Clinical Governance Lead for PTHB- Director for Innovation and Improvement	Signed by: Lucie Cornish on behalf of Amanda Ed 48844B7FC02A448...	4/22/2026
Senior Representative of Professional Group using the PGD **Paul Hooton**	Executive Director of Nursing and Midwifery for PTHB	Signed by: Paul Hooton EEABC83AC83F4B9...	4/22/2026

Appendix A provides a staff accreditation sheet. Individual practitioners must be authorised by name to work to this PGD.

Those using this PGD must ensure that it is organisationally authorised and signed by an appropriate authorising person, relating to the class of person by whom the product is to be supplied, in accordance with Human Medicines Regulations 2012 (HMR2012)[1]. **The PGD is not legal or valid without signed authorisation in accordance with HMR2012 Schedule 16 Part 2.**

The final authorised copy of this PGD should be kept by PTHB for 25 years after the PGD expires.

[1] This includes any relevant amendments to legislation.

Characteristics of staff

The decision to administer any medicine rests with the individual registered practitioner who must abide by the PGD and any associated organisation policies.

Qualifications and professional registration	Current contract of employment with Powys Teaching Health Board. Practitioners must only work under this PGD where they are competent to do so. Practitioners working under this PGD must also be a registered healthcare professional (HCP) listed in The Human Medicines Regulation 2012, Schedule 16 Part 4 legislation as able to practice under Patient Group Directions, registered with the following body: • nurses and midwives currently registered with the Nursing and Midwifery Council (NMC) The practitioners must also fulfil the training and additional requirements detailed below. Check Appendix A: Staff accredited to use the Patient Group Direction to confirm whether all practitioners listed above have organisational authorisation to work under this PGD.
Initial Training	The registered HCP authorised to operate under this PGD must have undertaken appropriate education and training and successfully completed the competencies to undertake clinical assessment of individuals ensuring safe provision of the medicines listed in accordance with local policy. Suggested requirement for training would be successful completion of a relevant contraception module/course accredited or endorsed by the CoSRH (sign in with your Athens account, then search for Contraception), HEIW or a university or as advised in the RCN training directory. Individual has undertaken appropriate training for working under PGDs for the supply and administration of medicines. Recommended training eLfH PGD elearning programme. PTHB staff to access via ESR. The healthcare professional has completed training and is up to date with at least level 2 safeguarding or the equivalent, for safeguarding children and vulnerable adults, as applicable to the role.

	Additionally, the practitioner: • must have received training in the administration of Medroxyprogesterone Acetate Injection 150mg and knowledge of its uses, contraindications and adverse effects, and be alert to changes in the BNF (https://bnf.nice.org.uk) and Summary of Product Characteristics (www.medicines.org.uk) • must have received training and be competent in the recognition, management and reporting of adverse drug reactions, including anaphylaxis • must be competent in the administration of adrenaline 1 in 1000 and have up to date Basic Life Support skills (BLS) • must be competent to assess the individual's capacity to understand the nature and purpose of the treatment and capacity to give or refuse consent to treatment • must have access to the PGD and associated online resources • should fulfil any additional requirements defined by local policy **THE PRACTITIONER MUST BE AUTHORISED BY NAME AS AN APPROVED PRACTITIONER, UNDER THE CURRENT VERSION OF THIS PGD BEFORE WORKING ACCORDING TO IT.**
Competency assessment	Registered healthcare professionals (HCPs) operating under this PGD must be assessed as competent (see Appendix A). The individual must complete a self-declaration of competence for contraception administration following training, in their Personal Appraisal and Development Review (PADR). The **personal development plan** (yellow) section of the PADR booklet should be used to record completion of Statutory and Mandatory training, including annual PGD e-learning. Registered HCPs operating under this PGD are encouraged to review their competency using the NICE Competency Framework for health professionals using patient group directions. Practitioners must be competent, recognise their own limitations and personal accountability and act accordingly. Evidence of training in BLS and anaphylaxis.

Ongoing training and competency	Registered HCPs operating under this PGD are personally responsible for ensuring they remain up to date with the use of the medicine included in the PGD (Updating at least every 2 years on the use of Medroxyprogesterone Acetate Injection 150mg)- if any training needs are identified these should be discussed with the senior individual responsible for authorising staff to act under the PGD and further training provided as required. Organisational PGD and/or medication training as required by PTHB: • Annual PGD training- evidence of ongoing PGD training to be submitted to Line Manager annually- this should include an annual completion certificate of PGD e-learning or a dated screenshot of the PGD e-learning assessment results as proof of completion. • Practitioners must ensure they are up to date with relevant issues and clinical skills and management of anaphylaxis, Basic Life Support Skills, with evidence of appropriate Continued Professional Development (CPD), which must be maintained and made available on request. • Compliance with all mandatory NHS training including safeguarding at the level relevant to the role. **It is the responsibility of the healthcare professional to maintain their own competency to practice within this PGD.**

Clinical condition or situation to which this PGD applies

Clinical condition or situation to which this PGD applies	Contraception. **It is the responsibility of the administering healthcare professional to ensure that the individual is within the inclusion criteria, and that there are no reasons for exclusion before proceeding with the treatment. If there is any reason for concern, seek medical advice.**
Criteria for inclusion	• Individual (age from 13 years and from menarche to 50 years) presenting for contraception. • Informed consent given. NB Refer to PTHB Consent to Treatment and Examination Policy. • The individual should be informed they are being treated using a PGD. • Individuals 13, 14 or 15 years of age must be assessed as competent using Fraser guidelines. • Medical and drug history taken, no reason for exclusion. • Medical history and risk assessment completed in line with UKMEC (UK Medical Eligibility Criteria) checklist, no reason for exclusion. **UKMEC must be determined and documented before issuing contraception.** Any vulnerable adult or child protection concerns should be referred to Safeguarding and PTHB safeguarding policies followed, where appropriate. Where there are safeguarding concerns (Child Protection or Protection of Vulnerable Adults, POVA) advice from the local Safeguarding team should be sought (see below).

Criteria for exclusion	• Informed consent not given. • Individuals 13, 14 or 15 years of age and assessed as not competent using Fraser Guidelines. • Individuals 16 years of age and over and assessed as lacking capacity to consent. • Individuals less than 13 years of age. If the individual is less than 13 years of age and known to have engaged in sexual activity a referral to Children's Services/social services should be made in line with All Wales Child Protection Procedures. Refer to local safeguarding lead and follow the local safeguarding policy. • Established pregnancy. Note - risk of pregnancy with a negative pregnancy test is not an exclusion. • Known hypersensitivity to an active ingredient or to any constituent of the product – see the individual Summary of Product Characteristics which can be accessed on the EMC website • Unexplained vaginal bleeding suspicious of a serious medical condition present before commencing the method. • Acute porphyria. • Metabolic bone disease. • Post-partum (0 to <6 weeks) with other risk factors for venous thromboembolism (VTE) • Major surgery (initiation) NB: Major surgery includes major elective surgery (>30 minutes' duration) and all surgery on the legs, or surgery which involves prolonged immobilisation of a lower limb. • Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies) • Known chronic kidney disease (CKD) (all stages) • Positive antiphospholipid antibodies • Conditions outside of the clinical situations criteria **Cardiovascular disease** • Current or past history of ischaemic heart disease, vascular disease, stroke or transient ischaemic attack. • Individuals with multiple risk factors (defined as more than one risk factor) for cardio-vascular disease (such as smoking, diabetes, hypertension, obesity (BMI>30kg/m^2) and dyslipidaemias) • Hypertension with vascular disease. • Active thromboembolic disease • History of VTE or current VTE (on anticoagulants) • Individuals with multiple risk factors (defined as more

	than one risk factor) for VTE are excluded. Clinical judgement should be applied and advice from a prescriber sought. Examples of VTE risk factors include (but not exclusively) ○ family history of VTE, ○ immobility, ○ BMI> 35kg/m^2, ○ superficial VTE, ○ ovarian and endometrial cancer, ○ inflammatory bowel disease, ○ sickle cell disease **Cancers** • Currently being treated or completed treatment for breast cancer • Malignant liver tumour (hepatocellular carcinoma) • History / diagnosis of meningioma. **Gastro-intestinal Conditions** • Severe hepatic impairment. • Known severe (decompensated) cirrhosis. • Benign liver tumour (hepatocellular adenoma). **Interacting medicines** – see current British National Formulary (BNF) https://bnf.nice.org.uk or individual product SmPC which is available on the EMC website. Refer to section 'action to be taken if the individual is excluded or declines treatment'
Cautions including any relevant action to be taken	• If the individual is 13, 14 or 15 years of age an assessment based on Fraser guidelines must be made and documented. • Discuss with appropriate medical/independent non-medical prescriber if the individual has multiple allergies, or any medical condition or medication of which the healthcare professional is unsure or uncertain. • Individuals 13, 14, 15, 16 or 17 years of age should not use IM DMPA first line for contraception because of its effect on bone mineral density. IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. • Individuals of any age with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of IM DMPA – IM DMPA may be considered if all alternative

	contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include: ○ Alcohol abuse and/or tobacco use ○ Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids ○ Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia ○ Previous low trauma fracture ○ Family history of osteoporosis ○ CKD • Medication should not be re-administered pending examination if there is a sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should not be re-administered**.** • **Offer Long Acting Reversible Contraception (LARC) to all individuals in particular those with medical conditions for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan.** • **If an individual is known to be taking a medication which is known to be harmful to pregnancy a highly effective form of contraception is recommended. Highly effective methods include the LARC methods: IUD and implant. If a LARC method is unacceptable/unsuitable and an IM-DMPA is chosen then an additional barrier method of contraception is advised. See CoSRH statement: Contraception for women using known teratogenic drugs (Feb 2018) FSRH.** Check for any other medications that the individual is taking, including topical or inhaled products, food supplements and herbal or homeopathic products. (Refer to BNF/SPC). Under Section 128 and 130 of the Social Services and Wellbeing (Wales) Act 2014, staff have a duty to inform the Local Authority if they have reasonable cause to suspect that an adult or child is at risk. Any vulnerable adult or child protection concerns should be referred to Safeguarding and PTHB safeguarding policies followed. Consider discussing with GP. Where there are safeguarding concerns (Child Protection or Protection of Vulnerable Adults, POVA) advice from the local Safeguarding team should be sought.

	The child protection team must be contacted for children less than 13 years of age who present having had sexual intercourse. Any young person (under 18 years) who attends for sexual health/contraception should have their risk for child sexual exploitation assessed using CSERQ. Any safeguarding concerns need to be directed to Safeguarding Hub: • To generic email address: PowysTHB.Safeguarding@wales.nhs.uk And • Central Safeguarding number: 01686 252806 • Out of hours: 0345 0544847 Advice can also be sought from local Safeguarding leads.
Actions to be taken if the individual is excluded or declines treatment	• Explain the reasons for exclusion to the individual and document in the consultation record. • Record reason for declining treatment in the consultation record. • Where required refer the individual to a suitable health service provider if appropriate (eg. GP or local Sexual Health Service) and/or provide them with information about further options. • Offer condoms if appropriate and no suitable hormonal alternative • If the individual is less than 13 years of age, the child protection team must be contacted for children under 13 years of age who present having had sexual intercourse. PTHB Safeguarding Team must be notified.

Description of treatment

Name, form and strength of medicine	Medroxyprogesterone Acetate 150mg in 1 mL Injection (vial/pre-filled syringe)
Legal category	POM
Route or method of administration	Intramuscular injection (IM) **Advice for administration:** • Follow manufacturers' guidance for administration

	• Shake the syringe/vial vigorously before administration • Deep intramuscular injection into the gluteal (preferred) or deltoid muscle • Ensure that the full contents of the syringe/vial is administered • Do not massage the site after the administration of the injection.
Off label use	Best practice advice given by College of Sexual and Reproductive Healthcare (CoSRH) is used for guidance in this PGD and may vary from the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website. This PGD includes inclusion criteria and dosage regimen which are outside the market authorisation for many of the available products but which are included within CoSRH guidance: • Can be administered after day 5 of a cycle • Can be administered 10-14 weeks after previous dose. Refer to CoSRH guidance for administration after 14 weeks. • Administration after five days postpartum if not breast feeding/before six weeks postpartum if breast feeding. CoSRH guidance supports the use of IM DMPA any time after childbirth for both breastfeeding and non-breastfeeding individuals (providing risk factors for VTE allow). Medicines should be stored according to the conditions detailed in the Storage section below. However, in the event of an inadvertent or unavoidable deviation of these conditions the local pharmacy or Medicines Management team must be consulted. Where medicines have been assessed by pharmacy/Medicines Management in accordance with national or specific product recommendations as appropriate for continued use this would constitute off-label administration under this PGD. The responsibility for the decision to release the affected medicines for use lies with pharmacy/Medicines Management. Where a medicine is recommended off-label consider, as part of the consent process, informing the individual/parent/carer that the medicine is being offered in accordance with national guidance but that this is outside the product licence.

Dose and frequency of administration	• Single IM injection (150mg/1ml) on day 1-5 of the menstrual cycle with no need for additional protection. • IM DMPA can be started at any time after day 5 if it is reasonably certain that the individual is not pregnant. Additional precautions are then required for 7 days after starting and advise to have follow up pregnancy test at 21 days after last UPSI (unprotected sexual intercourse). • When starting or restarting IM DMPA as quick start after levonorgestrel emergency contraception, additional contraception is required for 7 days and follow up pregnancy test no sooner than 3 weeks after most recent UPSI. • In line with CoSRH guidance, individuals should delay starting or restarting hormonal contraception for 5 days following use of ulipristal acetate for emergency contraception. Avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised for a further 7 days and follow up pregnancy test required no sooner than 3 weeks after most recent UPSI. • Can be started any time after childbirth. If started after 21 days additional barrier method / abstinence required for 7 days. • IM DMPA dose should be repeated 13 weeks after the last injection. • If required a repeat injection can be given up to 14 weeks after the previous dose with no additional contraceptive precautions. • If required on an occasional basis, IM DMPA injection may be repeated as early as 10 weeks after the last injection. • If the interval from the preceding injection is greater than 14 weeks the injection may be administered- the professional administering the injection should refer to CoSRH current guidelines- Progesterone only injectables for advice on the need for additional contraception and pregnancy testing. • For guidance on changing from one contraceptive method to another, and when to start after an abortion and postpartum, refer to CoSRH - Switching or Starting Methods of Contraception (log in required)and CoSRH Clinical Guideline: Contraception after Pregnancy
Quantity to be administered	Single dose is to be administered per episode of care.

Duration of treatment	For as long as individual requires IM DMPA and has no contraindications to its use. **Note** - In individuals of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use every 2 years. In particular, in individuals with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of IM DMPA – IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include: • Alcohol abuse and/or tobacco use • Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids • Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia • Previous low trauma fracture • Family history of osteoporosis • CKD **If no risks are identified then it is safe to continue IM DMPA for longer than 2 years until the age of 50.**
Storage	Medicines must be stored securely according to national guidelines and in accordance with the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website
Drug interactions	The efficacy of IM DMPA is **not** reduced with concurrent use of enzyme-inducing drugs. All concomitant medications should be checked for interactions. A detailed list of drug interactions is available in the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website or the BNF https://bnf.nice.org.uk. Refer also to CoSRH CEU Guidance: Drug Interactions with Hormonal Contraception (May 2022) | CoSRH. These information sources must be consulted. Refer to a prescriber if any concern of a clinically significant drug interaction.

Identification and management of adverse reactions	A detailed list of adverse reactions is included in the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website or the BNF https://bnf.nice.org.uk. The following possible adverse effects are commonly reported with IM DMPA (but may not reflect all reported adverse effects): • Headache, dizziness • Disturbance of bleeding patterns • Changes in mood • Weight change • Breast tenderness • Loss of libido • Abdominal discomfort or distension, nausea • Alopecia, acne, rash • Genitourinary tract infection • A delay of up to 1 year in the return of fertility after discontinuation of IM or SC DMPA. • Association with a small loss of bone mineral density which is recovered after discontinuation of the injection The available evidence suggests a possible association between current or recent use of hormonal contraception (including progestogen-only injectables) and a small increase in risk of breast cancer; absolute risk remains very small. There is a weak association between cervical cancer and use of DMPA for 5 years or longer. Any increased risk appears to reduce with time after stopping and could be due to confounding factors. Individuals should be advised that evidence suggests a link between the prolonged use of medroxyprogesterone acetate and a small increased risk of intracranial meningioma requiring surgery. In case of an acute anaphylactic reaction occurring, adequate treatment provision must be available for immediate use: Anaphylaxis and resuscitation equipment including adrenaline (1 in 1000) injection and a working telephone must be available for immediate use. In case of anaphylaxis:- • Refer to adrenaline (epinephrine) PGD 0017 and anaphylaxis procedure

	• Request medical assistance urgently. If this is not immediately available dial 999 to transfer to A&E • Ensure reaction is fully documented in individuals notes • Ensure all individuals records are marked **ALLERGIC TO Medroxyprogesterone acetate 150mg injection**. • The individual may be advised to wear a MedicAlert or similar device to alert other healthcare providers Report via Datix Once for Wales Reporting system
Additional facilities and supplies	• Access to working telephone • Suitable waste disposal facilities • Immediate access to in-date anaphylaxis kit (IM adrenaline 1:1000)
Management of and reporting procedures for adverse reactions	• Healthcare professionals and individuals/carers are encouraged to report suspected adverse reactions to the MHRA's Yellow Card scheme on: http://yellowcard.mhra.gov.uk or search for MHRA Yellow Card in the Google Play or Apple App Store. For established medicines, serious adverse events in adults or all suspected adverse reactions in children that may be attributable to the medication should be reported. Guidance on the yellow card system is available at the back of the BNF, or using the above link. • Record all adverse drug reactions (ADRs) in the individual's clinical record. • Report via organisation incident policy via the Once for Wales Reporting System. • It is considered good practice to notify the individual's GP in the event of an adverse reaction.
Written information and further advice to be given to individual or carer	• Provide manufacturer's information leaflet (PIL) provided within the original pack. • Explain mode of action, side effects, risks and benefits of the medicine. • Offer condoms and advice on safer sex practices and possible need for screening for sexually transmitted infections (STIs). • Ensure the individual has contact details of local service/sexual health services. • Advise there may be a delay of up to 1 year in the return of fertility after discontinuation of IM or SC DMPA. • Give appropriate advice if medication is used off-label.

	• Advise individuals of the importance of attending for next appointment to maintain contraceptive cover and ensure they are aware of when next injection is due. • Individuals should be advised not to drive or operate machinery if affected by dizziness.
Advice /Follow-up treatment	• The individual should be advised to seek medical advice in the event of an adverse reaction. • The individual should seek further advice if they have any concerns. See NHS 111 Wales for services in Wales http://www.nhsdirect.wales.nhs.uk/ and NHS for services in England NHS website for England - NHS

Records to be kept	Record consultation details as required by local procedures. In addition, record:
	• The consent of the individual and
	  ○ If individual is under 13 years of age record action taken
	  ○ If individual is 13, 14 or 15 years of age document capacity using Fraser guidelines
	  ○ If individual is 13, 14 or 15 years of age and not competent, record action taken.
	  ○ If individual over 16 years of age and not competent, record action taken
	• Record name of the representative who gave consent if appropriate
	• If individual not treated under PGD record action taken
	• Name of individual, address, date of birth
	• GP contact details where appropriate
	• Relevant past and present medical history, including medication and family history
	• Any known allergies and previous adverse events
	• Printed name and signature of registered health professional
	• Name, form and strength of medication administered
	• Date of administration
	• Dose administered and route and site of administration
	• Batch number and expiry date of administered product in line with local procedures
	• Any reasons for exclusion or referral, including actions taken
	• Advice given, including if excluded or declines treatment
	• Individual has been advised on the date/s for next

	appointment as required • Details of any adverse drug reactions and actions taken • Advice given about the medication including side effects, benefits, and when and what to do if any concerns • Any referral arrangements made • Any administration outside the terms of the product marketing authorisation • Recorded that administration is via Patient Group Direction (PGD)- record PGD title, number and version. Records should be signed and dated (or a password-controlled e-records) and securely kept for a defined period in line with local policy. All records should be clear, legible and contemporaneous. A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with local policy. All records should be kept in line with NHS Wales Records Management Code of Practice. This includes individual data, master copies of the PGD and lists of authorised practitioners.

Key references (accessed December 2025)

- Electronic Medicines Compendium
- Current edition of British National Formulary
- NICE Medicines practice guideline MPG2 - Patient Group Directions – Last Updated 27 March 2017
- College of Sexual and Reproductive Health Clinical Guidance: Progestogen-only Injectable Contraception (December 2014, amended July 2023)
- College of Sexual and Reproductive Health Drug Interactions with Hormonal Contraception – May 2022
- College of Sexual and Reproductive Health CEU Statement: Response to new study by Roland et al (2024). Use of progestogens and the risk of intracranial meningioma: national case-control study.
- College of Sexual and Reproductive Healthcare UK Medical Eligibility Criteria for Contraceptive Use (2025)
- College of Sexual and Reproductive Healthcare Clinical Guideline: Quick Starting Contraception (April 2017)

Appendix A Staff accredited to use the Patient Group Direction
Authorising Manager: I confirm that the practitioners named below have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of Powys Teaching Health Board for the named healthcare professionals below who have signed the PGD to work under it. *The authorising manager must use the competency checklist (below).*

Practitioner: By signing this PGD you are indicating that you agree to its contents and that you will work within it. PGDs do not remove inherent professional obligations or accountability. It is the responsibility of each professional to practise only within the bounds of their own competence and professional code of conduct.

I confirm that I have read and understood the content of this Patient Group Direction and that I am willing and competent to work to it within my professional code of conduct.

Printed name of registered health professional	**Signature of registered health professional**	**Printed name of senior representative authorising health professional**	**Signature of senior representative authorising health professional**	**Date**

The authorising manager should retain a copy of the list, which will be required for audit purposes. This list should be kept by PTHB for 25 years after the PGD expires.

The healthcare professional should retain a copy of the document after signing.

Competency check list for manager or senior team lead to use as part of the authorising process for health professionals to work to a Patient Group Direction (PGD). Review of authorisation will take place on each PGD update and at the individual's annual PADR.

Name: **Role:**		Sign / Initial	Further training identified (Y/N) Specify in "comments	Comments
1	The PGD sign off is for the following PGD:(document the exact title and PGD number) _____			
2	We have discussed the expiry of the PGD and are using a version accessed electronically			
3	The member of staff has the appropriate qualifications and professional registration as outlined in the PGD			
4	The Patient Group Direction has been read in full by the staff member			
5	The identified training has been completed as specified in the PGD and is in date			
6	We have discussed some examples of inclusion criteria and exclusion criteria			
7	The staff member is confident in the administration method and doses			

Staff member print & sign name		Date
Manager or senior team lead to print & sign name		Date

Please send a copy of this completed form to individual's line manager, to the staff member, in conjunction with the PGD Appendix A authorisation sheet. A copy of this form should also be kept by service lead in the training file.