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Coaching and mentoring: will you chose your comfort zone or an exciting new adventure?
What have your National Officers been up to since Conference 2014?

**Development & Strategic**
- APTUK Foundation Pharmacy Framework
- Develop Champions
- Deliver Training to 28 Champions
- Respond to consultations
- Apprentices - feeding into the Trailblazer Group
- Supporting the Conference Team
- Modernise the Award application process

**CPD and Branch & Projects**
- Champion specification and training
- Organise Branch Day
- Communication with Branches
- Piloting the collaboration between APTUK and CPPE
- CPD pre-review service - 1 member per month
- Sits on the Education Strategy Group (ESG)
- Reply to enquiries, phone messages and emails

**Education**

**Treasurer**
- Reviewing company documents and job descriptions
- Arranging short listings & interviews for membership co-ordinator
- Attend work stream & officer meetings
- Budgets
- Contributes to key press releases
- Yearly Invoicing

**Secretary**
- Limited by Guarantee
- Paperwork
- Attend work stream & officer meetings
- National Officer Job Descriptions
- Organise Recruitment process
- Representation of the Rebalancing Programme Board

**Marketing**
- “Special products” and “Nova laboratories” have both confirmed that they will purchase a sponsorship package.
- Secured several job vacancy adverts bringing in extra funds to support our Journal and the website.
- I became lead for the Communication Team this year and have been trying to ensure that we communicate with each other within the team and with the other work streams.

**Website**
- Website updates - info, job adverts, and press releases
- Works with the APTUK News Reporters
- Updates Facebook and Twitter
- Publicises APTUK Events & Conference
- Created Promotional Videos
- Answer info@aptuk.org enquiries
- Assists with Technical issues
- Attend work stream & officer meetings
- Branch Chairman for Gloucestershire APTUK Branch
- Represented APTUK at an RPS meeting held in Gloucestershire

**Communication**

**Administration**
- Attend work stream & officer meetings
- Budgets
- Contributes to key press releases
- Yearly Invoicing

**Branch Chairman for Gloucestershire APTUK Branch**

**Represented APTUK at an RPS meeting held in Gloucestershire**
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or call us on: +44(0) 1932 690325
After 14 years, some reflections and farewell!

As I write this I am gripped by an odd blend of excited liberation at forthcoming retirement and the sadness of impending loss, it will be hard to leave the PTJ behind but for me its time for a new challenge.

The spring 2015 issue marks my last with the Pharmacy Technician Journal, PTJ as it’s now affectionately known. It was 14 years ago at a conference following no candidates Julie Mathieson managed to persuade me I could take on the challenge of a national officer role. At that time the "Journal of the Association of Pharmacy Technicians" was a 12 page newsletter printed by a locum company who supported us and hand packaged it into envelopes a mammoth task, photos and some articles were still sent by post! Back then I could barely send an email what a learning curve it has been at times difficult but definitely worth it.

I’ve been reflecting on past issues of the PTJ looking for themes, for developments, for ideas, for this valedictory editorial after fourteen years as its editor. A few may be worth offering. First some general impressions. The enthusiasm and passion that being a pharmacy technician still seems to inspire in those who write about it leaps out of the PTJ’s pages. So does the enormous breadth of the practice along with the expanding roles and opportunities we now have at our fingertips.

One of the most agreeable benefits for me has been the friendships, intellectual with many and personal with quite a few, with people whom I would otherwise have never met, that the PTJ has facilitated and it was good to find so many of these friends communicating with me as I browsed through the journal’s pages. Let me also take the opportunity of thanking all my friends and colleagues who have helped me produce and edit this journal and all of the other issues over the years, APTUK members, pharmacists, columnists, CPPE, RPS, UKCPA, advertisers and my personal friends who often write especially commissioned pieces and all those who actually make the journal appear once the editor has chosen its contents. While I don’t have space to name all whom I thank, particular tribute is due to the national officers who have been with me for all of my editorial years, Caitlin and Tony at Truprint who make the magic happen (in function if not title the production editors of the journal).

I’ve always subscribed to the advice of working with people smarter than yourself (some will say that’s not a very high bar in my case), and I think it’s paid off. All of the pharmacy technicians, pharmacists, healthcare professionals, admin staff and patients I have met on my journey are tremendously talented and dedicated professionals of the highest order.

Another pleasure that I derived from browsing through old journals was to find that on the whole my intention to continually raise the profile of pharmacy technicians and everything we can achieve, encouraging us to promote and showcase our exceptional benefits to patient care has been achieved with each issue going from strength to strength. The journal has provided a successful forum for reasoned discussion of the entire range of practice issues facing today’s pharmacy technician. Some other achievements of the journal have given me particular pleasure. One of the most satisfying has been the journal’s continuing involvement with its members and sharing stories from the coal face of your innovative approach to new models of care.

It is with great sadness I will not be joining you at APTUK conference this year however I am looking forward to keeping updated via twitter and the summer journal, hearing about the pharmacy technicians of the year and all the other exciting news!

And an apology
One major regret is for my own slowness in processing this my final issue due to my own ill health — and I seize this opportunity to apologise to all whom I have kept waiting too long for this issue and I hope you enjoy it as much as I have, I can assure you that my young and efficient successor will do far better!

I’m enormously proud to have been allowed to edit the journal for the last fourteen years it has been an honour and a privilege: I wish the new editor as much fun and as much satisfaction in there editorship as I have had in mine.

Happy Reading

Rachael Lemon
Editor
Association of Pharmacy Technicians UK

Cover art courtesy of Pill Man UK
Dear Members

As I write this journal’s President’s column my thoughts are focusing on the changes within the profession of pharmacy; where we are along the road of change, where and what this may lead to and the many opportunities this could bring for us, pharmacy technicians, wherever we are working, either community or hospital or which UK country, England, Scotland, Wales or Northern Ireland.

Although political devolution has given rise to differences in health policy between the four countries in the UK, there are similarities in that they are all focused on safe, effective and patient-centred care and give visions for the next 5 years and beyond. They all recognise that there is a need for greater emphasis on public health and that an increasing and aging population will, and is already, bringing challenges to the overstretched NHS. Community pharmacies, as high street health specialists, have been urged to become the ‘first point of contact’ for minor ailments and many long term conditions that would traditionally have been or are dealt with by GPs or hospitals.

In December 14, Pharmacy Voice, Pharmaceutical Services Negotiating Committee (PSNC) and the Independent Pharmacy Federation (IPF) challenged policy makers and commissioners of NHS pharmacy services to champion community pharmacy. The new manifesto launched gives 5 pledges that are all based on the accessibility that patients have to their community pharmacy and how with greater access to patient records, patients can benefit from effective and safe care that could increase and improve patient outcomes.

We have all listened to media coverage about our overstretched urgent and emergency care systems and I have been representing APTUK at a number of events looking at how all the healthcare professions can work as part of a single service. To move to a ‘one system’ that is easy to use by patients and that makes the best use of all resources requires a transformation of care. Research undertaken by the Royal Pharmaceutical Society (RPS) shows that cough and colds cost the NHS £1.1 billion a year more when patients are treated at A&E or GP surgeries rather than at community pharmacies. The RPS calls for pharmacists to be incorporated into A&E departments and GP surgeries, as independent prescribers, to manage medicine related issues. APTUK suggests and emphasises that pharmacy technicians also have a role to play in supporting these services, as professionals who are an integral part of the medicine supplies chain. In addition pharmacy technicians already work within medicines information and have skills and knowledge that could, with additional training and working as part of a pharmacy team, be transferred across to help support the NHS 111 helpline where a high number of calls are medicines related.

To realise new ways of working and in supporting innovation to deliver high quality patient centred care, good systems are needed to help teams to get involved in daily improvement and learning. As you will see in this journal, also in previous journal articles and on the website, APTUK have been working alongside the RPS and PFNI, to develop an online resources hub that can help pharmacy staff build quality into any new system or way of working. I urge you to all to have a look at this website, as it’s a valuable resource for us all to use: www.pharmacyQS.com.

As a system regulator, the GPhC is obliged to promote safe and effective practice and the GPhC standards for registered pharmacists have been ‘designed to strengthen the regulation of pharmacies and improve the quality of pharmacy practise’. The GPhC emphasises that everyone who works in a pharmacy has a role to play in helping to improve the health and wellbeing of patients but also to keep them safe. Over the last 18 months the GPhC has looked at the registered pharmacy standards and has redesigned them to focus on what pharmacies and their staff are achieving for patients and people who use pharmacy services. The redesigned standards have moved away from a rules based tick box approach to a new approach to pharmacy inspections which now includes speaking to the whole pharmacy team, including pharmacy technicians.

To allow the GPhC to fully implement this outcome based approach requires a change in pharmacy legislation as the currently the law states that the pharmacy standards must be set in legislative rules. At the moment, if a pharmacy fails to meet the standards this can result in improvement notices being given, which if breached could lead to criminal proceedings or removal from the premises register. The Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board (RPB) is seeking to amend the ‘Pharmacy Order 2010, so that the standards will no longer be in the rules. Thus any failures to meet the pharmacy standards can be dealt with by the GPhC in the same way it would deal with pharmacist and pharmacy technician registrants. This approach is better for achieving goals and in the best interests of patients, by providing a more flexible approach to promoting the safe and effective practice at registered pharmacies. It will also allow the GPhC to publish inspection reports.

The other aspect of the ‘Rebalancing Medicines Legislation and Pharmacy Regulation Programme’ is to provide a defence against section 63 and 64 of the Medicines Act 1968, for registered pharmacy professionals making a single inadvertent dispensing error. Currently pharmacists and pharmacy technicians are subject to triple jeopardy if they make an error when dispensing a medicine. This means that an individual could be subject to professional regulation, medicines legislation criminal sanctions and general criminal law. Pharmacy professionals
are the only healthcare professionals that this applies to. The proposed defence will only be possible if certain conditions are met. These are that the medicine is sold or supplied by a registered pharmacist or pharmacy technician from a registered pharmacy premises; that the sale or supply is in pursuance of a prescription/directions; that the registered pharmacist/technician acting in the course of their profession; and the patient promptly notified of error, unless considered unnecessary.

Occasions when notifying the patient may not be necessary could be if the patient has reported the error to the registered pharmacy professional or the patient may be a child.

By removing the fear from criminal prosecution under the Medicines Act 1968, it is hoped that more dispensing errors will be reported and that pharmacy as a whole can learn from these to try and prevent them happening again.

As indicated one of the conditions to be met for the defence is that the medicine is dispensed from a registered premises. You may already be thinking that not all hospital pharmacies are registered and so where does that leave pharmacy technicians working in these pharmacies. This is a complex issue, as there are also other considerations, such as not all medicines are dispensed in the pharmacy; they could be dispensed on the ward or in clinics. Also what we see as prescriptions in hospital are more than likely to be in-patient charts, discharge forms or out-patient forms and the medicines are requested on a direction of a doctor rather than on a legal and valid prescription form. The RPB is working through this and is looking to formulate a workable solution that will provide hospital registered professionals with the same defence as their community colleagues.

You may already have seen, on the website, that a consultation into these proposed changes was launched on the 12th February 15 and closed on the 14th May 15. I hope you were able to engage with this important legal change and either give your opinions individually or feedback through one of your local branch events. We gave the branches information and resources to help with this, along with running two Webinar’s.

The changes I have talked through and others I have not, all come back to us as healthcare professionals putting the patient at the centre of their care. It requires us all to deliver this care within the principles and values of the NHS constitution and our own professional behaviour. Our annual professional conference this summer is all about patient centred care and how we can empower patients to get the most from pharmacy services. So please come along to share, network and see how we can embrace change to empower ourselves for the good of patients.

In the words of Mahatma Ghandi ‘You must be the change you wish to see in the world’.

Tess Fenn BA Hons MIfL MApharmT
APTUK President

Integrated Care. Out with the old in with the new...

The NHS Five Year Forward View
There is a high probability that the vast majority of qualified pharmacy technicians were trained in an environment centred around silo working where ‘qualifications (are) usually gained through work experience in just one sector,’ (Jee, et al., 2014), where healthcare professionals aren’t encouraged to liaise with each other about their patients and with care being centred around disease states not individuals (Department of Health, 2014). We know this leaves patients feeling like they are having things done to them instead of in partnership with them leading to the notion that they have little or no control over their care.

There is recognition that this scenario is not sustainable and that there must be a radical shift in the way that health and social care is delivered as recently set out in the NHS Five Year Forward View (NHS, 2014). This seminal document sets out the vision for the whole of the NHS in the next five years and has cross party political support.

There are four cross cutting themes within the Five Year Forward View:

- A radical upgrade to the way that the prevention and public health agendas are delivered
- Patients at the centre of, and with greater control over, their care
- Breaking down barriers (including those between professional groups)
- Creation of a number of New Models of Care

Fundamentally this is about the NHS moving to delivering person centred care (Foot, et al., 2014) and that is a seismic shift for us all.

It’s no secret that the NHS is facing the ongoing challenge of significant and enduring financial pressures whilst at the same time grappling with some of the following statistics (The King’s Fund and the Local Government Association, 2014):

- 2/10 adults are smokers
- 7/10 men and 6/10 women are overweight
- A third of people have potentially harmful drinking patterns
- Half of women and a third of men get insufficient exercise
- Mental illness is the most common illness amongst 15-44 year olds
The media is full of stories about the pressures that GPs and A&E Departments are under. Pharmacy professionals can and should have a role to play in reducing the burden on those other services.

**How can pharmacy technicians play a part?**

How your patients’ access medicines and medicines advice outside of your care is just as important as how they access those things when in your care making it vital to understand the whole person and the journey they undertake.

As an example if you are involved in the discharge of a patient with a stable long term condition are you aware of the services that community pharmacy can offer to support that patient? It could be that your patient would benefit from the *Repeat Dispensing Service* but do they know about it? Do you? How can you help them access it? Was it a medicines related admission? If so would they benefit from a *discharge medicines use review* once back in the care of the community pharmacy? In either a hospital or primary care setting has the patient been prescribed a new medicine? Will you refer them for a *New Medicine Service* consultation? Have you considered the mental health status of your patients with long term physical health conditions and do you recognise the term *Parity of Esteem*? If you are working in a community pharmacy and a young woman seeks access to *Emergency Hormonal Contraception* but your pharmacy isn’t commissioned to provide this service are you able to signpost her to a pharmacy or other provider that does? Is your working environment dementia friendly? Are you a *Dementia Friend*? Do your patients need help and support with stoma and continence products? Could a Dispensing Appliance Contractor help to provide that support? Are you a Stop Smoking advisor? Do your patients know that ‘smoking is a major risk factor in the development of cataracts’? (Action on Smoking and Health (ASH), 2014) Have you recommended they visit an optometrist? Are you aware that a particular service could be commissioned by NHS England, a clinical commissioning group or a local authority? If you and/or your colleagues have ideas for a new service would you know which one of those commissioners to approach?

In essence these questions seek to answer whether your knowledge of the services provided by pharmacy and other healthcare providers in the area where you live and practise match the needs of the patients you serve? With that knowledge you are more likely to be delivering the holistic care that the *Five Year Forward View* sets out to achieve.

**New Models of Care**

Briefly turning to the New Models of Care; there are many opportunities for pharmacy ranging from making more appropriate use of community pharmacy particularly in supporting the urgent and emergency care network (e.g. minor ailment services) (Loader, 2014). to pharmacists working with GP practices. There are likely to be many more that emerge along the way but the key to the success of them all will be their ability to provide integrated care. The *Five Year Forward View* is quite clear that ‘the result would be a far better future for the NHS, its patients, its staff and those who support them.’ (NHS, 2014)

**References**


**Alison Hemsworth**

National Programme Lead, Pharmacy Projects and Contracts, NHS England
A Day in the Life of a Pharmacy Technician Working with the District Nursing Service

The role of the pharmacy technician is one which has evolved significantly over recent years. As pharmacy technicians, we play an integral role in our own right. We play a vital role in ensuring medication safety, and optimising the use of medication in patient care. As our career path expands, it offers non-traditional roles for pharmacy technicians to be able to impact upon patient care.

I have a role I think is very unique. I work for Whittington Health NHS Trust, as a Senior Pharmacy Technician in the District Nursing Service. Whittington Health is an integrated care organisation providing both hospital and community services. The trust brings high quality services closer to home and speeds up communication between community and hospital services, improving our patients’ experience, particularly for those who need different levels of care. The District Nursing Service provides 24-hour expert care to housebound adults over the ages of 16 in the London Boroughs of Haringey and Islington.

We carry out a variety of tasks as part of a multi-disciplinary team made up of nurses, healthcare assistants, assistant practitioners, phlebotomists and administrators.

I start on duty at 8.30am. We receive our allocation of patients to visit the afternoon before, via email. We receive this onto our iPads, and then we are able to start at 08:30am directly at a patient’s home, which enables us to have more time to provide patient care.

I make contact with the team’s co-ordinator for the day. As part of the “lone working policy” we keep in telephone contact throughout the day. The co-ordinator is the first point of contact and is able to provide support or advice when needed.

Today my first patient is to Rose, a lady who has recently been started on insulin for Type 2 Diabetes. I read through the progress notes, and check the care plan to ensure I am fully aware of the care to be provided. I check her blood sugar level using a glucometer, and then inject the prescribed dose of insulin subcutaneously into her lower abdomen. I document my care within the District Nursing notes which are kept in the home. I also identify that Rose only has a one week supply of insulin and needles left and I am able to order more using my trust issued iPad. This holds all the forms we require to be able to correspond with other healthcare professionals. I complete the documentation, and send it via email.

My next visit is to John who has been prescribed Dalteparin (fragmin®) twice daily. It is therefore essential that we visit as early as possible, as this will impact on the time our twilight service can visit to give the evening dose. John was recently discharged from hospital following diagnosis of deep vein thrombosis (DVT).

I then visit Michael, who has been discharged from hospital following cataract removal surgery. He has come onto the caseload for a nearby team, and I have been asked to visit Michael to assess whether he can self-administer his eye drops. He has been prescribed a four week course of four times daily eye drops (Dexamethasone and Chloramphenicol). Michael explains his other long term conditions including COPD, and how he manages his oral medications, inhalers and nebulisers. Michael has poor dexterity and struggles to administer the eye drops. We then try using an auto-dropper device, but Michael doesn’t have the strength to grip this. I therefore make the decision that Michael is unable to self-administer and will require a visit four times daily. I feed this back to the team verbally over the phone, and also document everything in an email to the team’s co-ordinator and team manager, and then once I get back to the office I can copy the contents of the email onto Rio, which is our electronic patient records system.

I complete the rest of my scheduled visits for the morning, and then return to the office for lunch, and to complete the outcomes of my visits on our electronic patient records system. We then have our clinical handover after lunch, before proceeding to see our afternoon patients.

In a normal day, we will visit around 14 patients, but this is dependent upon the care required. A basic visit would be 15 minutes, but some care or assessments may take around 1hr.

As a Pharmacy Technician within the District Nursing Team, my main tasks are:

- Administering medication – including oral, subcutaneous and intramuscular injections, as well as administering intravenous antibiotics via PICC lines.
- Performing medication use reviews to ensure patients are able to manage independently and check what interventions we can put in place to aid independence.
- Health promotion activities – we try to encourage patients to live healthier lifestyles, such as stopping smoking, reducing alcohol intake and eating healthily.
- Competency assessing of healthcare assistants and pharmacy technicians to ensure they meet the necessary competencies to administer medication independently.
- Providing medication advice to our colleagues in the team with queries, or re-directing queries to appropriate people (GPs, community pharmacy, Whittington Health Medicines Information)

Names have been changed to protect anonymity.

Kieran Casey-McEvoy
Senior Pharmacy Technician, District Nursing Services
Whittington Health NHS Trust
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Mr Dispenser

Five words to ruin a Pharmacy Interview

@Smartie_Counter: Sorry, I can’t read that
@skyrmish: Hey! Isn’t that MY PEN!?
@HLPAmanda: What is your wifi password?
@rosshferguson: I’m really passionate about homeopathy
@KidDoseapp: Yes, but I didn’t inhale.
@pillmanuk: GPs should do all dispensing
@MrDispenser: Medicines Optimisation, is that real?
@QaneetaHaseeb: Do we get smoking breaks?
@paddy_arkwright: Ever tried a methadone McFlurry?
@QaneetaHaseeb: I’m not a people person
@EPSPharmacist: I don’t do IT
@QaneetaHaseeb: What is your wifi password?
@pillmanuk: I’m really passionate about homeopathy
@MrDispenser: Medicines Optimisation, is that real?
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@paddy_arkwright: Ever tried a methadone McFlurry?
@QaneetaHaseeb: I’m not a people person
@EPSPharmacist: I don’t do IT
@QaneetaHaseeb: What is your wifi password?

Why did the pharmacy technician cross the road?

Lou Baxter: To go and borrow a pack of tablets from the pharmacy on the other side!
Denise Wain: To buy a lottery ticket in the hope of winning and never having to come back
Spammy Spammerson: To get a dentist to stamp his prescription.
Lindsay Anne Wright: Because they forgot to give a patient an owing slip for 2 paracetamol tablets
Shalini Patel: To run after a customer who stole their pen!!!
Nicky Pettersen: Because that’s where the chocolate is sold
Sue Jewell: To avoid someone asking them if their prescription is ready on their day off
Abie Wilson: To avoid talking to the old woman who, no matter where you are, expects you to know if her script is ready...
@pharm112: To run away from head offices targets
@JemimaMcC: To drag Mrs Smith back in, for an MUR
@4773: To unload the Alliance van because it is quicker to do it yourself
@4773: To avoid the GPhC inspector
@Cleverestcookie: Home delivery
@Sunil_Kochhar: To fertilise the chicken’s egg to make this year’s flu vaccinations!
@BecciTeece: To borrow stock from another pharmacy!
@jaydoublu: To take another prescription back to the Dr’s surgery as it hadn’t been signed!
Information to help pharmacies make the most of the

Electronic Prescription Service

With 97% of pharmacies and most dispensing appliance contractors now using the Electronic Prescription Service (EPS) across England, here are some top tips from the Health and Social Care Information Centre (HSCIC) about the new, improved version of the prescription tracker, electronic repeat dispensing and nomination.

New, improved Prescription Tracker

Following the upgrade to Spine 2, an improved prescription tracker has been introduced allowing you to trace the status and history of electronic prescriptions.

What’s new?

- Search by NHS number, date range or prescription ID.
- Obtain contact details of the prescribing/dispensing site.

www.hscic.gov.uk/eps/tracker

- Practice and pharmacy can check the current status of a particular prescription and can advise patients with confidence.
- The tracker helps to resolve disputes between pharmacies as it shows which pharmacy has downloaded the prescription.

For more information on EPS visit: www.hscic.gov.uk/eps  @EPSnhs
Quick Guide to Electronic Repeat Dispensing

Release 2 of the Electronic Prescription Service provides electronic support for repeat dispensing.

- A prescriber will authorise a prescription with a number of issues; each issue contains the same items. The **Spine will then manage the release of each individual prescription issue**. The first issue will be available immediately and subsequent issues will be created on the Spine ready to be pulled down once the previous issue is marked as dispensed or not dispensed.

- Once all authorised issues of the prescription have been dispensed, or if the prescription has expired, patients should be advised to contact their GP for another repeatable prescription.

- The Spine will automatically send the nominated dispensing site a repeat dispensing prescription seven days before the expected due date, based on the date the previous issue was dispensed.

- A pharmacy can pull down issues in advance of them being sent automatically from the Spine, for example when a patient is going on holiday.

- Patients can choose to change their nominated pharmacy during the repeat dispensing regime. In this case, all outstanding issues will be transferred to the newly nominated pharmacy.

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Nomination Tips

To use EPS, patients must nominate or choose the pharmacy or dispensing appliance contractor they want to dispense their electronic prescription. It’s important to remember that patients must be fully informed about EPS before their nomination can be set on the system, so all staff need to be able to explain EPS to patients.

Here are some key points to follow about nomination:
- Nomination is suitable for most patients, but particularly those on regular repeats.
- Patients must opt-in.
- You can collect and set nominations in advance of a GP practice going live.
- Once a nomination is set on the Spine, it doesn’t need to be reconfirmed.
- Nominations do not expire. They can be changed or removed, but only at the patients request.
- Nomination doesn’t have to be in writing; you just need to have an auditable process in place.
- Nominations should be entered onto your pharmacy system on a regular basis.
- All staff need to know about EPS and be able to explain it to patients.
- Speak to all of your current prescription collection service patients about nomination.
- Let your customers know that EPS is available at your pharmacy by displaying patient information leaflets, posters, EPS window stickers and attaching information to prescription bags.

For the full nomination guidance, including principles of nomination and complaints, visit www.hscic.gov.uk/epsp Pharm

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Sign up to the EPS Bulletin for the latest news  www.hscic.gov.uk/epssignup
How can you encourage medicines optimisation for patients with rheumatoid arthritis?

In this article, Geraldine Flavell complements the material in the medicines optimisation briefing on rheumatoid arthritis (RA).

These briefings have been developed for pharmacists and pharmacy teams working in England and Wales.

Medicines optimisation is all about supporting patients so that they get the best possible outcomes from their medicines. It means using effective consultation skills (see: www.consultationskillsforpharmacy.com) in talking and engaging with individuals to understand their beliefs and concerns about their medicines and what they would like their medicine to achieve. It also involves ensuring that the medicine chosen for the patient is clinically appropriate, safe, effective and will help them to achieve their goals. It is about supporting the patient to continue to use their medicines in a way that fits with their lifestyle.

The medicines optimisation briefings we have produced are for pharmacy professionals working in all sectors of healthcare. We believe that, as experts in medicines and their use, pharmacy professionals are well placed to support patients to get the best outcomes from their medicines.

Medicines for rheumatoid arthritis

The briefing distributed with this week’s issue of The Pharmaceutical Journal focuses on medicines that are used for rheumatoid arthritis. This is the first in a series of briefings that complement and build on each other. The content is not intended to be exhaustive; the aim is to improve your approach to and understanding of patients who have rheumatoid arthritis.

Rheumatoid arthritis (RA) is a long-term, auto-immune condition for which there is no cure, but which can be managed by medicines and lifestyle changes. RA is a systemic disease affecting not just joints, but also other body systems including the eyes and lungs. Dry eye is commonly experienced and can be treated symptomatically. Rheumatologists often order chest X-rays at diagnosis of RA for a baseline and before prescribing biological medicines (often referred to as anti-TNF medicines), to rule out tuberculosis.

Patients with RA may have other conditions, such as depression, cardiovascular disease, diabetes or osteoporosis, and be taking other medicines so pharmacy professionals need to watch out for and question the patient about any possible interactions.

Pharmacy professionals should ensure that they and their RA patients keep a complete patient medication record (PMR), that includes all over-the-counter, hospital only and homecare service medicines, to help advise on drug interactions and side effects.

Pharmacy professionals can be involved in helping a young person make the transition from supported child to independent adult with RA, by discussing medication and management of their RA.

Patients should be encouraged to manage their RA by recognising symptoms which may indicate the onset of a flare-up and by optimising their own pain relief. They need to take their medicines even when they are in remission and even on good days they need to pace themselves and not overdo things. They should attend their monitoring appointments, know their disease activity score, or DAS28 (see box) and learn to recognise when they need to seek advice. Disease modifying anti-rheumatic drugs (DMARDs) and biological medicines can make their lives much better, so patients should be reassured so as not to be anxious about taking any of these medicines. They should not seek to diminish the impact of their disease on their lives or underplay their pain or stiffness as this will minimise DAS28 which can affect decisions about therapies, dosage and medicine use.

Patients may be worried about having to take medicines for the rest of their life, but reassure them that with the appropriate RA medicines, they can live a much better life than without and the risk of irreversible joint damage is significantly reduced.

Their annual review is not just to monitor their joints – RA is a systemic disease and the doctor or specialist nurse needs to check that their eyes, lungs and cardiovascular health are not compromised by the disease.

Disease Activity Score in 28 Joints (DAS28)

DAS28 measures:
- pain and swelling in 28 joints
- a 1-10 scale patient assessment of pain and disease activity
- how many minutes of joint stiffness in the morning
- erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) blood test results.

These are all computed to reach a DAS28 score: greater than 5.1 signifies active to severe disease, less than 3.2 indicates moderate to low disease activity, 2.6 or less is considered clinical remission.

Things to think about when talking with patients about their medicines for rheumatoid arthritis

There are many things to think about when talking to patients about medicines for rheumatoid arthritis. Pharmacy professionals should check and add to what the prescriber has said:
• Is a new medicine instead of, or more likely in addition to, their existing medicines? For example, methotrexate enhances the effects of biological medicines and protects against auto-antibodies which render them ineffective. Two or more DMARDs are usually better than one.

• Folic acid should be prescribed with oral methotrexate.

• Are they taking any other medicines from the hospital, prescribed by the GP, borrowed from a relative or friend or bought over-the-counter?

• When should they expect a new drug to start working (by six months for a biological medicine), how will they know it is working and who will they contact if they think it is not working?

• If the patient notices that symptoms are getting worse, they may be having a flare-up of the disease. Sometimes flares resolve themselves within a couple of weeks, during this time they should be advised to rest as much as possible, get enough sleep and manage their pain relief adequately. If the flare does not resolve in two weeks, they should contact the rheumatology team for advice. A systemic steroid depot injection or directly into a specific joint may be appropriate.

• Patients should not stop their medicines just because they feel better. They need to continue taking them and manage their pain relief adequately.

• Help patients access their medicines by using easy-open caps, popping blister packs for them or supplying or signposting them to aids to meet their needs.

• Pharmacy professionals should make sure they have supplies of up-to-date steroid cards and methotrexate dosing booklets. If the patient is on a biological therapy they should always carry a biological therapy alert card.

• Make sure the patient knows when their medicines will be reviewed and by whom – add contact details names of specialist nurse, GP or consultant to their PMR.

Tips

Tips for pharmacy professionals to support patients with rheumatoid arthritis include:

Starting medication

• Agree with patients on a shared agenda – if they want to feel better, they have a responsibility to take the medicines that have been prescribed and adhere to the other therapies recommended eg, exercise or dietary management.

• Methotrexate is the gold standard treatment for RA and, if tolerated, they are likely to be taking it for the rest of their life, whatever else the rheumatologist or GP may also prescribe. You should remind them that the dose is weekly and add the day of dosing to the label. A simple reminder might be methotrexate Monday and folic acid Friday. Can they tell the difference between them?

• Patients sometimes worry that DMARDs and biological medicines are toxic. Point out that they are toxic to the RA not to the patient, providing they take sensible precautions; these medicines have the potential to make their lives much better, but they do have to be taken or used as prescribed to have an effect. These medicines are monitored carefully and action taken if blood results show any abnormalities or cause for concern.

• Patients should have been supported to learn how to self-inject their drugs if this is how they are administered (eg, methotrexate and some biological medicines are in syringes or auto-injector pens) – check that they feel confident and encourage them to contact their supplier or rheumatology nurse/helpline if not. Check that they have a sharps bin and they know how to dispose of it.

• If taking paracetamol (alone or in combination), take 4 g per day, not less.

• Both men and women taking DMARDs need to use effective contraception and to discuss if they wish to start a family with their specialist nurse and/or consultant as some DMARDs may require a ‘wash out’ period before a child is conceived/fathered.

• Encourage patients to keep an eye on their own disease between monitoring appointments. Help them to recognise what their body is telling them – is the RA better or worse today? Keeping a pain/fatigue diary can help.

• Do patients need a home visit to check what help they need to open and take their medicines?

• Encourage pneumonia and annual flu vaccinations.

• Signpost to, and learn from, local patient groups such as those organised by NRS or Arthritis Care.

• If a patient is commencing biological therapy for their RA ensure they have a biological therapy alert card.

Side-effects and talking to people about them

• As usual, carry out private consultations in your consultation area.

• Let patients know what side effects may occur, how long they are expected to last for and what they can do to minimise their effects.

• Ensure that proton pump inhibitors (PPIs) are prescribed for patients taking NSAIDs.

• Warn patients that sulfasalazine turns urine and tears orange.

• If the patient is taking complementary therapies see: www.arthritisresearchuk.org/arthritis-information/complementary-and-alternative-medicines/complementary-therapies.aspx

• Patients should STOP methotrexate and biological medicines if they have a sore throat, a cold or any other signs of infection and RESTART when they feel better.

• They should STOP methotrexate, other DMARDs and biological medicines if they get the red flag signs: shortness of breath, unexplained bruising, blurred vision or uncontrolled diarrhoea and vomiting and consult their GP, consultant or specialist nurse immediately.

• Advise patients to let you know if side-effects last longer or are worse than they expected.

Lifestyle

• Talk to patients about whether their medicines fit in with their daily routine. If not, encourage patients to talk to you about this and the possible alternatives rather than stopping their medicines eg, if taking a medicine makes them feel sick or fatigued perhaps taking before retiring to bed may be a better approach.

• Ask patients if they smoke; stopping smoking is the most effective change a patient with rheumatoid arthritis can make to significantly improve their health as well as the
effectiveness of their medications. Offer patients smoking cessation advice when they are ready for it and signpost them to support groups. Have ‘quit kits’ ready for when they are needed.

- Advise patients to drink very little alcohol (less than recommended levels) when taking methotrexate.
- Advise weight control aiming for a BMI of 25 or less.
- Exercise and keeping joints mobile is key. Even gentle exercise makes a difference. Swimming, yoga, pilates and tai chi are all recommended for RA.
- Patients can still enjoy sex: www.nras.org.uk/publications/emotions-relationships-and-sexuality
- If patients plan to travel, give guidance on travel medicine and vaccines and advise on medicines carrying and storage (see separate box) – will they have access to a fridge?
- In their hand luggage they should carry medicines in a cool box with a letter from their rheumatologist explaining why.
- Injections can be delayed by one day per week to allow for situations such as camping trips where there is no fridge, but see below as times left out of the fridge can vary.
- Encourage patients to consult you before buying or trying complementary therapies, as ‘natural’ or herbal supplements may interact with prescribed medicines as well as have their own side-effects.
- Find out about local initiatives and projects for patients with rheumatoid arthritis, such as swimming or exercise programmes. Do you know how patients can access these and who is eligible?

**Storage of biological medicines**

Five biological (anti-TNF) RA medicines may be self-administered subcutaneously. They should be stored in a refrigerator at 2-8°C.

**Etanercept (Enbrel)** may be stored at temperatures up to a maximum of 25°C for a single period of up to four weeks, after which it should not be refrigerated again. Any remainder should be discarded if not used within four weeks of removal from refrigeration.

A single **adalimumab (Humira)** pre-filled syringe/pen may be stored at temperatures up to a maximum of 25°C for a period of up to 14 days. The syringe/pen must be protected from light, and discarded if not used within the 14-day period.

In exceptional circumstances, if **certolizumab (Cimzia)** injection has been left out of the fridge and been stored at a temperature not exceeding 25°C (+/- 2°C), the injection may only be used for up to 24 hours after leaving the fridge.

**Golimumab (Simponi)** may be left out of the fridge (at temperatures of 10-20°C) without detriment for up to one week. This reduces to no more than one day for temperatures of 20-25°C.

**Abatacept (Orencia)** is stable for up to eight hours if left out of the fridge provided that it has been kept in normal light and at a temperature not exceeding 25°C.

For further information, refer to the UKMI Fridge Database: www.ukmi.nhs.uk/applications/fridge/ (password required).
Lifestyle messages
- Stop smoking – it reduces the effectiveness of your medicines
- Try swimming, tai chi, pilates or other gentle exercise to keep your joints moving, but don’t overdo it, even on good days!
- Rest and practice relaxation when possible
- Stay well below safe drinking levels of alcohol
- Manage your weight to a BMI of 25 or less
- Be wary of “natural or herbal” supplements as some will have interaction with prescribed medicines and can be harmful.

ALWAYS ensure you speak with your pharmacist before trying “complementary or alternative” therapies.

Where’s the evidence?
- NICE quality standard 33
- Technology appraisals 130, 143, 195 and 280
- NICE RA pathway www.nice.org.uk/Guidance/Conditions-and-diseases/Musculoskeletal-conditions/Arthritis

Signposting patients
- National Rheumatoid Arthritis Society (NRAS) www.nrass.org.uk
- Health Unlocked Online Community www.healthunlocked.com/nras
- Arthritis Research UK (ARUK) www.arthritisresearchuk.org
- Arthritis Care www.arthritis-care.org.uk
- Self Care Auxiliary Aids www.medicinesresources.nhs.uk/upload/documents/Communities/SPS_E_SE_England/Self Care Auxiliary Aids-ESDW.pdf
- NHS Choices www.nhs.uk
- Health talk online www.healthtalk.org/peoples-experiences/bones-joints/rheumatoid-arthritis
- Patient information leaflets www.medicines.org.uk
- Side effects can and should be reported by both patients and pharmacists using the yellow card system www.yellowcard.mhra.gov.uk

Where can I learn more about this?
CPPE learning programmes www.cppe.ac.uk
Consultation skills for pharmacy website www.consultationskillsforpharmacy.com
NRAS resources for professionals www.nrass.org.uk/for-professionals

www.cppe.ac.uk
Medicines Optimisation Briefer

This medicines optimisation briefing focuses on patients with rheumatoid arthritis (RA) and is designed for pharmacy professionals in any sector to use in their practice.

Patient experience

I am worried about having to take toxic medicines for the rest of my life. I don’t like having injections, let alone injecting myself, and the thought of biologicals scares me. Also I want to be brave about pain, so I may tell nurses, doctors and you that I feel better than I do. When my disease is in remission, it feels like I am cured, so I don’t always take my medicines. I want to be helped to live as normal a life as possible. I want to be able to go out and to travel. When I get a flare, I want to be able to manage it myself.

Evidence – is the medicine appropriate?

RA is a fluctuating condition which can be effectively managed. Early combination treatment works to reduce the symptoms and joint damage caused by RA. Methotrexate is a very effective medicine and the gold standard for RA. Other medicines are added and methotrexate can boost their efficacy. In addition, methotrexate may protect the heart. Smoking can reduce the effectiveness of DMARDs and biologics. Any exercise such as swimming, tai chi and pilates helps RA patients keep mobile.

Steps you can take:

- Remind me that although there is no cure for RA, it is manageable providing that I pace myself and keep taking the medicines that I’ve agreed to take
- Reassure me that the medicines are toxic to RA, not to me, and that disease-modifying anti-rheumatic drugs (DMARDs) and biological medicines are both safe and effective, with years of evidence to support this
- Advise me on getting the best pain relief when I get a flare
- Help me with opening medicine packs, aids to daily living and travel.

Steps you can take:

- Remind the patient that it can take up to three months for effects of medicines to be felt and some may take up to six months
- Emphasise adherence to medication; investigate reasons for non-adherence and refer if necessary
- Advise patients to stop DMARDs and biologicals during some infections and restart them when they have recovered
- Provide help to stop smoking.
The principles of medicines optimisation describe how healthcare professionals can help patients to improve their quality of life and outcomes from medicines use by having a focused emphasis on the need to optimise patients’ medicines.

Read more at harms.com/medicines-safety/medicines-optimisation.asp

Rheumatoid Arthritis

Medicines optimisation as part of routine practice

Getting to know your RA patients can be very rewarding for you and them. Become familiar with their lives, their RA and their needs. They will come to you for advice once they know that you are interested and well-informed. Practise your consultation skills so that you develop a shared agenda. Talk to them about what they hope to achieve with their medicines and help them to reach these goals.

Steps you can take:

- Make sure you understand the whole picture – what’s happening at home, who is there to help, what else do they need?
- Help patients understand why they are taking these medicines and what they can expect
- Check that patients are still getting the desired effect from their medicines
- Signpost to patient groups and to their websites for help with all aspects of their condition
- Encourage and offer support to stop smoking if they smoke.

You can take:

- Make sure you have access to the patient’s core medication record, including OTC purchases and hospital-initiated medicines, and encourage them to keep a record of their medicines
- Encourage patients to keep a record of their medicines
- Encourage patients to keep a record of their medicines
- Encourage patients to keep a record of their medicines
- Encourage patients to keep a record of their medicines
- Encourage patients to keep a record of their medicines
Case studies

Dot is taking methotrexate tablets and etanercept 50mg injection, both weekly.

She found it difficult to get to the hospital so had not had her regular blood tests. She comes into the pharmacy with a flare-up of her rheumatoid arthritis and asks your advice on pain relief. On questioning her, you discover that because her GP has not received blood test results, the surgery will not issue her with a methotrexate prescription so she has had no methotrexate for four weeks, just the etanercept injection. You discuss this with Dot and point out that methotrexate is not only the cornerstone of her treatment for her RA, it also enhances the effects of etanercept. She promises not to miss her blood tests in future so that she can continue to receive both medicines.

You notice Chiu-Lee at the medicines counter with a herbal medicine pack in her hand.

You intervene and ask her what she is buying as you know that she takes methotrexate and another DMARD for her RA. She tells you that she wants echinacea in order to boost her immune system to ward off colds. You remind her that the purpose of the RA medicines is to damp down her immune system to stop it attacking her joints so there is no point in boosting it up again with echinacea.

Julie is taking methotrexate weekly and two other DMARDs. She reports that she feels so nauseous on the days that she takes methotrexate that she now suffers from nausea the day before, in anticipation.

On your request, her GP agrees to prescribe prochlorperazine 5mg tds prn. This helps to reduce her anticipatory nausea, but a month later she is still suffering from nausea after taking methotrexate. The rheumatology team then agrees to try methotrexate injection, which suits her much better.

You can make a difference by supporting your patients – don’t assume someone else has already done your job for you.

John comes into the pharmacy to ask for an emergency supply of methotrexate because the GP has not provided the prescription he ordered, as his blood tests had not come through from the hospital.

You find that instead of taking his prescribed dose of eight tablets weekly, he has been eking out his supply by reducing his dose to 3, 3, 2 tablets in the previous three weeks. He has now run out and his joints are becoming more painful and stiff. You remind him of the importance of taking his prescribed dose regularly and phone both the hospital and GP on Monday to tell them what has happened and encourage better communication. John is grateful for your intervention but confesses that he finds prescription charges really mount up and he sometimes tries to make his methotrexate prescriptions last longer for that reason as well. This gives you a chance to encourage him to buy a prescription prepayment certificate, to ensure that he never again misses his medicines for reasons of prescription charges.

www.rpharms.com
Success Skills

So far we have covered self discipline, self organisation, assertiveness, and rapport building. Now we come to influencing:

Influencing

Unavoidably success will sometimes mean persuading people to do things for you. Being liked is clearly the first step towards that, (see above), but you may need to go beyond that and be really persuasive. Because of how our brains are wired (survival, pack animals, fear of dominant pack leaders, etc) there are certain things that work with persuading other people.

First, have a clear objective of what you want. Telling someone that you’re not happy with an existing situation isn’t much help – much better to have a suggestion for what will make things better. And ideally you would make it easy for them – “I’ve investigated suppliers, this is the best one, I’ve filled in the purchasing form, all you need to do is sign in and the problem is solved”.

Next is to realise that different people respond to different approaches. Some people want lots of detail, while others (including me!) lose the will to live within thirty seconds of too much detail. It’s not hard to tell what type they are – just listen to how they talk. Then there are those who are interested in facts and numbers, and others who are more interested in people and feelings; a feelings-based argument won’t work on a facts person!

Listening is key to influencing – how does the other person think, what motivates them, what are their objections to your plan: all these require questioning and listen to find them out. And while you are finding these out you can subtly overcome their objections by asking things like “If there was a better way to do it, would you be prepared to look at it?” and “How do you know that there isn’t another, even better, way?”

A good influencing tactic, particularly with quick decision makers, is to give them a choice of two solutions – for example, there’s been a problem so would you rather have the job a bit late, or pay a bit extra to get it brought back onto schedule? This is much better than just “The job is late” because it gives them some control, and while they are choosing which option they aren’t thinking about saying No to the whole thing.

Generally people-based and more cautious thinkers are influenced by whether other people are doing what you are asking, so if you can give evidence of others who are finding it successful then that is going to be persuasive.

Quick decision-making risk takers are influenced by scarcity, amongst other things. If something is likely to run out they will quickly snap it up – this might be an appointment to see you, or a service that you or someone else is offering. Demonstrate scarcity if you can.

If they have an objection to your request, for example ‘Not enough time’, then first you should peel the onion (“Apart from the time problem, do you think it’s a good idea?”) to establish the real objection, and then, if you don’t have an immediate idea on how to handle the objection, you can use Feel-Felt-Found: “I know how you feel, I felt the same way to start with, but when I tried it / looked into it more, what I found was....”

Sometimes, in order to get a successful resolution, it might be necessary to negotiate; to give a little in exchange for what you want. Certainly it’s a good idea to negotiate instead of reluctantly agreeing to something you don’t want to do, or instead of just saying No. After all, there might be a way they can make it acceptable to you, which would be a win-win, so at least explore for that.

My top three rules when negotiating in an influencing situation would be: get them to open first – it might be good news; ask for the most you could hope for – you never know, you might get it and even if you don’t you’ll get more than you would have got; and trade rather than concede – otherwise your opening position will look dishonest, and of course you are getting something back in each trade, so the losses are smaller and in fact you might even gain more than you lose.

Chris Croft

Chris Croft has an Engineering Degree from Cambridge and an MBA, worked as a senior manager in manufacturing for 10 years and then as a university lecturer for five years before starting his own training company in 1995. Since then he has trained over 40,000 people, and his free email tips are sent to 10,000 people (www.free-management-tips.co.uk). Chris runs training courses in Project Management, Time Management and similar subjects almost every day, and has also produced a range of books (see www.chriscrofttraining.co.uk and www.lulu.com), including “Time Management”. Chris runs successful Certificate in Management (CMS) and Diploma in Management Studies (DMS) courses validated by Edexcel for clients including the NHS South West and others in the public sector.
Professional Development Award Assessment and Supply of Individual Patients’ Medicines

Is it making a difference to the practice of our Scottish pharmacy technicians? – A pilot study

Introduction
The Professional Development Award (PDA) in Assessment and Supply of Individual Patients’ Medicines was accredited by the Scottish Qualifications Authority (SQA) in 2011. The PDA was designed to provide Continuing Professional Development (CPD) and career progression for pharmacy technicians who are employed in a patient focused role, supporting the provision of pharmaceutical care to individuals in a variety of healthcare settings such as acute, community and primary care.

NHS Education for Scotland (NES) provided funding for pharmacy technicians (1st cohort) to undertake the PDA for the 2012-2013 academic session with a Scottish College.

The PDA consists of:
• The existing SQA Higher National (HN) Unit: Procedures for Pharmacy Dispensary Checking Technicians (PDCT)
• 3 Scottish Vocational Qualification (SVQ) units
• Pharm 29 – Take a medication history from an individual
• Pharm 30 – Prepare to conduct a review of an individuals’ medicines
• Pharm 31 – Determine the suitability of an individuals’ own medicines for use.

Thirty-six pharmacy technicians enrolled with a Scottish College for the PDA. Of these, 30 completed the course, 4 withdrew and 2 did not submit the required material to qualify for the award.

Aim
To measure the perceived ‘change of practice’ of pharmacy technicians as a result of completing the PDA in Assessment and Supply of Individual Patients’ Medicines.

Objectives
1. Identify if the PDA induction day met the needs of participants.
2. Identify the challenges and facilitators associated with the qualification.
3. Determine any perceived changes in practice from pharmacy technicians who completed the PDA.
4. Identify why some pharmacy technicians did not complete the qualification.

Methodology
A semi-structured telephone interview schedule was developed, piloted and applied to measure pre and post change using a 5 point Likert scale. A Wilcoxon Matched Pairs Test was used to compare confidence scores. Using qualitative data analysis, codes were identified and then themed; Constant Comparative Method. Findings were analysed in order to measure any perceived change of practice attributable to the PDA.

To identify the views and opinions of this first cohort, telephone interviews were carried out with as many participants as possible. Four pilot interviews were carried out initially to assess the validity of the interview schedule, minor changes were identified and made, and subsequently interviews took place with 23 people who had completed the course, 3 who had withdrawn and 1 who did not submit.

Results and discussion
Results identified a statistically significant difference in perceived learners’ confidence in taking medication histories from an individual (p<0.01), preparing to review individuals’ medicines (p<0.01), and determining the suitability of individuals’ medicines (p<0.01) pre and post PDA.

Demographics of the study group
Of the 27 pharmacy technicians interviewed, 25 were female and 2 male of which the majority were in the age range 34 – 42 (10) and 43 – 51 (10).

1. Identify if the PDA induction day met the needs of participants

How helpful was the induction day?

<table>
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<th>Response</th>
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</thead>
<tbody>
<tr>
<td>not helpful</td>
<td>0</td>
</tr>
<tr>
<td>unhelpful</td>
<td>0</td>
</tr>
<tr>
<td>neither helpful nor unhelpful</td>
<td>4</td>
</tr>
<tr>
<td>helpful</td>
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<tr>
<td>very helpful</td>
<td>5</td>
</tr>
<tr>
<td>did not attend</td>
<td>2</td>
</tr>
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</table>

The majority of interviewees made positive comments about the induction day. These included that the induction day was well organised, presented an appropriate amount of information, was informative and well explained, and related well to the work of the course. Ten people expressed some reservations about the day; negative comments included suggestions that too much information was crammed into the time available; that as the course is new the presenters were unsure of the details; that some questions were not answered; that not enough detail was given of the course.
requirements, such as the self-reflection report; that the repetition in the units should have been explained. Some interviewees mentioned that medication history taking should have been explained by a pharmacist or junior doctor.

2. Identify the challenges and facilitators associated with the qualification
2.1 Challenges
In terms of challenges of the PDA qualification, time management was the biggest problem identified. 8 people mentioned that staff shortages made it hard for them to find sufficient time in the workplace to complete the PDA, while 6 said that their own work commitments had got in the way. One interviewee said that their line manager did not appreciate what the PDA entailed and so had not allocated extra time for the work, while another felt that it would be valuable if the line manager and the ward pharmacist were informed in advance about the demands of the PDA.

On the positive side, 10 interviewees reported that they had received valuable support with the PDA qualification from their line manager while 7 mentioned having support from their co-workers. Five people said that pharmacists and nurses had been helpful.

What did you enjoy least about the PDA course?
Once again several interviewees gave more than one response. The most common response, provided by 9 people, was that they were confused by repetition of performance criteria over the three units. Paperwork was the least enjoyable aspect for 8 people and understanding the specifics of the units was mentioned by 5. Three interviewees suggested finding time for coursework and 2 mentioned lack of support. Four people did not reply to this question.

What, if anything, would you change about the PDA course?
Seven interviewees said that they would change nothing about the PDA course. Six people answered that they would prefer the repetition of performance criteria over the units to be amended. The induction day was mentioned by 6 people, who either felt that the amount of information provided at the event would have justified extending it to a further half day or even two days, or else suggested that a second local induction day would be beneficial. Two pharmacy technicians thought that the induction day should include details of the course paperwork.

Other comments were that if several pharmacy technicians in one workplace are undertaking the course at one time it can put an unacceptable strain on staffing arrangements, and also that paperwork on the course should be reduced.

2.1 Facilitators
What did you enjoy most about the PDA course?
Several of those interviewed gave more than one response to this question. Fourteen said that they enjoyed having more variety, more involvement at ward level and more engagement with individuals, for example taking medication histories and assessing individuals’ own medicines. Five people reported that they value having a certificate as accreditation of their skill set, while 4 said that the most enjoyable aspect had been learning new skills. Another 4 interviewees said that they had most enjoyed the induction day and the opportunity to network with other pharmacy technicians.

Would you recommend the PDA to your colleagues in the future?
Eighteen people said that they would recommend the PDA to colleagues. Additional remarks included comments that the qualification will benefit the workplace, increase job satisfaction, allow participants and the staff they work with to develop a better knowledge base, and is a great opportunity for role development and a good training tool. Many interviewees thought that the award would be a good stepping stone for pharmacy technicians who are new to ward duties.

Four pharmacy technicians gave a qualified answer, saying that they would only recommend the PDA in particular circumstances. These involved the course only being suitable for pharmacy technicians who are new to ward work or who have one-to-one patient contact. Others said that they would only recommend the course if the qualification becomes widely recognised and acknowledged by hospitals and other institutions. One person did not reply to this question.

3. Determine any perceived changes in practice from pharmacy technicians who completed the PDA
Interviewees were asked to rate, on a scale of 1-5, how confident did you feel about taking a medication history from an individual prior to starting the PDA and after completing the qualification?

<table>
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<tr>
<th>Response</th>
<th>Before PDA (n=23)</th>
<th>After PDA (n=23)</th>
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</thead>
<tbody>
<tr>
<td>Mean score</td>
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<td>4.7</td>
</tr>
<tr>
<td>Median Score</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

The mean score before the PDA course was 3.2 and after the course 4.7. The median score before the course was 3 and after the course 5. A Wilcoxon Matched Pairs test was used to compare reported confidence before and after the course, and the result suggested a significant difference (p<0.01).

Interviewees were asked to rate, on a scale of 1-5, how confident did you feel about preparing to conduct a review of an individual’s medicines prior to starting the PDA and after completing the qualification?

<table>
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<tr>
<th>Response</th>
<th>Before PDA (n=23)</th>
<th>After PDA (n=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean score</td>
<td>3.7</td>
<td>4.8</td>
</tr>
<tr>
<td>Median Score</td>
<td>4</td>
<td>5</td>
</tr>
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</table>

The mean score before the PDA course was 3.7 and after the course 4.8. The median score before the course was 4 and after the course 5. A Wilcoxon Matched Pairs test was used to compare reported confidence before and after the course, and the result suggested a significant difference (p<0.01).
The mean score before the PDA course was 4.6 and after the course 4.8. The median score before the course was 3 and after the course 5. A Wilcoxon Matched Pairs test was used to compare reported confidence before and after the course, and the result suggested a significant difference ($p \leq 0.05$).

**In what ways has the PDA changed the way you work?**

Nine people reported that they had not changed the way they work but they had experienced other benefits such as reinforcement of knowledge, clarification of Standard Operating Procedures (SOPs) and the roles and responsibilities of the various team members. Eight interviewees mentioned that the course had increased their confidence and 5 people reported increased efficiency.

**What do you do now at work that you were not able to before?**

Fourteen interviewees said that so far there is nothing they are able to do at work that they could not do before the course. Six people reported that they can now carry out a review of individuals' medicines or take a medication history from an individual, 3 said that they can engage further with individuals, and 2 explained that their new role allows them to free up some of the pharmacist's time.

**Has the PDA changed your level of job satisfaction? If so, in what way?**

Seven people reported that their level of job satisfaction had remained the same, while a further 7 said that although their level of job satisfaction had not changed they had experienced various other benefits such as increasing their confidence or reinforcing their knowledge. Nine pharmacy technicians reported that their job satisfaction had increased. Overall, 5 people said that their knowledge had been reinforced and 4 said that their confidence had increased. Six interviewees mentioned that they value having a certificate as a result of their work on the course. Two people said they feel they can now make a difference at work. Therefore overall the PDA had a positive effect on job satisfaction for the majority of pharmacy technicians.

**4. Identify why some pharmacy technicians did not complete the qualification**

Four pharmacy technicians who did not complete the PDA were interviewed to ascertain their views and opinions.

The 4 interviewees gave a variety of reasons: 2 found the time required to be too demanding in conjunction with staff shortages, lack of support from management, and other training being undertaken simultaneously. One person had been ill, and the fourth felt that the PDA was very similar to their current role.

Two interviewees replied that they had decided to abandon the course before making a proper start. Of the other 2, 1 said that the decision had been made midway through the course, and the other answered that she had decided in the last two months.

One person said that they would change the location of the induction day to Glasgow. Another replied that they would change the practice of removing the Kardex for photocopying as a means of gathering evidence from individuals as this is not appropriate.

Half of those who did not complete said that they would consider taking part in the PDA in the future, explaining that the idea of formal certification is attractive and that the course would encourage learning. Another comment was that having the award would allow the pharmacy technician to support others doing the course.

All four replied that they would recommend the course to colleagues. However the majority qualified this by noting that this recommendation would only apply to newly qualified pharmacy technicians or those new to working at ward level.

**Conclusion**

The majority of interviewees found the induction day helpful in that it was well organised and the relevant information was provided. Some indicated that the presenters were unsure of the detail however it was acknowledged this was first time the course had been delivered.

Almost all pharmacy technicians found the PDA workload manageable with the main challenges identified as time management in the workplace and the repetition of performance criteria within each of the units.

Although this pilot study involved small numbers, the PDA has facilitated pharmacy technicians in developing their role at ward level, with evidence showing a statistical difference in pharmacy technician confidence in all these patient-focused activities, with all now confident in taking a medication history from a patient.

Overall interviewees highlighted that completing the qualification not only benefited the workplace and increased job satisfaction it also allowed participants and the staff they work with to develop a better knowledge base.

**Changes made since research was carried out**

The following changes have now been made in light of comments received from interviewees:

1. The structure of the induction day has been changed e.g. internal verifiers (IVs) are now present to answer any specific questions on the content and assessment process.
2. The documentation has been reviewed with candidates now receiving this on the induction day.
3. Colleagues in the pharmacy technician's workplace have been made aware of the time implications in relation to collecting evidence in the workplace, to ensure that sufficient time is allocated on a regular basis.

**References**


**Authors:**

Vijay Vetri Thiruppugazh, Victoria Mason, Valerie Findlay, Frances Notman, Ailsa Power, NHS Education for Scotland

**Acknowledgements:**

Lorna Bruce, Lynn Leitch, Angela Cannon, Edinburgh College.
Jil’s Quiz Corner

Across
1. ------- care? (7)
3. one that prescribes (10)
5. the modern way to prescribe (10)
7. the last stage (8)
11. solid dose-form for oral use (6)
14. vitamin d (14)

Down
1. useful for re-population? (9)
2. apply to this area (8)
4. mrs sprat could not eat this (4)
6. wanted by aptuk (7)
8. metal mickey? (5)
9. best kept low (11)
10. Do you pay for your prescriptions? (9)
12. instructions for use on this (5)
13. lovely! (4)

Devised by Jil Betts  MAPharmT
Weston General Hospital, Weston-super-mare.

Answers can be found on the member’s only area of the website at www.aptuk.org

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APTUK Swindon Branch Meeting

When? Wednesday 17th June 2015 at 7pm
Where? Holiday Inn, Coate Water, Swindon, SN3 6AQ

Topic: Management of Dysphagia for patients with learning disabilities
This will cover:
• Swallowing difficulties in patients with learning disabilities
• Swallowing difficulties in patients with dementia
There will also be the opportunity to:
• Hear about the APTUK 2015 Conference (see www.aptuk.org for more details)
• Learn more about APTUK - the professional leadership body for pharmacy technicians

• Gain CPD support from your local APTUK CPD facilitator

The evening is free of charge and open to all Pharmacy Technicians, Pre-Registration Pharmacy Technicians, Pharmacy Assistants & Dispensers

For more information or to confirm your attendance please contact either Anna Hazelden (Branch Chair) or Katherine Watkinson (Branch Secretary)

Email: aptukswindon@hotmail.com
Follow us: @APTUKSwindon on Twitter

Quality systems in pharmacy
February 2015

Reporting on progress in the development of “quality systems” in pharmacy

In 2013 the Royal Pharmaceutical Society (RPS), the Association of Pharmacy Technicians UK (APTUK) and the Pharmacy Forum of Northern Ireland resolved to develop and maintain good systems in pharmacy which support teams provide quality care and pharmacy services for patients, and empowers involvement in daily workplace improvements.

The work matured in the context of “quality” being a key part of the national healthcare agenda across Great Britain, developments in pharmacy regulation, and the work of Professor Don Berwick in improving safety for patients in the NHS where he identified ‘the most important single change in the NHS’ as being ‘a system devoted to continual learning and improvement of patient care, top to bottom, and end to end’.

To achieve this aim for pharmacy, work was started on creating a resource for the pharmacy team that could introduce or reinforce understanding of “quality”, promote the value of “quality improvement” and the good systems, or “quality systems” needed for quality improvement to be widespread.

Embedding “quality systems” in pharmacy will further align the profession to quality, improve quality of care for patients, enhance leadership, improve workplace culture and professional empowerment, and help pharmacy providers thrive in a quality-focused regulatory and healthcare environment.

Progress
Work from 2013 and 2014 tapped into the knowledge of pharmacists and pharmacy technicians from community, hospital, community and academia sectors and the expertise of practitioners of “quality improvement” sciences. This led to the development of an online resource (www.pharmacyQS.com) which was launched as prototype in July 2014.

PharmacyQS.com
The quality system resource for pharmacy

1. Learn about how good quality systems benefit your practice
2. Improve 10 ways to improve your service
3. Electronic Quality Improvement Tools and checklists for use
4. Visit our Quality Support Centre and learn more about our role

For more information or to confirm your attendance please contact either Anna Hazelden (Branch Chair) or Katherine Watkinson (Branch Secretary)

Email: aptukswindon@hotmail.com
Follow us: @APTUKSwindon on Twitter
Prototype testing has been completed and the resource was fully launched in January 2015.
It is an open-access resource and will continue to evolve and grow.
Its purpose is to be an engaging resource to raise awareness, inspire and challenge teams to learn about quality improvement and the systems needed to help pharmacy teams use quality improvement.
The resource regularly refers users to respected publishers of information about quality, including

- The resource also serves as a platform for sharing pharmacy improvement stories to help the spread of best practice.

Recent successes
Quality on the agenda
- Work on developing www.pharmacyQS.com has regularly been promoted in the Pharmaceutical Journal, the APTUK pharmacy technician journal, RPS, APTUK and Pharmacy Forum NI websites and communications since 2013 and has also been supported by engagement briefings and conversations. This has supported putting “quality systems” into the pharmacy agenda, raising awareness. Whilst engaging with community superintendents about quality, one inspiring outcome was the serious consideration by a multiple to including “quality” in the role of area pharmacy managers following quality systems conversations.

Pharmacy improvement stories
- A growing number of pharmacy improvement stories have been collected from community and hospital teams in the development of www.pharmacyQS.com including improvements in response to dispensing errors and near misses, use of quality improvement tools, and wider improvements e.g. a summary by PharmacyVoice in response to chloramphenicol dispensing errors. Stories are edited and added to the resource to spread experiences and the site will continue to expand through the collection more of improvement experiences.

Allied workstreams
- In support of leadership, a key component of a good quality system, the RPS has launched the Leadership Development Framework 2015 (open-access) will be overseeing the leadership themes at Clinical Pharmacy Congress 2015 and will be running a series of leadership masterclass events.
- The RPS Hospital Pharmacy standards were re-launched in 2014. These illustrate what a good quality system looks like in the provision of hospital pharmacy services.
- RPS and APTUK are both leading on Foundation Pharmacy Frameworks for early years pharmacists and technicians respectively, supporting embedding of quality into early years development.

Next steps
Our work to maintain and develop good systems in pharmacy aligned to quality have shown RPS, APTUK and the Pharmacy Forum NI that there are good examples of quality improvement and quality systems in use by pharmacy. This excellence and commitment to quality can be spread wider.

In 2015 we plan to:
- Continue engagement and raise awareness of quality and the pharmacyqs.com resource with support from senior pharmacy leaders and RPS, APTUK and Pharmacy Forum NI structures.
- Continue to collect pharmacy improvement stories to spread good practice
- Host a “Quality Systems” session at the APTUK annual professional conference in Q2/Q3 2015
- Host a “Quality Systems” developmental event in Q3/Q4 2015
- Evaluate the pharmacyqs.com resource in Q4 2015

Setting up the London branch…
a mini mission of its own!

Setting up the APTUK London Branch has been in the pipeline for almost 2 years! 2 years and we finally launched and had our first branch meeting on Tuesday 25th November 2014!
The blood, sweat and tears were worth it though, meeting all those Pharmacy Technicians and Pre-Registration Trainee Pharmacy Technicians (PTPTs) that evening made it all worthwhile.

After conference last year, I went back to work and the first thing I did was send out an email to all those that were interested in helping set up the London Branch, next a meeting took place and individuals were allocated roles. I was selected as branch secretary, Chris Watts as Chairman, Liz William as Treasurer and Stephen Sheehan as publicity and events coordinator.

We set up a quick survey and sent it to all APTUK members (in London) as well as many Pharmacy Technicians’ and PTPTs that we could. We used the power of social media too! We wanted to get a feel of what members and non-members wanted from their branch.

The results were conclusive; all wanted a place where they will get up-to-date information, learning opportunities and a place to network. Thus giving our branch the main purpose ‘a place where pharmacy technicians and PTPTs
could come to network and learn from one another’.

What a better way to link learning and using the resources readily available to us!

I got in touch with Yinka Kuya, our local CPPE tutor, who was more than happy to help and we all agreed to choose leadership as the topic of our first meeting. Once decided it was all hands on deck!

We advertised the first meeting through posters, emails and social media and to be honest we were all quite excited!

What we didn’t expect was the mass number of attendees (always a good sign though!). We were expecting about 20 attendees but 2 days before the big meet we calculated 36 and we needed another venue and fast, so I called in a favour with my husband and my old working environment and managed to secure their clinical seminar meeting room. It wasn’t the best room but enough space to hold our first meeting and with the resources we would need. Tweeting, Facebook messages and manic email to alert all attendees of change of venue went out.

The BIG day!
The day arrived and it kind of went smoothly….

Last minute posters and email to my department to inform them that there has been a change of venue (just in case attendees headed to the original venue) and collecting refreshments for all and we were ready.

Chris opened the first meeting as chairman and Tess Fenn (President of APTUK) soon followed fully opening the branch. Yinka Kuya then kicked off the CPPE Leadership Skills for Pharmacy Professionals Session. It was an interactive lesson (like all CPPE sessions) and pitched at a level we all understood. The session gave everyone the opportunity to ask questions and network. Yinka’s first question to us was ‘What is Leadership and what is management?’ now this was an interesting discussion… We all had different opinions and thoughts on this and what our definition of a leader is.

When asked, I, and a few others, sprinted to the point in the room where it had a sign saying ‘Great leaders inspire people at every level to demonstrate leadership qualities themselves; to make personal ‘stands’ on those things that they have a passion for.’ This quote stuck with me. The person who had inspired me to be the person I am today; has these qualities.

Every attendee went away with a workbook and a certificate of attendance (emailed shortly after) with, in true E&T style, a CPD record to complete.

This was our first meeting and the response from everyone was brilliant and positive one! We had Pharmacy Technicians and PTPTs come from all over London and Alison Hemsworth came in to offer support (she was passing though… Thanks Alison).

Our only upset was that a few Pharmacy Technicians didn’t make it to the venue in time (hopefully this hasn’t put them off coming to future meetings) and we’ve learnt from this – no last minute venue changes!!

What’s next for APTUK London?
London is a massive city, and we are aware that we cannot cover the whole of London, so we are calling on Pharmacy Technicians across the city who would like to set up a sub branch of the London Branch! We can support each other to ensure that everyone has access to a local APTUK branch!

So if you are interested please contact us!

We are continuing to work with our local CPPE teams and have also recently started working with Pharmacy Education South London (PESL), to bring more learning and networking opportunities to Pharmacy Technicians and PTPTs (both hospital and community based).

Dates for diaries:
Tuesday 31st March 2015: APTUK Foundation Pharmacy Framework: What is it?
Rebalancing Medicines Legislation – Your views
Wednesday 8th July 2015: Minor Ailments with PESL Venue: Lower Marsh - Waterloo)

Don’t forget to like our Facebook page and follow us on twitter for updates on meetings and other relevant news and topics! Contact us to book your place(s) at our next meetings too!

Pam Bahia, MAPharmT
CPPE have launched a new learning campaign, supporting older people, which began on 11 May 2015. During this campaign they will post a new distance learning programme, Older people, to you and set you six challenges to get you thinking about how you can support older people in your practice.

We all need to consider the changes that come with ageing and the impact these have on health, and think about the care we give to older people. Pharmacy professionals are ideally placed to offer support and make a positive difference to older people.

Our learning campaign
From 11 May 2015, CPPE will set you a challenge a week for six weeks. Look out for CPPE emails and posts on Facebook and Twitter. Let them know what you are doing by posting your feedback on our social media pages.

It will also focus on you improving and enhancing your consultation skills. Older people still want to have a say in decisions about their medicines, and you can facilitate that by displaying effective consultation skills.

Consultation skills for pharmacy practice In order to aid your development, the Consultation skills for pharmacy practice six-step learning and development pathway provides many useful resources. From determining why your consultation skills are important, to figuring out how to improve, the pathway runs alongside the Supporting older people campaign. You will have the chance to check your progress and assess your knowledge and skills with our e-assessment, while continuing your development.

For more information, visit: www.consultationskillsforpharmacy.com

Keep an eye out for news from your local CPPE tutor about Consulting with older people workshops.

Orders, bookings and general enquiries
You can order a programme or book an event either online or by telephone:

Online: www.cppe.ac.uk
Telephone: 0161 778 4000

For general enquiries, please contact us on:

Email: info@cppe.ac.uk
Telephone: 0161 778 4000

You know the feeling… you haven’t felt like doing any CPD for a while. When you have a stretch of free time, you end up surfing the web or watching bad TV, then feel guilty about it later. You have higher ambitions, but can’t commit yourself. If you had to sum up your attitude to CPD in one word at the moment, it would be ‘blah’.

Welcome to the slump!

Hitting a slump and feeling unmotivated affects everyone from time to time, even those who love every aspect of their pharmacy career! Whatever the reason, your CPD slump doesn’t have to continue. Here are a few ways to get out of this slump and find something new to re-energise your learning and development:

1. Break an Aspect of Your CPD Routine

Routines, although valuable in many ways, sometimes prevent us from venturing outside of our comfort zone. Identify those ‘same-old, same-old’ elements of your current CPD routine and break them! Instead of reading a journal article by yourself, ask a colleague to discuss it with you or form a lunchtime journal or learning club for the whole team. Or why not try a different learning medium? A wealth of learning material is now available via radio, and to some extent television, which has the potential to inform and facilitate learning for pharmacy professionals. These small changes can make you feel more spontaneous and invigorate you to put your learning into practice.

Try:
• CPPE ‘e-challenge’ – a regular quiz on what’s new and happening in pharmacy, medicines and the NHS
• The ‘Learning Pharmacy’ (www.thelearningpharmacy.com) for team learning

2. Reconnect with your pharmacy peers (or find new ones).

If professional colleagues are not in abundance due to your working environment, find like-minded peers to fill that role. Regularly check the CPPE website for workshops and learning events in your area where pharmacy colleagues are able to get together to discuss patient case studies and network. Alternatively, get involved in one of the many topical discussions with a large pharmacy community on social media. Spending more time with people with a “let’s do it” attitude can help you change your CPD outcomes for the better.

Try:
Attending local workshops facilitated by a CPPE tutor
Join Twitter and get started by following @cppeengland
@APTU1 and @PharmTechUK
Or join a growing Facebook community at facebook.com/pharmtechnician

3. Commit Yourself to Trying Something New.

It’s one thing to write your CPD idea down, another to actually do it. You could stop reading this article right now
This article is aimed at informing PTPTs of how coaching and mentoring can be incorporated within the work setting to support development of key skills acquired during the two year transition to registration. Nicola Arnold, who has provided answers to the questions, is the Chief Pharmacy Technician for Education and Training at Royal Surrey County Hospital NHS Foundation Trust. She has been conducting a pilot by providing PTPTs and PRPs with monthly coaching sessions to provide a platform for trainees to recognise their own potential and become confident, creative and fulfilled individuals. In her personal time she has started her own coaching company, Enkindle Life Coaching www.enkindlelifecoaching.com.

What is coaching and mentoring?
They are processes that enable people to reach their full potential. They involve the exploration of needs, skills and thought processes, to name a few, to help people make real change.

Why coaching and mentoring important to PTPTs?
The benefits are to improve skills, make individuals self-aware, improve time management and organisational skills, provide clarity, talk situations through and realise potential.

“I have used the coaching to help make the most of the PTPT course by gaining the confidence to ask questions and push myself. I have used the self-confidence skills gained from coaching multiple times throughout the year, specifically for presentations and recently for a community pharmacy placement. I have also used it to help manage my workload and avoid ‘meltdowns’ by using techniques gained from coaching to retain a positive attitude and appreciate my ability” PTPT Yr 2

About me: My name is Laura and I am the CPPE National Tutor Lead for Pharmacy Technicians. I have been a pharmacy technician for >10 years, working in a variety of primary and secondary care environments before specialising in education and training full-time. With each journal issue, I will be taking you through some different approaches to CPD that will get your creative juices flowing, boost your confidence and improve outcomes not just for yourself as learners but for your patients too!

Stay in touch with your questions and suggestions:

Email: laura.mcewen-smith@cppe.ac.uk
Twitter: @ljmcewens
Facebook: facebook.com/pharmtechnician

Coaching and Mentoring
Skills for Pre-Registration Trainee Pharmacy Technician’s (PTPTs)

Does it just focus on work and training?
No, these processes focus on the whole person, so sometimes something can be going on at home that impacts on work and it is important to recognise this.

“Coaching has helped me to establish a greater self-awareness about my values and work ethic which also resonates with my personal life. My coaches’ outlook and drive along with her professionalism is something which I aspire to as I transition from a trainee to a GPhC registrant” PRP

What are the most common issues PTPTs struggle with?
Procrastination! This is putting something off. Sometimes this is due to poor time management or trying to avoid having to do something, but at other times it is because of a lack of confidence in the task at hand.

What could you achieve if you redirected the energy you currently use to procrastinate?

START

It's time to make a decision.
It's time to change.

© Sleigh-Hepple Coaching 2015
How could PTPTs be helped with this issue? Can they do something for themselves?

Yes they can try the following exercise to help them to identify the issue and work towards a solution.

Procrastination self-help exercise:
I’ll do it another day!
What tasks or activities have you been involved in this week that you feel confident and competent to undertake without any hesitation? Thought of a few? That’s great. Do you feel a sense of purpose and satisfaction for being able to complete these or is it just second nature. So what drives you to complete these? We find it much easier to complete activities that we enjoy, find easy and where we feel there is benefit from accomplishing them. Consider these questions:
• What are you most proud of achieving in the last week?
• Why does it stand out?
• Does it align with your values and life purpose?
Take a few moments to answer these questions and really connect with the feelings these bring forth.

Now consider the things you have been putting off. Tomorrow is going to be a busy day right? Pushing today’s to do list to tomorrow only delays that feeling of having to complete the chore you really don’t want to do. It’s time to ask yourself:
• Why am I putting it off?

How can PTPTs get further information?
They may have a coaching or mentoring programme in their workplace and should look to seek this out and get support. If not there is plenty of information on websites at the International Coach Federation (ICF) or they can contact me at www.enkindlelifecoaching.com or check out my Facebook page for updates and information www.facebook.com/Enkindlelifecoaching

Nicola Arnold

Considering your current working role
If you were stood at a crossroads which path would you take: Comfort zone or new exciting adventure?

I am the Education and Training Manager within the Pharmacy at Royal Surrey County Hospital NHS Foundation Trust. I am responsible for the design, development and management of the education and development service provided within pharmacy to all pharmacy technicians and support staff. I was very keen to find out more about coaching and how I could use it to providing our trainees with a positive and balanced platform to be confident, creative and fulfilled individuals. After all they are the profession of tomorrow.

So what is coaching?
Coaching enables you to explore the different avenues of your life and focuses on the whole person. This is different for everybody and can include work, career, home life, goals, aspirations, wanting to be more confident in several aspects of your life and ultimately fulfilment in everything that you do.

We all have an inner strength that lays dormant and coaching enables this to be awoken and the opportunity to tap into your full potential.

The International Coaching Federation (ICF) defines coaching as partnering with clients in a thought-provoking and creative process that inspires them to maximise their personal and professional potential.
(http://coachfederation.org/need/landing.cfm?ItemNumber=978&navItemNumber=567)

In the case of coaching people in the workplace it could be focussed around helping to develop self-confidence, decision making, skills around time management and even motivation for completing learning.

What are the benefits of coaching for you as the coach or the coachee?
Mentoring and coaching is an area that can sometimes take a back seat in the National Health Service as we focus on
patient centred care. I want to champion the coaching ethos and empower others to recognise the positive impact coaching can have on individuals. I am currently piloting the use of coaching sessions for our trainees during their training placement. The initial feedback has been very positive. Trainees have commented that they find the coaching sessions empowering and I have noted a positive impact in their attitude and working practice since meeting with them. They appear more self-aware, confident and able to recognise their own potential.

I have now taken my training to the next level and am completing a qualification that is recognised by the ICF after receiving a partial scholarship from the Coaches Training Institute (CTI) in the summer. To support my learning I have set up a website and blog to create awareness of coaching and a Facebook page too. Please feel free to take a look and share your findings, especially with anyone who is currently supporting trainees or championing colleagues to complete the APTUK Foundation Pharmacy Framework. If anyone would like to know more about coaching please do get in touch.

For example if you are the type of person who procrastinates and really finds it difficult to commit to action you may find this blog article useful:


If you’re struggling to commit to making or sticking to New Year’s resolutions you might like to take a look at this one: http://www.enkindlelifecoaching.com/#!Ill-do-it-tomorrow/ctu0/180680B7-ED11-4F3A-8A5E-5501CE211F90

Having written many articles for the APTUK journal in the past I have agreed to write a short coaching column for the journal and will be providing handy tips and advice to help you focus on yourself and how you can tap into your full potential and also regarding applying for jobs and preparing for interviews. Alongside this the APTUK FB page will post links to articles and blogs I have signposted to help you.

So I leave you with a question to consider regarding your working practice and what you would like to achieve:

*What’s the one thing you’re always thinking about but never do anything to change it?*

Nicola Arnold
Co-Active trained Coach
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www.facebook.com/Enkindlelifecoaching

*If you want something, you can’t just wish for it... You’ve got to make it happen!*

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Caring for the increasing number of frail older people with multiple health conditions is extremely complex and requires more effective integration of health and social care services. The development of effective strategies to improve medicines optimisation has a key role in the delivery of better care to this vulnerable group.

This masterclass will appeal to pharmacy staff involved in the care of frail older people in all healthcare settings.

Attending this event will help you advance your professional practice and could be used as evidence in your RPS Faculty portfolio.

Aim
The aim of this masterclass is to provide an understanding of the assessment of people with complex needs and to outline medicines optimisation strategies in frail older people

Learning Outcomes
At the end of this masterclass, participants will be able to:
- Describe the impact of frailty on the assessment and management of older people with complex needs
- Identify strategies for appropriate, safe and judicious prescribing in older people
- Outline current issues around reducing medicines burden

To register online, please visit: [http://tinyurl.com/p34smvn](http://tinyurl.com/p34smvn)

For further information please contact the UKCPA office
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