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The Pharmacy Guild

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PBS MEDICINES OUT OF REACH FOR MANY

I want to take this opportunity to look at an issue which is vitally important to community pharmacy and to our patients.

This is the situation we find ourselves in regarding the cost of Pharmaceutical Benefits Scheme (PBS) medicines and how quite frankly they are distressingly out of reach for a growing number of this country's patients.

Our research has found rising concerns over the cost of food and fuel are matched by fears that the increasing cost of medicines are putting many out of reach for a lot of Australians.

The research, conducted by independent research firm, Insightfully, found that more than one in 10 people have gone without prescribed medicines because they could not afford them.

Put simply, medicines in Australia are relatively expensive and in many cases unaffordable.

What this means is that there is no real universal access to the PBS which is the foundation of our health system. At present, the situation is damning.

The research goes on to show that more than 20 per cent of people aged from 18 to 64 describe prescription medication as unaffordable. Most people in this age group are general patients who have been paying up to $42.50 every month for each PBS medicine they are prescribed since the co-payment went up again on 1 January.

Sadly, at the current rate of increase every 1 January, these Australians will find themselves paying nearly $50 a month for some PBS medicines in the next five years.

The concerns people feel over health are very real and our research shows the most pressing concerns for people at present are the coronavirus, followed by health, climate change, cost of living and then the economy.

At the moment, there are 19 million Australians facing the prospect of the high general co-payment.

Women in particular are bearing the brunt of this untenable situation, and many are struggling to afford medicines for themselves and their families, with nearly 32 per cent of women 35–54 years of age and without a concession card saying they have found it difficult to pay for prescribed medicines in the past three years.

Clearly, many Australians are finding it harder to afford essential medicines.

What that means is that people are increasingly finding themselves having to choose between buying the medicines they need and other non-discretionary purchases like rent, groceries and petrol—the basics we all need to live.

This is disproportionately affecting women—they know exactly what a loaf of bread, a litre of milk and a rapid antigen test cost, and they know that it all adds up fast.

I see mothers in my pharmacy forced to choose which child gets the medicines prescribed by the doctor or not filling their own scripts because there's nothing left in the budget. These are Australia's forgotten women.

With the cost of living outpacing wage increases, more and more Australians are going to find themselves having to choose between buying the medicines they and their families need and paying the rent, mortgage or other household essentials.

At the Pharmacy Guild we have put forward a proposal which we believe will address this issue of inequity.

Reducing the general co-payment to $19 will make about 70 per cent of PBS medicine more affordable for more than 19 million Australians.

What this means is that we can avoid the heartbreaking situation we see all too often today where families requiring regular use of multiple PBS medicines have to choose which medicine they forgo, or which family member will do without so they can afford to have prescriptions filled.

Our proposal is sound policy, and we are campaigning strongly for its uptake by all politicians across all parties.

As community pharmacists, we are raising the alarm. When medicines become unaffordable, it means there is no real universal access to the PBS, which is the foundation of our health system.

Trent Twomey
National President

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CHRIS OWEN

Committee Chair of Corporate, Governance and Services

Tell us a little about yourself

I am a third-generation pharmacist, with my grandfather starting as a pharmacy apprentice after the war, and Mum and Dad meeting while studying pharmacy at UQ. As self-proclaimed 'city kids', they decided to try rural pharmacy 'for a few years' around 1980. Loving the lifestyle this offered, they are still there 40 years later. Dad has always been my mentor and idol in business and life. Mum is the steadying influence on both of us, lending some common sense to our ambition.

I bought my first pharmacy in 2009 and joined the family business. I gradually added responsibility to my role, bought a second store and transitioned to Managing Director of the group a few years later. I started in leadership roles with a more moderate endeavour, as Secretary of the Queensland Chemist Golf Association, before being elected to QLD Branch Committee and subsequently, National Councillor, then QLD Branch President and National Vice-President – Finance.

Being a family business, I remember growing up working over holiday periods with Mum and Dad. I really felt a part of the community—engrained in it. Everyone knew my parents, and they knew everyone. This sense of community probably inspired me to give back to the profession and to advocate for the role and scope of pharmacists, particularly in rural areas.

Role of Corporate, Governance and Services Committee

The role of the CGS Committee is an internal face to provide governance oversight, strategic direction and advice; to drive organisational excellence, proper financial management and operational leadership to support the Guild.

While many pharmacies are small business operations, the best explanation for the committee is all the functions of the Guild to keep it operational, financially stable and compliant whilst ensuring good governance. CGS's aim in fulfilling this role is to maintain a well-governed and high-performing organisation.

Some may accuse the topics as being dry and using board 'double-speak', but it is essential work on which all the other committee work is built on. Some of our key functions are Governance, Performance, Review, Succession, Finance, Risk, Audit, Membership, HR & ICT.

What is your role in the committee?

As the chair, I am the beacon of culture and organisational excellence. There is a mantra which resonated with me, and subsequently I have implemented in all my work environments, 'The standard we walk past is the standard we are willing to accept'. I think whether in life or business, this is a good mantra to drive and motivate teams through personal accountability, not only as members of the team, but as leaders as well.

As CGS Committee members, we stay current on trends and changes around governance topics. Part of this work entails comparing strategies and governance with those of competitors and the broader market. Our committee supports good governance; in part, by promoting the healthy development and functioning of the board, its committees and individual members. In this and other ways, the committee helps the board carry out its due diligence. The governance committee is the board's primary resource on governance issues. By staying current on governance trends, the committee monitors the effectiveness of board operations, board performance and governance policies. Duties of the governance committee include recommending action to the board for structural changes to ensure the company is compliant with its legal and fiduciary duties. The governance committee is accountable for the board and the company's governance guidelines and policies.

Three issues that are top of mind

Workforce

I am passionate for pharmacists, young and old, to upskill themselves. I believe that community pharmacy is a speciality within its own right. This speciality requires its own set of skills and techniques which aren't taught at university. While being perfect for community pharmacists, it also offers business and management skills for all pharmacists—no matter where they practise.

Upskill yourself and don't undervalue your worth. One of the common themes of concern amongst students and ECPs is pay and conditions. My advice is don't undervalue yourself. The only reason some employers offer award rates or slightly above is because pharmacists are willing to accept them. If you accept that award rate, you have just set your worth. Don't accept it. Upskill yourself or make a tree change to a rural area.

Rural Health Care

There is a looming crisis with a lack of rural pharmacists despite pay and conditions double (or more) the award rate. The sense of community and cost of living within rural towns and regional centres cannot be replicated. To grow professionally, you need to go outside your comfort zone, so do something different. Start a leadership course or try out rural for a few years. Initiatives led by the Guild such as the Full Scope of Practice trial will provide rural patients more accessible primary health care, especially where these are underserviced by General Practice.

There is a looming health crisis in Primary Health, and allowing pharmacists to assist, by removing the legislative barriers, will aid health outcomes for those more vulnerable by nature of the postcode they live in.

Digital Transformation

The uptake of electronic prescriptions across the past two years has led to a fundamental shift in the technical process of dispensing a prescription. We moved forward a 'decade in digital' over that time. Significant investment in people and process was required and, for some, this has been done better than others. With further automation in dispensing process, it is important that we continue to recognise the cognitive skill and expertise of the pharmacist and their role in the patients' outcome and safety. To ensure efficiency, we must find a way to embed systems seamlessly. Digital products are conducive to the enthusiastic adoption of digital health options that community pharmacies have always demonstrated. We also need to be cognisant that there are risks associated with new systems and processes, and ensure legislation keeps pace with new business models to ensure the safety of the patient.

STATE OF THE INDUSTRY UPDATE

Words | Dr Philip Chindamo Chief Economist, Pharmacy Guild of Australia

Introduction

Community pharmacy is well placed to make the most of growth opportunities as the economy recovers from the COVID-19 pandemic of the past two years. In order to do so, community pharmacy owners need to have a strategy with respect to all segments of their operations, including retail and front of shop segments.

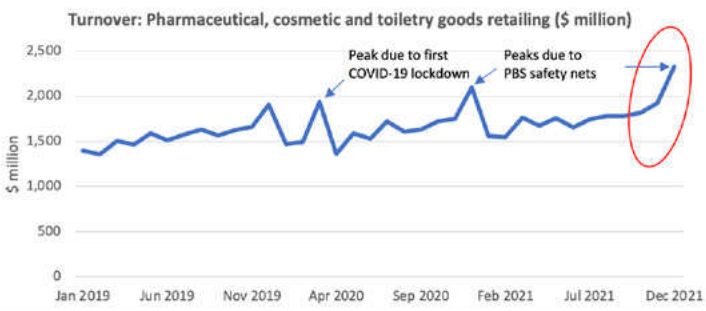
The Macroeconomic Environment

Australia's economy has weathered the COVID-19 Omicron outbreak relatively well with year-on-year economic growth for the December quarter 2021 of 4.2% and disposable income increasing 3.7% over the same period. Unemployment is very low by historical standards and employment growth continues. Household spending is also recovering – while during the peak of COVID-19, household spending declined by 12% in the June quarter 2020, the largest quarterly decline since the 1950s, and then also dipped in 2021 over a similar period, households have raised their savings and rebuilt their balance sheets, boding well for household spending to pick up in 2022. Population growth has been relatively weak because of border shutdowns and emigration, but as international borders re-open, there will also be a boost to spending from population growth over the next year. Labour supply disruptions during the COVID-19 period are now also easing. These are all good indicators for the state of the economy and for the year ahead.

Some of the headwinds against the economic recovery include ongoing supply chain disruptions, which are partly feeding into higher inflation and the re-emergence of workforce shortages in some sectors of the economy. In terms of the inflation outlook, the Reserve Bank of Australia will be monitoring whether recent price rises represent a level shift, or an acceleration in price increases. If it is the latter, then they may seek to quell this with an official interest rate rise.

Recent Pharmacy Industry Performance

The community pharmacy industry is coming out of the COVID-19 period strongly. This is illustrated by Chart 1 which shows turnover for pharmaceutical, cosmetic and toiletry goods retailing ($ million).



Source: *Retail Trade, Australia, ABS.*

Prescriptions continue to account for over 60% of pharmacy sales. Prescription volumes grew by 1.8% in 2021 relative to 2020 (only 0.8% in 2020 relative to 2019), showing that spending on these essential items remains solid. Moreover, combining all pharmacy categories (dispensary, over the counter products, front of shop and professional services), annual turnover growth in pharmaceutical retailing in 2021 has outpaced annual turnover growth in all retail as illustrated in Table 1.

Pharmacy	All Retail
7.2%	5.3%

Source: *Retail Trade, Australia, ABS.*

While nationally annual turnover growth in pharmaceutical retailing in 2021 was 7.2%, it has varied across jurisdictions. The northern and western States and Territories have experienced strong growth in 2021 relative to 2020, whereas the southeast jurisdictions have performed less strongly. For example, South Australia recorded a drop in pharmaceutical retailing in 2021 while Tasmania recorded zero growth.

Two challenges facing community pharmacies currently relate to unfilled job vacancies and rent expenses. With very low unemployment, aggregate labour market conditions are the tightest since 2008, moreover so for the market for pharmacists where the job vacancy to unemployed ratio is currently at 2.8. This means, for every unemployed pharmacist, there are up to three job vacancies. This means wage pressure to keep or attract pharmacists from other employers. Since July 2021, pharmacists have been listed on the Federal Government's Priority Migration Skills List, which should, over the medium term, help ease pressure on filling job vacancies.

Pharmacy rents and occupancy costs represent another increasing cost to pharmacy operations. Barring isolated locations, all other pharmacy locations have experienced an increase in the average rent per square metre in 2021, with neighbourhood, sub-regional and community locations experiencing the largest annual increase of around 13%. These were followed by major regional locations recording an increase of 8% and strip locations recording a similar increase compared to 2020.

Strategies to Seize Growth Opportunities

As household savings rates have improved over the COVID-19 period, and with growth in disposable incomes, household spending on discretionary goods in 2022 will increasingly augment spending on essential items, such as prescription medicines. For example, front of shop health-related products are natural complements to prescription medicines.

Without a strategy, community pharmacies will not be able to fully take advantage of the rise in discretionary household spending. Strategies worth considering include:

- Reviewing your Stock Keeping Unit (SKU) categories: variation in producer purchase prices into store can be substantial and influenced by promotions. There can be a long tail of products which contribute little to overall pharmacy performance and profitability.
- Reviewing and improving your purchasing from suppliers: concentrating purchasing minimises distribution costs at a time when transport costs are rising due to higher petrol prices.

Overall, a strategy focused on your business practices involves examining your procurement, replenishment and category management.

In addition, a consumer attraction and retention strategy is worth considering and implementing. This involves examining customer spending trends with respect to front of shop items purchased in the pharmacy and in alternative locations (such as supermarkets, department stores, convenience stores). In addition, looking at which front of shop products are complementary to each other (purchased together) or substitute products (purchased instead of) and having pricing strategies for those items. Guild commissioned research shows 49% of people use one pharmacy exclusively for everything and 17% of people use one pharmacy exclusively for something. However, the same research found 25% of people use multiple pharmacies and 47% of people visit a pharmacy up to 11 times a year to buy any kind of non-prescription item. Hence, having a consumer strategy to attract and retain customers can make a significant difference to the performance of a community pharmacy.

Online Sales

During the COVID-19 period, households shifted part of their expenditure from services to goods because the lockdowns restricted expenditure on some services. Online sales became the norm for some product categories, but yet the proportion of online sales to total retailing is only around 10–11%. For community pharmacies, it is around half that proportion. But it is the rate of growth of online commerce that is important, and community pharmacies having an online presence, whether to make sales or merely to provide consumers with details of the professional services on offer, is critical. Digital enablement more generally is one of the pathways in the Guild's Framework for Change.

Conclusion

The economy is set to further improve in 2022, and household spending will again broaden out to discretionary items that were less prevalent during the COVID-19 period. Some of these discretionary items include health and beauty products that form part of community pharmacies front of shop offering. Community pharmacies can take advantage of this switch in household spending by having in place strategies around procurement, replenishment and category management as well as customer attraction and retention. The opportunity will be seized by community pharmacies that proactively plan and implement these strategies.

[1] ORIMA Research (2018). 'CP2025 Market Research'.

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Research has shown the eugenol in clove oil has analgesic properties - meaning it can help relieve pain.[2,3]

This is why clove oil has been used in dental practice since ancient times – it helps relieve local pain associated with a toothache. [3]

A Real Pain in the... Tooth

A toothache happens when there's a problem with the teeth or gums. There are many things that can cause a toothache – including tooth decay, receding gums, inflammation or loose or broken fillings.[4]

The most important thing to do for toothache is to refer your patients to their doctor or dentist for advice. Also, making sure they are taking care of their teeth and mouth by regularly brushing and flossing.[4]

Next time a patient is looking for relief from a toothache, invite them to take a trip to the Spice Islands, with 100% pure essential oil, Gold Cross Clove Oil 100%.

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For more information, reach out to your FarmaForce representative. Stay tuned for the next edition!

REFERENCES

1. LiverTox, Clinical and Research Information on Drug Induced Liver Injury [Internet]. Bethesda (MD)- National Institute of Diabetes and Digestive and Kidney Diseases; 2012-. Eugenol (Clove Oil). [Updated 2019 Oct 28].
2. Ulanowska M and Olas B, Int J Mol Sci. 202;22(7):3671.
3. Alexa VT, et al. Molecules 2020;25(23): 5502.
4. Healthdirect, Toothache and Swelling. Available from: https://www.healthdirect.gov.au/toothache-and-swelling (accessed September 2021).

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PROBIOTICS

A Digestible Summary

Gut health has become a topic of significant focus both in the mainstream media and clinical investigation, and healthcare professionals are finding themselves fielding questions about probiotics more and more frequently. As with all things, it is our responsibility to remain updated on current probiotics research in order to be able to make appropriate recommendations for specific patient populations.

Words | Bridget Scrogings

Definition

The World Health Organisation (WHO) classifies probiotics as `live organisms which when administered in adequate amounts confer a health benefit on the host'.[1]

The Gut Microbiome

To understand probiotics, it is important to first have an appreciation of the roles of the normal intestinal microbiome (commensal microbiota). The human gastrointestinal tract is home to trillions of microorganisms, most of them bacteria, but also viruses, fungi and protozoa.[2] Increasing evidence suggests that gut microbes play an essential role in human health by protecting against pathogen colonisation,[2] facilitating dietary digestion and absorption,[2] synthesising essential vitamins,[2] producing beneficial metabolites[3] (more recently being referred to as postbiotics), maintaining the integrity of the intestinal epithelium[3] and regulating immune system development.[4]

Yet, it isn't exclusively beneficial microorganisms that reside in the gastrointestinal tract. In healthy individuals the `good' and the `bad' microorganisms live in harmony providing beneficial health outcomes. However, when there is an imbalance within the microbiome, there is potential for the beneficial mechanisms to be disrupted, which is known as dysbiosis and can be associated with inflammation and disease.[4]

Who Would Benefit From a Probiotic?

The marketing of probiotics often suggests that their consumption will simply improve overall health by increasing the number of good bacteria colonised in the gut. Unfortunately, this is misleading. Research has demonstrated that probiotics are not able to colonise in the gut and rarely do they exert any effect on the commensal microbiota.[4] Instead, probiotics are considered helpful visitors who do not improve overall health but rather exert highly individualised health benefits that are dependent on the specific strain.[4]

As health professionals, it is essential to emphasise to patients this highly individualised nature of probiotics. Probiotics are identified by the specific strain of bacteria which includes the genus, the species, the subspecies (if applicable), and an alphanumeric strain designation.[6] Strains of bacteria, even if within the same species, can have significantly different therapeutic actions, properties and characteristics.[6] An analogy that can help patients conceptualise the probiotic classification system is to liken it to different breeds of dogs. All dogs belong to the same genus and species, yet within the species there is a great diversity in behavioural and physical characteristics. A poodle for example is very different to a Rhodesian ridgeback.

Therefore, with these considerations, probiotics would be applicable when there is sufficient clinical research to justify the use of them for relief regarding a specific condition. Currently, there is evidence to suggest probiotics may provide some relief for symptoms of irritable bowel syndrome (IBS),[8] ulcerative colitis,[9] acute infectious diarrhoea,[10] diarrhoea associated with antibiotic[11] use and *Clostridium difficile* (C.diff) associated diarrhoea.[12]

Selecting the Appropriate Probiotic

There are three things to consider when recommending a probiotic supplement to a patient. First, it is essential to ensure the product contains an adequate number of live organisms, which is referred to as a colony forming unit (CFU).[6] While the exact amount is strain-dependent, the minimum dose for most strains is 10^9 CFU/day, so when unsure it is best practice to recommend a probiotic product that contains bacteria in concentrations >10^9 CFU/dose.[7]

Secondly, integrity of the probiotic must be fit to survive transit through the intestinal tract, enduring the acid and bile contents in the upper-GI tract before reaching the small intestine and colon where they exert their effects.

Finally, the product must have demonstrated a positive benefit which has been documented in human studies.[6]

Some examples of probiotic strains and their benefits are listed in the table below.

Genus	Species	Strain	Benefit
Lactobacillus	acidophilus	CL1285	• Prevention of antibiotic-associated diarrhoea • Prevention of *Clostridium difficile*-associated diarrhoea • Improvement in severity of abdominal pain in IBS • Improved tolerance to lactose
		NCFM	• Decreased duration of upper respiratory tract infection
	casei	DN-114	• Prevention of antibiotic-associated diarrhoea • Prevention of *Clostridium difficile*-associated diarrhoea
		DG	• Improvement in symptoms in uncomplicated diverticular disease
		Shirota	• Reduced incidence of upper respiratory tract infections
	fermentum	VR1-003	• Improvement in severity of abdominal pain, bloating, constipation and flatulence in IBS
		CECT5716	• Decreased duration of upper respiratory tract infection (URTI)
	plantarum	299v	• Maintenance of clinical remission in IBD – ulcerative colitis • Improvement in severity of abdominal pain in IBS
	reuteri	DSM17938	• Reduction in therapy-related side effects in treatment for Helicobacter pylori (HP) • Decreased risk of developing diarrhoea associated with antibiotic use
	rhamnosus	GG	• Decreased risk of developing diarrhoea associated with antibiotic use • Reduction in therapy-related side effects in treatment for Helicobacter pylori (HP) • Decreased duration of upper respiratory tract infection (URTI)

Bifidobacterium	animalis	DN-173	• Improvement in QOL in constipation-predominant IBS
	infantis	35624	• Improvement in IBS symptoms
	lactis	B94	• Decreased risk of developing antibiotic-associated diarrhoea
		Bb12	• Improvement in stool frequency in constipation
		BI-04	• Decreased duration of upper respiratory tract infection (URTI)
	longum	35624	• Maintenance of clinical remission in IBD – ulcerative colitis
Bacillus	coagulans	MTCC 5856	• Decrease pain, improve constipation in IBS
Escherichia	coli	DSM17252	• Improvement in severity of abdominal pain in IBS • Maintenance of clinical remission in IBD – ulcerative colitis
		Nissle 1917	• Improvement in stool frequency for patients experiencing constipation
Saccharomyces	boulardii	CNCM1-745	• Treatment of acute diarrhoea in adults • Prevention of antibiotic-associated diarrhoea • Treatment of traveller's diarrhoea in adults • Reduction in therapy-related side effects in treatment for Helicobacter pylori (HP) • Reduction in IBS discomfort and improvement in IBS QOL score

Fermented food

In addition to manufactured supplements, patients can also consume live bacteria and cultures naturally in the form of fermented foods. This can include dairy foods like yoghurt, kefir and certain cheeses, as well as non-dairy products such as kimchi, sauerkraut, miso, sourdough bread, tempeh and cultured non-dairy yoghurts.

Yet controversially, the interpretation of the definition excludes these traditional ferments from being labelled probiotics. While it is likely that these foods impart some general beneficial outcome and should be recommended, they cannot be relied upon for specific therapeutic effects in the same way as well-defined strains of probiotics.[7]

Prebiotics

Since probiotics and fermented foods are considered living organisms, it should be no surprise that they also require a metabolic fuel source. Prebiotics are non-digestible carbohydrates mostly consisting of nonstarch polysaccharides and oligosaccharides that provide nourishment for gut microbes, influencing their activity and growth and promoting the release of beneficial metabolic by-products.[6]

Good dietary sources of prebiotics include dried beans and other legumes, garlic, asparagus, onions, leeks, certain artichokes, green bananas and wheat. To get the most out of probiotic and fermented food supplementation, it is recommended to consume at least 10 grams of prebiotics each day.

As indicated, patients should be encouraged to select probiotics as they would select a medication, with advice from their healthcare provider and specific to the condition they are hoping to relieve their symptoms.

References available upon request

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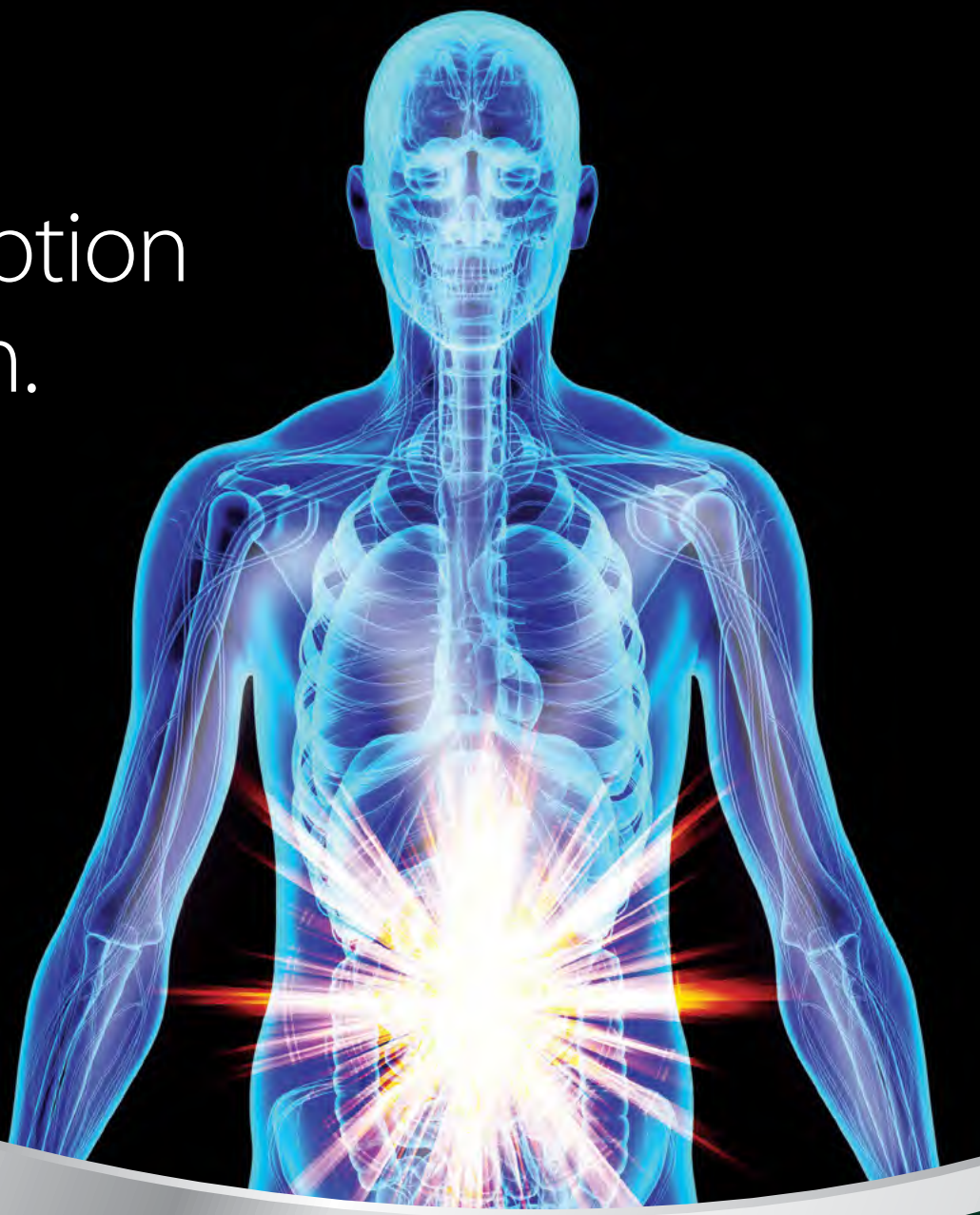

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SOCIAL PRESCRIBING

Beyond the repair shop

At a time when pharmacies, GPs, mental health providers and the broader health system are straining at the seams, we are presented with another great opportunity to look at the way we approach caring for those in our community who are ill, and to take a proactive and non-clinical approach where relevant.

Words | Joanne Winwood

Social prescribing is an awkward term; it was coined to highlight the contrast of writing a traditional pharmaceutical prescription, with a 'social prescription' (social plan) when more appropriate. Social prescriptions can help people improve their health by addressing the root cause of their illness—to determine a solution—rather than solely relying on trying to repair the consequences.

Social prescribing has rapidly caught on in other countries around the world as a powerful and proven approach to increasing wellbeing, producing positive outcomes for individuals, communities and the health economy. It's also been endorsed by the World Health Organisation, has its own global movement and is starting to gain traction here in Australia. Throughout this column series, we'll take a look at exactly what social prescribing is, who could most benefit, examples already in place and the role pharmacists can play.

To kick off, let's look at the social determinants of health. The contemporary approach to health and wellbeing recognises that the extent to which we connect with others and the world has significant bearing on our health and longevity. Human beings are complex creatures, with a range of factors contributing to our wellbeing. There are the basics such as age, place and gender; and the social, economic and political landscapes that surround us. And then there are our individual needs and preferences across a range of domains, including occupational (purpose), spiritual, intellectual, social, financial, emotional, creative and environmental.

Physical and mental illness often show up when our needs are unmet, so it's important to dig beneath the symptoms for a holistic look at what it is that's making us unwell.

You can **click here for the Feros Care video** which explains social prescribing in detail or **here to view the playbook** developed by the Global Social Prescribing Alliance.

Research shows that up to 50% of an individual's health is the outcome of a range of 'social determinants'. This has played out through the current health crisis. By seeking to protect our physical health (against COVID), our ability to achieve almost all other determinants of health has been compromised. Socialising, working, volunteering, and doing community activities and hobbies have been almost impossible; church has been halted and the arts crushed. We've become increasingly lonely, with an estimated two in five adults experiencing problematic loneliness (up from 1 in 4 in 2019).

> **"BECAUSE WE ARE MEMBERS OF A SOCIAL SPECIES, LONELINESS IS A DANGEROUS DISEASE, INCREASING THE RISK OF ANXIETY, DEPRESSION, DISTURBED SLEEP, COGNITIVE DECLINE AND OTHER HEALTH ISSUES."**
>
> – Hugh Mackay, author of *The Kindness Revolution*

Loneliness is the leading cause of anxiety and depression, whilst obesity, cardiovascular disease, hypertension, sleeplessness, addiction and substance abuse are all strongly linked to loneliness and isolation.

'Chunk, hunk or drunk?' I heard someone ask a friend about the effects of COVID on their life. Funny as it was, this is exactly what the research is predicting—that the long tail of COVID, or 'shadow pandemic' will bring a swathe of poor health outcomes linked to prolonged poor social health. But as leading researcher Juliann Holt-Lunstad tells us, 'While social factors are the most important protectors against mortality, individuals rank them least important".[1]

Being popular and liked by others is such an important part of the human psyche, so it's no wonder there is also stigma attached to admitting loneliness. Not only are most of us unaware that our social health is as important as quitting smoking (loneliness is as bad for you as smoking 15 cigarettes a day) or eating well, but we're ashamed to tell anyone too.

'It's embarrassing.' Peta, 15 years old

'I just don't want to be a burden.' Charles, 87

Many of us need help to understand that our health relies on more than physical inputs and that we have our own individual needs. We need help to dig into 'What matters to me?' as much as 'What's the matter with me?', and to nut out 'What's missing in my life that's making me unwell?' And for many, we need help to address any barriers and start making the links to connect.

That's a time-consuming job and not one that all GPs are resourced to do. 25% of GPs say their time is spent on non- clinical matters and that's too much. It takes far more than 15 minutes to help a person understand their social health, and as for helping them link to community, that's another skill entirely.

Many areas in Australia are now trialling forms of social prescribing, where the person is referred to a 'link worker' (just one of a long list of titles for the same role), who is a health coach and community connector all in one, for a social prescription instead of, or alongside, a clinical prescription. Generally time limited, with a focus on building skills to manage their own social health and using validated tools to assess impact, these pilots are mounting evidence that this approach has huge potential on many levels.

The widow who isn't sleeping at night recognises that she is sleeping in the day to pass the hours and is 'prescribed' a support group and some volunteering; the new single mum with hypertension is introduced to a new mums group and a free yoga class for mums which she didn't know existed.

One such pilot is Feros Care's Beating the COVID Blues (**www.feroscare.com.au/beating-the-covid-blues/clinicians-community**), a partnership with the Hunter New England and Central Coast PHN to help seniors suffering the impact of COVID self-isolation through a social prescription.

So, what does this mean for pharmacy?

Pharmacy staff are considered trusted advisors to many patients, and most pharmacy staff recognise those repeat patients who pop in for a chat about their health as much as to collect their script. Most will know of those who are lonely. If you have been advised of a local social prescribing program, it's great to refer; unlike the UK, most programs in Australia don't require a GP referral. There's also a pharmacist training program available for those wanting to learn and do more for those customers where medication may be only part of the solution, and over time, lobbying may create funding for pharmacies to provide a social script.

Over the coming issues, we will take a deeper look at loneliness, now considered 'the biggest social issue of our time', programs that are working and the circumstances where social prescribing delivers the best results.

Jo Winwood is the Head of Be Someone For Someone, an initiative of Feros Care to tackle loneliness in Australia. She is a member of a range of national and international organisations focusing on ending loneliness and improving social, heath and economic outcomes through evidence-based programs that tackle loneliness and isolation.

Feros Care (Feros) is a reputable not-for-profit organisation, providing a broad range of services in both the ageing and disability sectors across Australia. We are registered with the Australian Charities and Not-for-Profits Commission.

Our mission is to enable customers to grow bold, supporting them to live vibrant, healthy, independent and connected lives.

For years, what has become increasingly distressing for our teams is the amount of loneliness and isolation we see—a tragedy in itself and with devastating impacts on physical and mental health. Our model of care has repeatedly shown us that addressing social determinants of health is key to wellbeing and good health, supported by ever increasing academic and social research.

Feros is committed to tackling loneliness, now cited as the 'greatest social issue of our time', as a strategic imperative, establishing a major initiative, Be Someone For Someone, to spearhead this work.

References available upon request

Levoxine
levothyroxine sodium

NEW
PBS LISTED

INTRODUCING A NEW LEVOTHYROXINE EVOLVED

Apples for apples*

* Levoxine is bioequivalent and a-flagged on a same-dose basis with Oroxine and Eutroxsig[1,2]

Forget the fridge†

† Levoxine should be stored at below 25°C in the original pack and protected from light and moisture[1]

Find the right tablet‡

‡ Levoxine is available in four individually colour-coded strengths: 50 mcg white to off white, 75 mcg violet, 100 mcg yellow and 200 mcg pink[1]

PBS information: This product is listed on the PBS as a drug for the treatment of thyroid hormone replacement therapy.

Please review the Product Information before prescribing available from www.ebs.tga.gov.au or Sun Pharma by calling 1800 726 229.

WARNING: Levoxine is not bioequivalent on a same-dose basis with Eltroxin. If a decision is made to switch a patient from Eltroxin to Levoxine, then prescribers should have a plan for monitoring TSH. Prescribers should be aware that dose adjustment may be required.

Prescribers should tell their patients not to interchange Levoxine and Eltroxin unless a decision has been made to switch products, and there is a plan for monitoring TSH levels and review of dose.

Levoxine levothyroxine sodium 50, 75, 100 or 200 microgram tablets bottle pack. **Indications:** management of demonstrated thyroid hormone deficiency and suppress thyrotropin (TSH) for the management of TSH responsive tumours of the thyroid. **Contraindications:** Known hypersensitivity to thyroxine, untreated hyperthyroidism, uncorrected primary or secondary adrenal insufficiency, thyrotoxicosis, acute myocardial infarction uncomplicated by hypothyroidism, acute myocarditis, and acute pancarditis. **Precautions:** Presence of cardiac disorder; Cortisone deficiency; Effects on bone mineral density; Diabetes; Hyperthyroidism; Thyrotoxicosis; Long-standing hypothyroidism and myxedema, Levothyroxine should not be used for the treatment of obesity or weight loss; and Malabsorption syndromes. *Elderly Use:* Gradually introduce and individualise dosage especially in the presence of cardiac disease. *Paediatric Use:* Studies performed have not yet demonstrated paediatric-specific problems that would limit the usefulness of thyroid hormones in children, however neonates should be carefully monitored. **Interactions:** Oral anticoagulants, coumarin or indandione derivative, SSRIs, insulin and antidiabetic agents, beta-adrenergic blocking agents, ion-exchange resins, corticosteroids, oestrogen, antiepileptics, ritonavir, antimalarials, antibacterials, androgens and anabolic steroids, ketamine, lithium, tricyclic antidepressants, sympathomimetics, digoxin, medicines that partially inhibit the peripheral transformation of T4 to T3, weight loss drugs, pentobarbitone, dihydrotachysterol soya flour, sucralfate, calcium-, aluminium-, magnesium-, iron supplements, lanthanum, sevelamer and proton pump inhibitors. **Pregnancy:** (Category A) **Adverse effects:** Individual patients vary in response to both the maintenance dose of levothyroxine and to the size and frequency of dose increments. Too large an increment or too high a replacement dose can lead to manifestations of thyrotoxicosis. **Dosage and administration:** Best taken as a single daily dose first thing in the morning with water on an empty stomach, and at least 30 minutes and preferably 60 minutes before the intake of any food or other medications. *Initial dose:* 50 to 100 µg/day & in >60 year old and ischaemic heart disease patients 25 or 50 µg/day. Increase the daily dose by 25 to 50 µg according to response at not less than 4-weekly intervals, up to a *Maintenance dose:* 100 to 200 µg/day. **Date of preparation:** November 2021

Reference: 1. Levoxine Product Information. 2. PBS. Schedule of Pharmaceutical Benefits - Effective 1 February 2022. Department of Health, Canberra. ww.pbs.gov.au.

Sun Pharma ANZ Pty Ltd, ABN 17 110 871 826, Suite 2.02, Level 2, 12 Waterloo Road, Macquarie Park 2113. Ph: +61 2 9887 2600, Fax: +61 2 8008 1613. Medical Information and to report adverse events: adverse.events.aus@sunpharma.com or 1800 726 229.
SUNL001c Date of preparation: January 2022 LEV2021/12ITK

Scan this QR code to access resources and information about Levoxine

www.levoxine.com.au

LEADING TO CHANGE

The words *pivot* and *adapt* have been spruiked to death over the past few years. And by death, I mean that those that couldn't do this quick enough, well enough, or simply chose not to, have ended up, or soon will be shutting their doors.

Because here's the hard truth...

Words | Zamil Solanki
Pharmacist, Business Strategist & Entrepreneurial Coach

If the pandemic hasn't motivated you to strategically look at your business and lead your team through the necessary changes required to cater to the post-pandemic patient, **then nothing will.**

Not the rise of competition.
Not the government.
Not declining profit margins.
Nothing.

Unless you first *embrace* the need to lead to change.

For decades, advocates throughout not only the pharmacy industry, but the entire healthcare industry have been screaming for innovation and change to cater to evolving consumer healthcare needs and expectations.

Those that saw the writing on the wall and looked at the trends and embraced the changes required to improve their workflows, systems and processes years ago, are reaping the rewards today.

Their teams are happier, more productive and committed to the purpose of the business than those that didn't.

Their bottom lines have weathered the peaks and troughs much more effectively and efficiently.

And their patients are proud advocates for these businesses—happy to promote and refer their friends and family when things go right, and even more willing to understand and defend the business when things don't go to plan.

On the surface, it's easy to judge and make assumptions about the behaviours and leadership qualities of health business owners and talent within our businesses, but there's a lot more to it.

It takes guts to embrace and make change. Not just leading through change but making the call *to* change in the first place.

For too long we've focused on leading through change but haven't taken a step back to empower healthpreneurs to acknowledge the need to change from the start.

To understand why we haven't changed, or seemingly refuse to change, it's vital that we dig deep into understanding what's holding us back.

The Roadblocks to Starting Change

Many leadership coaches will focus solely on the things to be aware of when embarking on change, i.e., ensuring adequate communication, allocating appropriate resources and leading the team through the journey.

However, this is of little use if we aren't actually committed to starting change in the first place.

As leaders, *commitment* in all facets of our business is a clear sign to both ourselves and our teams that we're embarking on the journey, we're preparing to weather any turbulence along the way, and we're in it together until we've reached our destination and beyond.

In essence, leading to change is the summation of many actions following one key value: *we do what we say we will do.*

But while commitment is essential, getting to that point requires us to overcome 5 key roadblocks standing in our way:

01 FEAR OF FAILURE

Coming from an Asian background, I was instilled with the values of my culture and the expectations that come with it from a young age. The expectations to reach levels of academic achievement and financial success are all part of it. But failure is not.

In the real world however, this is completely contradictory. And unfortunately, we're now seeing this translate to the broader community as well.

The notion that success and failure are polar opposite events results in us having doubt in our abilities and the belief that despite trying new things and embracing change, our efforts won't be good enough. As a result, we simply don't start change, fearing that the changes we make will send us backwards, not forwards.

> "FAILURE IS NOT THE OPPOSITE OF SUCCESS, IT'S AN INTEGRAL PART OF SUCCESS"
>
> - Arianna Huffington

But if we reverse this notion and look at failure as an **opportunity to learn, review and refine** what we're doing, we flip the script from fear to something that we can leverage and build upon.

Having experienced this firsthand, I know that overcoming this is easier said than done. It's a daily practice and one that is truly never completely abolished. But with each small battle we win, we will quickly look back and realise that the fear wasn't as bad as what we made it out to be.

02 FEAR OF JUDGEMENT

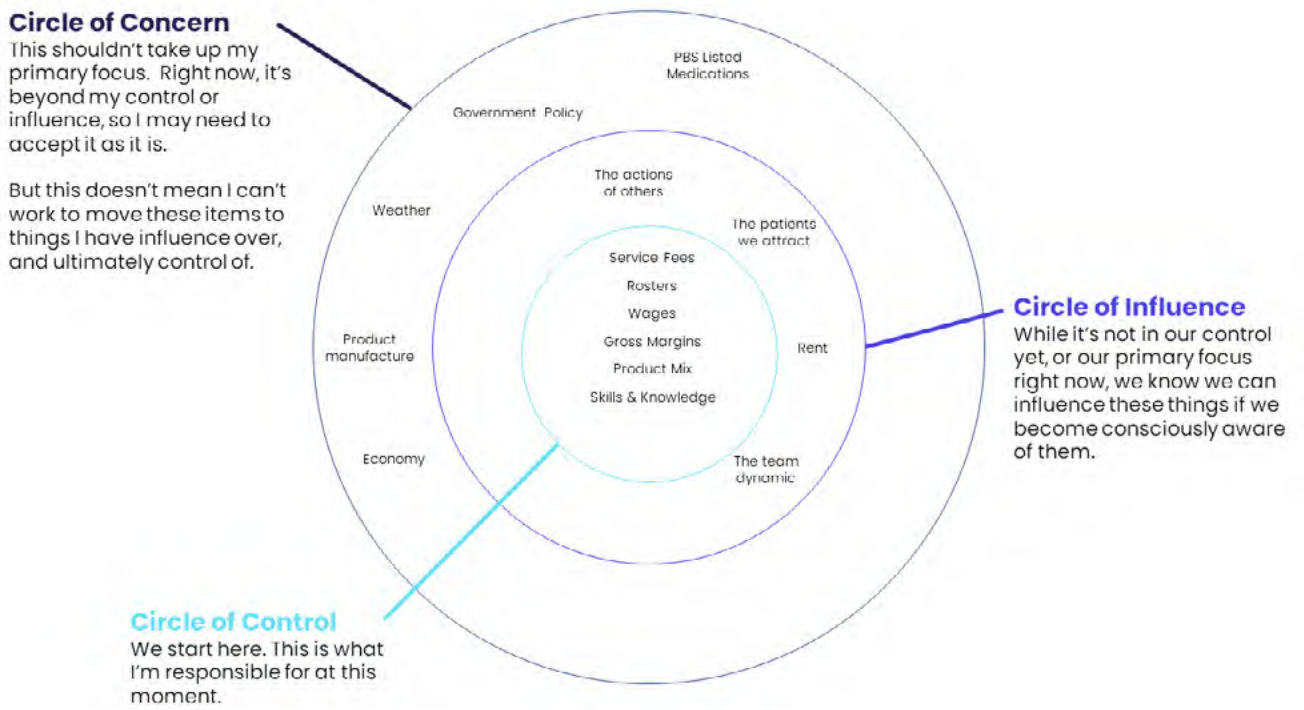
Like Fear of Failure, and many other fears, we ultimately worry: 'What will others think?'

Growing up in a close-knit community, both personally and professionally, and being very visible with what was happening in my world, I always thought about how others were perceiving me and my actions.

But the more I worried about this, the more I didn't achieve. And the more I didn't achieve, the more this fear was fuelled. It's a vicious circle and one that can quickly lead to isolation, exclusion and actual failure.

I quickly learned that as a leader, this comes back to our relationship with things we can *control*, things that we can *influence*, and things that *concern* us even though we have little to no control over them.

> "CHANGE HAS A CONSIDERABLE PSYCHOLOGICAL IMPACT ON THE HUMAN MIND. TO THE FEARFUL, IT IS THREATENING BECAUSE IT MEANS THAT THINGS MAY GET WORSE. TO THE HOPEFUL IT IS ENCOURAGING BECAUSE THINGS MAY GET BETTER. TO THE CONFIDENT IT IS INSPIRING BECAUSE THE CHALLENGE EXISTS TO MAKE THINGS BETTER."
>
> - King Whitney Jr.



Adapted from Stephen Covey's Circles of Concern and Circles of Influence, we can quickly identify things in our own world that can consume our focus and resources but are beyond our influence and control.

I've started filling out the graphic above but feel free to add to it to make it more relative to your own circumstances.

But let's be real here. Haters will always hate. Judgers will always judge.

There are plenty of people that voice negative opinions on the world's most progressive and innovative thinkers.

Take Elon Musk for example. He faces judgement and scrutiny each day for his ideas, methods and leadership skills. If he let the fear of judgement hold him back, whether it be from the oil industry, the space industry or even our global financial industry:

- Would we be seeing a radical shift to EV technologies?
- Would we believe that one day we will inhabit Mars?
- Would we be embracing the use of digital currencies despite their volatility and uncertainty?

Most certainly not.

By **letting go** of the things that concern us and are out of our control, the quicker we can remove these fears.

03 PROCRASTINATION

As healthcare practitioners, we're drilled throughout our university life that 'mistakes can kill people'. While rightly so from a healthcare perspective, it's the lack of mistakes that can kill our careers and businesses.

While this might sound odd, take a moment to re-read the previous sentence.

Does the link between procrastination and our fears of failure and judgement sound familiar?

For many of us, including myself at a point in time, we procrastinate because we seek perfection. We seek perfection because our minds have been wired to believe that a mistake can kill someone.

But if we don't take the plunge to make changes, knowing that there will be mistakes along the way that we can learn and build from, then we will forever be waiting for the perfect time, place and plan to embrace change.

And here's the kicker: there is no such thing as perfect, only progress.

Looking at the change through the lens of **progress over perfection**, taking the leap will help accelerate your growth and identify things that you didn't realise.

Of course, it might take time and resources to correct the mistake—but what's worse? Doing nothing and wasting time and resources to just survive, or trying something new that at the very worst, will teach you what not to do, so you can do the opposite?

04 IMPOSTER PHENOMENON

Let's face it, you're a high-performing individual. That's the nature of being a healthpreneur.

But have you ever felt like:

- you're not worthy to lead others?
- you think you don't know what you're doing despite all your training and knowledge?
- you think you're not smart enough?
- you don't deserve what you've achieved?

It's common to have these feelings at one point or another. But when it starts to impact our performance, despite all the external accolades, encouragement and accomplishments, addressing the imposter phenomenon is critical to ensure we can effectively lead to succeed.

The self-doubt of our abilities and the guilt felt when we do succeed leads us to **fear success.**

When we fear success, we don't actively pursue it. And as such, we don't embrace the mindset required to lead ourselves and our teams to change.

Flipping the script from 'Am I worthy?' to 'I am worthy!' is the first step to recognise that you deserve the changes that will help you, your family, your business and your community thrive.

05 LACK OF PLANNING

In order to lead to change, we need to understand where we want to get to. This is where planning comes in.

Planning helps to overcome our fears and procrastination by reducing risk, establishing contingencies and creating greater certainty. We'll dig deeper into *Planning* (aka our third pillar) in length in the next article. Stay tuned.

Leadership is an Active Process, Not Passive

At the core of leadership, is our ability to adapt and pivot. To recognise the challenges we face and to lead ourselves and our team to change when the old ways simply won't cut it anymore takes:

- courage
- passion
- grit
- endurance
- skill
- confidence.

Put simply, it takes work.

The 'set and forget' attitude to leadership increasingly highlights the frustrations felt by teams in many workplaces.

But it's those that take an active role in leadership, who empower themselves and others with the ability to make meaningful change that stand apart from the rest.

But it all starts with you first accepting, embracing and acknowledging the need to change.

By this point in time, you might still be thinking, 'I don't need to change'.

> **"CHANGE WILL NOT COME IF WE WAIT FOR SOME OTHER PERSON OR SOME OTHER TIME. WE ARE THE ONES WE'VE BEEN WAITING FOR. WE ARE THE CHANGE THAT WE SEEK."**
>
> - Barack Obama

Here are my top tips to looking at change a bit differently:

- Step into a place of neutral.
- Park the ego aside.
- Seek the support and guidance of people that have walked in your shoes before.
- Explore where your fears are coded from.
- Step back to step forward.
- Use those around you to provide feedback and insights about your leadership.
- Go against the norm to do what's best for you.
- Remember that you are solely responsible for the failures and successes of your business.

Before we sign off, it's important to note that change can mean limitless things.

It doesn't mean that you have to do a shopfit, spend millions of dollars on the latest and greatest gadgets, employ new team members or launch a new product or service.

It could simply be the change of mindset required to look at your business through a different lens.

Or it could be that you're simply asking the wrong questions to begin with. Reframing your questions to seek and consider alternative solutions rather than jumping at the first thought is critical to mine for the gold you seek (remember, the best answers come from the best questions).

But in all instances, be sure to seek input from those around you. The collective minds and thoughts will help you be the leader you need to be to embrace change from the beginning.

So given the above ... **What is your definition of change at this very moment? And how will you accept, embrace and build your skills to be a leader to change?**

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To become part of our global community supporting healthpreneurs from all walks of life, head to **facebook.com/groups/zamilsolanki** or scan the QR code below. As we're growing a like-minded community that truly values health, be sure to answer all of the questions to gain entry. There's no right or wrong!

ABOUT THE AUTHOR

Zamil Solanki works with healthpreneurs—from individuals to large multinational organisations—to help them overcome unique challenges and achieve their goals through curated training programs and tailored holistic solutions.

Unlike other coaches and consultants, we pair global research and techniques with our own experiences, having grown our own pharmacy by $4 million and exiting it for 3x the industry average multiple. To do this, we focus holistically using 5 key pillars: mindset, planning, leadership, marketing and sales and specialise in workflow, innovation, automation and systems.

Zamil Solanki
Pharmacist, Business Strategist & Entrepreneurial Coach

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Brenden Seri,
Ingham Wholelife Pharmacy & Healthfoods, North QLD

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AUTOMATION IS CHANGING PHARMACY WORK

For the Better

Ingham Wholelife Pharmacy & Healthfoods in tropical North Queensland recently underwent a total renovation, with the acquisition of a BD Rowa™ Automatic Dispensing Robot and BD Rowa™ ProLog being a couple of the main improvements. Staff now claim these machines have become indispensable parts of their work life, increasing sales and freeing up time for pharmacists to better assist customers. We talked to pharmacy manager, Brenden Seri, who gave us a clearer picture of the benefits.

Words | Brenden Seri
Pharmacy Manager, Ingham Wholelife Pharmacy & Healthfoods

Please describe your pharmacy in a few words, and please tell us how long you've been running it.

Ingham is a rural town based predominately around the sugarcane industry and has one of the higher proportions of older residents in the state. Our pharmacy has been an icon of the town since the 1970s and has been under the current ownership since 2011. It's one of the main anchor tenants of the town's most well-known shopping precinct, Hinchinbrook Central. In April 2021, we started work on a total renovation and conversion to Ingham Wholelife Pharmacy & Healthfoods. Our BD Rowa™ Automatic Dispensing Robot is one of the focal points of the transition. We're now a forward-dispensing pharmacy and have enjoyed getting our pharmacists back in front of our customers.

You installed your BD Rowa™ Automatic Dispensing Robot with BD Rowa™ ProLog in May just last year. Was it a long decision-making process? What were the main reasons you decided to invest in a BD Rowa™ Automatic Dispensing Robot? What goals did you want to achieve for your pharmacy?

Yes, it was a long decision-making process. It started years before actually signing the order with Andrew from BD Rowa™. I always knew that if I refitted the store, a BD Rowa™ Robot would be high on my list of 'must-haves'. But I was motivated to not let the robot be the only change. I wanted to be able to leverage off its capabilities, but how I was going to do that became obvious when my Sigma representative introduced me to the Wholelife Pharmacy & Healthfoods franchise option. They had created a range of products within their stores that would be complementary to our pharmacy. The diverse range and the potential increase in availability of our talented staff to the customers created the right environment for the robot to become part of the team.

What was the initial reaction of your staff? Was the BD Rowa™ Automatic Dispensing Robot greeted with enthusiasm from the start?

Our staff couldn't believe we were getting such an item in our modest rural pharmacy. There were lots of questions because they hadn't had the advantage of ever seeing one before and what they were capable of. 'Sceptical' is probably the word that comes to mind, but I believe that feeling would be gone now.

Did it take time to get used to it? What were the biggest changes to routines and where did you notice the first improvements?

Because we changed our brand, our products and our layout, it was a lot to make work over the first three months. But what was immediately obvious was the fact that we didn't have to worry about the BD Rowa™ Automatic Dispensing Robot, and we could focus on learning the rest of the changes. As time passed and we sorted out our customer-facing problems, we started knuckling down on using the BD Rowa™ Mosaic software and the BD Rowa™ Automatic Dispensing Robot to their full potential. Putting away stock and Dose Administration Aids (DAA) dispensing runs were the first routines that changed for the better.

What has changed most in the daily routine of your pharmacy since then? Where have things changed for the better? How has this impacted your general business and the quality of patient consultations, and did you identify efficiencies and time saved? Did it help to increase your customer base?

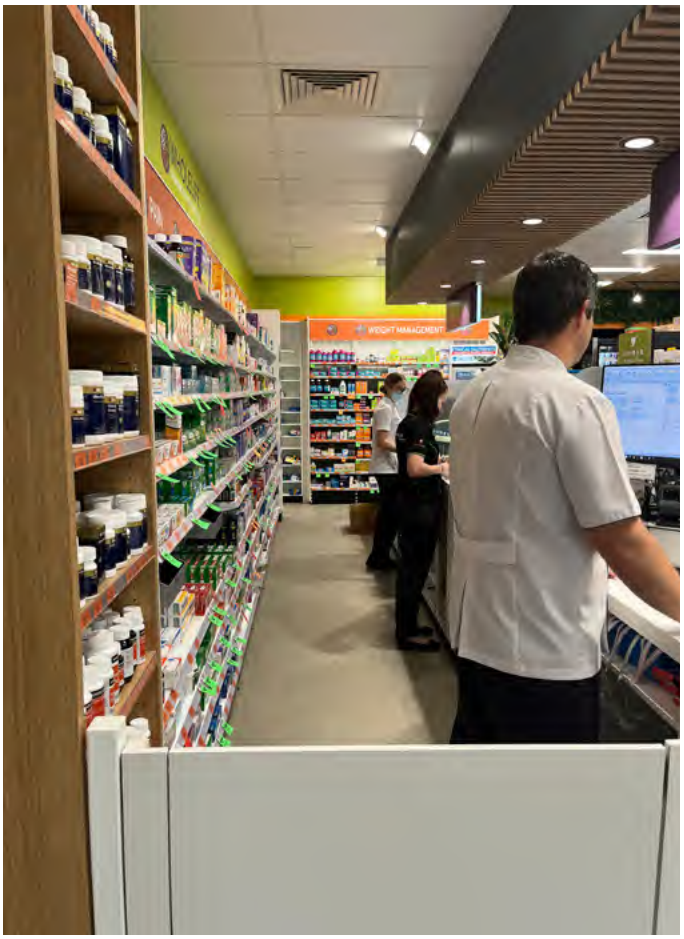
Putting away stock is the biggest difference. We used to have stacks of totes in front of the dispensary aisles that would sit there for days during busy times. This would lead to us having to rummage through trying to find the stock that hadn't made it onto the shelf yet—such a mess! E-prescriptions and a BD Rowa™ Automatic Dispensing Robot with BD Rowa™ ProLog are an exceptional match—all of the fundamental stuff is taken care of, and the pharmacist is able to spend more time checking interactions and liaising with the patients about how to achieve the optimal use of their medicines. We now have pharmacists at the script in-and-out counter doing above 80% of the consultations; probably up from 5% in our old workflow. Our customer base has grown since the refit was completed.

Did you notice a sales increase in health schedule over the counter (OTC) items after the installation of the robot? How did you calculate or measure the changes?

Wanting to be able to measure this—and in consultation with The Next Step consulting—we developed a report that measured our health schedule items vs. our prescription volume, excluding any facility dispensing we'd done. I believe that this measure would be the best way for us to see if forward pharmacy was achieving its goals. Not only forward pharmacy, but also our whole team's efficiency because if all our routines and staffing are optimised, then our most skilled staff will be in front of our customers a lot more often. This allows them to improve their health outcomes and recommend new products to complement their regimes. In 2021, we saw a 26.71% increase in this ratio when comparing the first six months to the second six months of the year.

Given the current challenges around resourcing, especially in a regional area, can you tell us if automation has helped alleviate these challenges?

This question requires a double-edged answer. Purely looking at our pharmacist employment, the BD Rowa™ Automatic Dispensing Robot helps the pharmacists do their job more efficiently. If we let them rest on their laurels, we wouldn't need to employ any more pharmacists. Dispensing, checking and labelling is very quick and easy. But we don't intend to let them rest, and since we're trying to achieve full scope of practice, the BD Rowa™ Robot will let the simple things become easy and there'll be no excuses for not interacting with patients and implementing new programs as they become reality. So really, recruiting pharmacists is still key when you have a BD Rowa™ Automatic Dispensing Robot.



How do you and your staff feel about your BD Rowa™ Automatic Dispensing Robot today? To what extent is it a fully integrated part of your team?

'Scriptor', our robots name, is part of the team now. He never complains, will work after hours, cleans himself and loves to work. Can't imagine not having him and doing things the way we used to.

For pharmacy owners considering automating with a BD Rowa™ Automatic Dispensing Robot, what would be your recommendation or advice to someone considering making the investment?

Go and see one in action. Speak to the owner and ask the floor staff what it has meant to their daily routines. Seeing is believing, I strongly believe that. It blows your mind. The trade shows don't do them justice. Unfortunately, there aren't a lot of quantitative facts and figures you can see—you need to experience it.

FIND OUT MORE

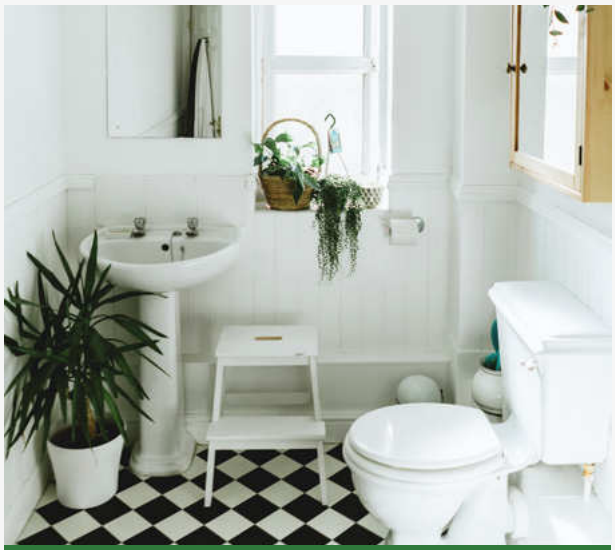
To learn more about BD Rowa™ solutions, you can visit the website: **bd.com/rowa**

This interview has been conducted by BD Rowa™ and produced in partnership with Gold Cross Products & Services, as a paid advertorial for Gold Cross publications.

CONTINUING PROFESSIONAL DEVELOPMENT

SUBMIT YOUR ANSWERS TO EARN CPD CREDITS

Answers can be submitted through GuildEd at guilded.guild.org.au. Australian College of Pharmacy members can submit answers online at acp.edu.au in the CPD Library.



ASSESSMENT Q'S | **P.55**

ASSESSMENT Q'S | **P.56**

42 Urinary & Faecal Incontinence

- List the different classifications of urinary incontinence
- Briefly describe the pathophysiology of urinary incontinence
- Discuss medicines and aids for the management of faecal and urinary incontinence
- List medicines and other substances that can exacerbate incontinence.

49 The Leadership Process

- Describe leadership using the Leadership Process Model
- Discuss insights from the Leadership Process Model in long-term leadership development
- Apply practical tools from the Leadership Process Model in long-term leadership development.

URINARY & FAECAL INCONTINENCE

While urinary incontinence (UI) is not a life-threatening condition, it does have a significant adverse effect on quality of life and is a major health burden in the older population. Incontinence is a key trigger factor in deciding to move older adults into long-term residential care and has been found to be second only to dementia. Apart from the social and emotional consequences, incontinence brings a greater risk of skin and urinary tract infections and is associated with a higher risk of falls.

Words | Jo Comper

Learning Objectives

After completing this activity pharmacists should be able to:

- List the different classifications of urinary incontinence
- Briefly describe the pathophysiology of urinary incontience
- Discuss medicines and aids for the management of faecal and urinary incontience
- List medicines and other substances that can exacerbate incontinence

2016 Competency standards addressed:

2.2, 2.3, 3.1, 3.2, 3.5, 3.6

apc ACCREDITED CPD

Accreditation Number: A2204ITK1

Expires: 31/03/2024

This activity has been accredited for 1 hour of Group 1 CPD (or 1.0 CPD credit) suitable for inclusion in an individual pharmacist's CPD plan which can be converted to 1 hour of Group 2 CPD (or 2.0 CPD credits) upon successful completion of relevant assessment activities.

Introduction

This article will briefly discuss the pathophysiology, treatment options and medications used in urinary incontinence for adults. The article will also briefly discuss the management of faecal incontinence.

Urinary Incontinence

Normally, the bladder and urethral sphincter work in unison to regulate the flow of urine. The bladder wall has a unique cellular structure that allows it to expand and accommodate an increasing amount of urine until voluntary bladder emptying occurs.

The urge to urinate typically becomes apparent with a urine volume of approximately 150 mL and becomes urgent with volumes of about 400 mL. Approximately 50 mL remains in the bladder after urination (residual volume).[ii]

The bladder has two modes of operation:

- storage/expansion
- contraction

During this cycle the urethral sphincter must resist the pressure exerted by the bladder until it receives the voluntary signal to relax. A few seconds after this, the bladder begins to contract, augmenting the flow of urine.[ii]

Urinary incontinence can occur when the system is disrupted. The different types of UI are summarised in Table 1.[iiii, iv]

Type of urinary incontinence	Description
Stress incontinence	The urethral sphincter is unable to resist the pressure (or stress) exerted by the bladder. Often leakage will be precipitated by exertion, lifting, exercise, coughing, laughing or sneezing.
Urge incontinence	The bladder contracts prematurely. This is accompanied by a feeling of urgency. The patient has difficulty holding their urine until they get to the toilet.
Mixed incontinence	A combination of failure of the urethral sphincter and premature bladder contraction leading to a mixture of stress and urge incontinence.
Overflow incontinence	Due to an overfilled and distended bladder from over activity of the urethral sphincter preventing normal urine flow or other outflow obstruction (e.g., enlarged prostate). Overflow incontinence can also be caused by a weakened bladder detrusor muscle that will not sufficiently empty the bladder. Overflow incontinence is sometimes also referred to as urinary retention.
Functional incontinence	No impairment of the lower urinary system, but cognitive or mobility factors prevent the person from getting to the toilet in time.

Table 1: *Summary of different types of urinary incontinence*

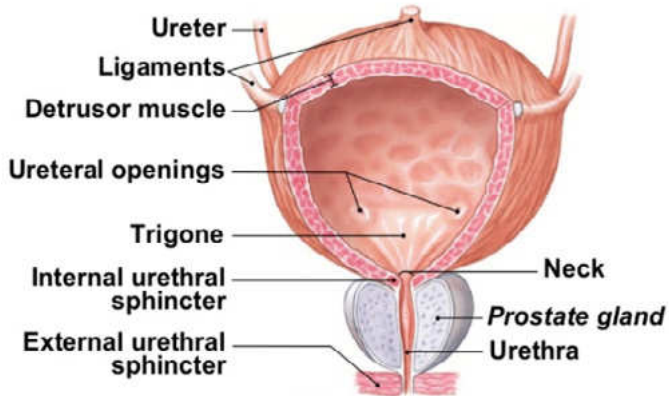


Figure 1: Diagram of the male urinary bladder

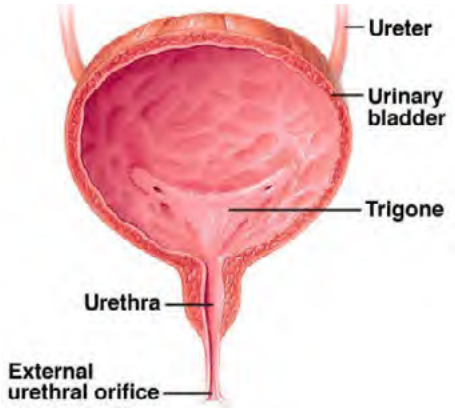


Figure 2: Diagram of the female urinary bladder

PREVELANCE OF URINARY INCONTINENCE IN AUSTRALIA

A 2013 report by the Australian Institutes of Health and Welfare summarised epidemiological data of UI in Australia.[v] In general, UI affects more women than men and increases with age. There are also different peaks in prevalence for the type of UI depending on the woman's age

- Stress incontinence peak: 25.3% of females aged 35-44 years
- Mixed incontinence peak: 20.6% of females aged 55-64 years
- Urge incontinence peak: 24.2% of females aged 75 years and over.

TREATING URINARY INCONTINENCE

Lifestyle modifications

There are a number of simple approaches that may be trialled before medications or surgery are instigated:

- Smoking cessation is critical in reducing chronic cough which results in pressure on the pelvic floor muscles, especially in women.[vi]
- Monitoring fluid intake, especially alcohol, carbonated beverages and diet beverages may highlight causative factors. It is suggested small amounts are drunk frequently, up to 2L/day. [vii]
- Reduced caffeine intake should be recommended, [viii] although high quality evidence does not support this strategy.
- Weight loss (8%) can provide significant improvement.[vii]
- Toilet scheduling, i.e., going to the toilet every 2–3 hours can be particularly useful for patients with reduced bladder sensation.[vi]

Pelvic Floor Exercises

There have been numerous trials of the benefits of pelvic floor exercises for the management of incontinence. They are considered the first-line treatment for most patients with stress incontinence, both men and women. Cure rates of about 50% can be expected in most women. For men, the evidence of the benefits of pelvic floor exercises after prostatectomy is less clear cut.[vii, ix]

Most exercise programs continue for at least three months and involve repeating the exercise two or three times per day. This eventually increases the urethral closure pressure and so reduces the incidence of stress incontinence. Exercise also seems to reduce/suppress the reflex involved in involuntary bladder contractions. Coaching by a qualified practitioner is a key to success to ensure that the exercises are completed correctly.[vii,ix]

Pharmacological Treatments

There are a range of medications commonly used to reduce long-term UI. The most suitable medicine will not only depend on the type of incontinence, but also other co-morbidities. Patients may have unrealistic expectations of the efficacy of drug treatments. Most medications will reduce but not eliminate incontinence. A combination of behavioural modifications and medicines have significant overall benefits when compared to medication-only strategies.[x] Finally, UI caused by a urinary tract infection is managed with antibiotics.

URGE INCONTINENCE

Antimuscarinic Agents

There are five types of muscarinic receptors found throughout the body. In the lower urinary tract M2 and M3 types predominate. The M3 receptors are primarily responsible for bladder contraction[ii]. Antimuscarinic agents are contraindicated in patients with urinary retention, gastric retention and untreated narrow-angle glaucoma. They should be used with caution in patients with clinically significant bladder outlet obstruction, decreased gastrointestinal motility, treated for narrow angle glaucoma and myasthenia gravis. They cause frequent adverse effects such as dry mouth, constipation, blurred vision and drowsiness. These effects are dose-related and can severely limit tolerability, especially in elderly patients. Antimuscarinics may also produce confusion, especially in elderly patients with pre-existing dementia.[xi]

The older non-selective antimuscarinic drugs, oxybutynin, tolterodine and propantheline will affect all types of muscarinic receptors, hence causing the typical anticholinergic side effects of dry mouth, sedation, blurred vision, constipation and dizziness.[xi] Oxybutynin was shown to be more efficacious than propantheline in a small randomised controlled trial (RCT). [xii] An RCT comparing oral oxybutynin and oral tolterodine reported significantly more side effects with oxybutynin.

Oxybutynin is also available as a twice-weekly patch and may have reduced levels of anticholinergic side effects compared to the tablets. There is however no advantage in efficacy and the patches cause skin reactions in approximately 10% of users. There are guidelines on how to apply the patch, application site and disposal. Consumer information is available at **https://www.nps.org.au/medicine-finder/oxytrol-transdermal-system.**

The newer more selective antimuscarinic agents, solifenacin and darifenacin are more (but not completely) specific to the M3 receptors found in the bladder. They have a reduced rate

and severity of anticholinergic side effects. However, at higher doses these side effects become more apparent. For example, the reported incidence of xerostomia in the general use of oxybutynin, tolterodine, solifenacin 10mg dose and darifenacin 15mg is as follows 12.1%, 35%, 27.6% and 35.3% respectively.[xi]

The benefits of antimuscarinics are modest. For example, darifenacin was found to reduce the mean number of incontinence episodes by two per week when compared to placebo. Solifenacin appears to approximately halve the number of incontinence episodes compared to placebo.[xi] Currently, oxybutynin and propantheline are the only medicines in this class that are listed on the Pharmaceutical Benefits Scheme (PBS).

QT prolongation

All antimuscarinics can induce QT prolongation; hence it is appropriate to pay particular attention to other medicines the patient is dispensed at hospital dispensaries and at other community pharmacies which can prolong QT interval e.g., moxifloxacin. Solifenacin has the highest rate of QT prolongation amongst this group.[xv]

β3-Agonists

Mirabegron is the first in class of a new type of β3-agonist used for urge incontinence. Activation of the β3 receptors in the bladder helps relax the detrusor muscle to increase bladder capacity. However, its efficacy seems modest with a decrease of 1.5 incontinence episodes per day compared to a decrease of 1.1 episodes with placebo, no significant difference.[xvi] Common side effects are relatively benign and at low rates. Cardiac side effects (tachycardia, hypertension, palpitations and atrial fibrillation) have been reported, suggesting non-specific agonist activity at β2 adreno-receptors also.[xvii] As of March 2022, it is not listed on the PBS.

Intra-vaginal Oestrogen

National Institute for Health and Care Excellence (NICE) both recommend intravaginal oestrogen for the treatment of urinary incontinence and symptoms of vulvovaginal atrophy in postmenopausal women.[viii] In women taking systemic oral conjugated equine oestrogen as hormone replacement therapy (HRT) who develop or have worsening urinary incontinence, discuss alternative hormone replacement therapies. A Cochrane review revealed oral conjugated equine oestrogen worsened urinary incomitance.[xviii]

Botulinum Toxin

A more targeted approach is to use botulinum toxin injected into the detrusor muscle during a cystoscopy. The botulinum toxin prevents the release of acetylcholine and so reduces the activity of the detrusor muscle. Injections will have to be repeated every 4–9 months as the toxin wears off. This approach carries the risk of temporary urinary retention (about 5% of patients) and increased risk of UTIs. Trials have demonstrated that botulinum toxin decreases the frequency of urge incontinence episodes by 2.65 per day compared to placebo (decrease of 0.9 episodes). About 27% of patients become fully continent.[xix]

Combination Pharmacotherapy

Mirabegron plus solifenacin might reduce daily incontinence episodes and micturition compared to monotherapy with either medicine in patients with overactive bladder.[xx]

STRESS INCONTIENCE

There are limited pharmacological treatments for stress incontinence. As previously mentioned, pelvic floor exercises are recommended as first-line therapy. Surgical techniques that use a sling to support the bladder outlet and urethra are the most common types of procedure.[xxi]

Duloxetine is a serotonin and noradrenaline reuptake inhibitor which has been licensed for use in stress incontinence in Europe after it demonstrated benefit in reducing mild stress incontinence in women.[xxii, xxiii]It is not licensed for this indication in Australia; however, it may be useful in patients with concurrent depression or diabetic neuropathy.[xxiv]

OVERFLOW INCONTIENCE

There are approaches that can be used to ameliorate overflow incontinence:

- Reduction in urethral closure forces or
- Catheters or surgical technique to bypass the bladder outlet.

Often with prolonged bladder outlet obstruction, the bladder will tend to become overactive. This is mediated via the M2 and M3 receptors. Hence, the antimuscarinic medication previously discussed may have a role. However, in men, more typically an α1 adrenoceptor antagonist or 5α-reductase inhibitor is used as first-line therapy.[ii,iii]

α1-Blockers help improve bladder obstruction by relaxing the smooth muscle around the bladder neck and prostate. [xxv] Tamsulosin, silodosin and alfuzosin are more selective for the α1 receptors that predominate in the bladder and prostate, whilst prazosin is less selective and more likely to cause hypotension as it also acts via α1 receptors in vascular smooth muscle. Prazosin has a short half-life of 2–3 hours and therefore needs to be dosed up to three times daily. Common side effects with α1 receptor blockers include hypotension (>10% for prazosin and <1% for selective α1-Blockers) and dizziness, nasal congestion (4% for prazosin and <1% for selective α1-Blockers), somnolence (6.9% for prazosin) and ejaculation disorder with up to 35% for the more selective agents, silodosin has the greatest incidence.[xxvi]

5α-reductase inhibitors (finasteride and dutasteride) reduce the conversion of testosterone to dihydrotestosterone, an androgen

that stimulates prostate growth. 5α-reductase inhibitors may take six months for symptoms to improve, and full benefit may take 12–18 months. The α-blockers tend to offer an improvement in symptoms after about two days and a full effect in 4–6 weeks. They are effective irrespective of prostate size. The 5α-reductase inhibitors tend to only be effective when the prostate is larger than about 30–40 cubic centimeters (cc). The advantage of the 5α-reductase inhibitors is that they reduce the rate of disease progression, reduce PSA (prostate specific antigen) levels by about 50% and reduce the risk of developing prostate cancer.[xxv] Common side effects include fatigue, loss of libido and erectile dysfunction. Dutasteride has a long half-life of up to five weeks, hence these side effects can last long after the medication has been ceased.[xi] Finally, gynecomastia develops (1–2% incidence). Two studies suggest 5α-reductase inhibitors are associated with serious prostate cancer, but no causal relationship has been proven.[xxv]

MEDICATIONS THAT EXACERBATE URINARY INCONTINENCE

Pharmacists are in a unique position to identify possible medications that exacerbate urinary incontinence. These are summarised in Table 2.

Type of Urinary Incontience	Mechanism of side effect	Main Examples
Overflow/Urinary retention	Excess relaxation of bladder or decrease bladder contraction	Anticholinergics, tricyclic antidepressants and antipsychotics with anticholinergic properties, calcium channel blockers, dopamine agonists, opioids, skeletal muscle relaxants
Stress	Reduction in urethral sphincter tone, or drugs that cause cough	Alpha blockers reduce sphincter tone, while ACE-Inhibitors (and ARBs) can cause cough.
Urge	Increased urine output or increased bladder contractions	Acetylcholinesterase inhibitors e.g., donepezil, incidence 1–3% and often transient following initiation Drugs with diuretic action including alcohol, caffeine, thiazide and loop diuretics
Functional	Medications that impair cognitive function, cause sedation, nocturnal diuresis	Alcohol, antidepressants, antipsychotics, opioids, sedatives, antihistamines, skeletal muscle relaxants

Table 2: *Medications that can exacerbate urinary incontience* [xi]

Faecal Incontinence

Like urinary incontinence, many patients are reluctant to seek help for faecal incontinence due to embarrassment. The pharmacist is well placed to encourage patients to seek further information and talk to their GP about the problem.

The definition of faecal incontinence varies, but typically specifies the involuntary passing of flatus, liquid or solids. Like urinary incontinence, the incidence of faecal incontinence rises with age with no significant variation between male or female patients. For adults under 40 years, faecal incontinence is more common in women, mainly due to a previous history of birth by vaginal delivery.[xxviii,xxix]

Faecal incontinence is typically multifactorial but is broadly classified into two main types:

- Urge incontinence where the patient is sensitive to the need to defecate, but is unable to resist
- Passive incontinence occurs without prior sensation.

The consistency and type of stool is important. Larger than normal volumes of loose stools can overfill the rectum. Hard stools can lead to faecal impaction and subsequent overflow diarrhoea.

Medications can be one important risk factor. These are highlighted in Table 3.

Mechanism	Examples
Altered sphincter tone	nitrates, calcium channel blockers, β blockers, SSRIs
Broad spectrum antibiotics	penicillins, cephalosporins
Increased loose stools	metformin, orlistat, SSRIs, digoxin, magnesium contain-ing antacids, laxatives
Constipation-causing drugs leading to overflow diarrhea	loperamide, codeine, tricyclic antidepressants
Reduced alertness	multiple sedatives, antidepressants, antipsychotics, opioids

Table 3: *Medications associated with faecal incontinence*[xi]

Diet is also worthy of investigation. There are many foods and drinks that can cause loose stools. These include figs, plums, prunes and rhubarb (which contain natural laxatives), chilli and artificial sweeteners. Beers and stout are also likely to soften stools.[xxviii]

Apart from ruling out medication and dietary related factors, there are a limited range of pharmacological treatments. Loperamide can be used to firm up the stools by slowing colonic transit time and possibly increasing the internal anal sphincter tone. There is very little absorption (0.3%) with loperamide and hence has rare central nervous system (CNS) side effects.[xi] There is a risk of causing constipation and subsequent overflow diarrhoea. Loperamide should be dosed 30 minutes before meals and prior to social events or travelling to avoid accidents. Fibre supplements can be used when there is chronic diarrhoea and normal storage capacity in the bowel. However, if the bowel's capacity is small then a low fibre diet may be beneficial to reduce the volume of stool the bowel can accommodate. Fibre should be introduced slowly to reduce flatulence.[xxviii, xxix]

Pelvic floor exercises also have a role in improving faecal incontinence. Like any exercise program, doing the exercisecorrectly and consistently is the key to success.[xx]

Selecting Continence Aids

Selection of continence aids can be challenging, and advice from pharmacy staff is often welcomed by patients and their caregivers. Factors that impact on product selection include:

- Type of incontinence
- Severity of incontinence
- Sex of the patient
- Degree of manual dexterity of the patient
- Level of independence or access to care
- Body shape
- Cost
- Lifestyle considerations
- Personal preference.

Most patients will opt for absorbent pads, with women finding pads more acceptable. Some men may prefer a device such as a catheter. However, there is a good range of devices for both men and women, including protective mattress pads. Patients with functional incontinence may require a urinal (available for males and females) or a commode if they find they are unable to get to the toilet in time.

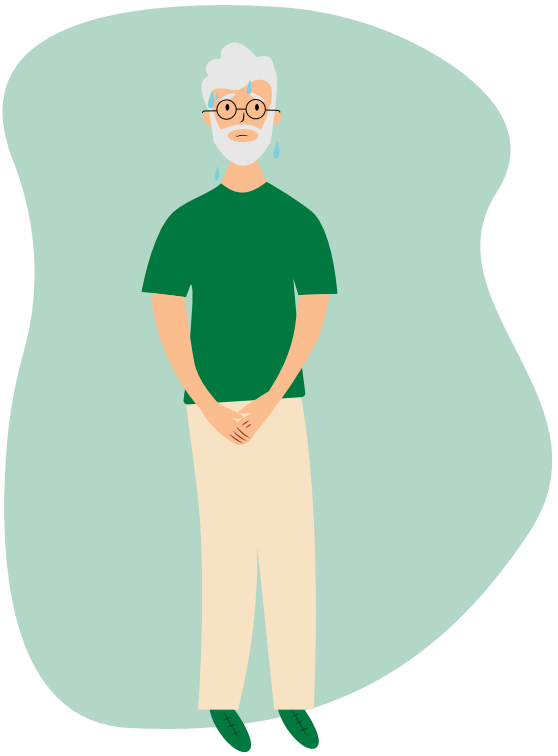
A handy guide to help pharmacy staff select the correct continence aid can be found at **http://www.continenceproductadvisor.org/.**

Referal to Other Health Professionals

Often the patient's GP is the first port of call for advice on incontinence. A specialist urologist, gynaecologist, geriatrician or colorectal surgeon may also be consulted.

Referral to a continence nurse advisor is valuable for specialised assistance and development of an incontinence management plan. This can be done in clinic or in the home.

Some physiotherapists specialise in women's health or pelvic floor exercises, and occupational therapists help with co-ordination of care to ensure the patient maintains their desired level of independence.



Conclusion

Successful management of urinary or faecal incontinence requires careful consideration of lifestyle and medication factors that may be exacerbating the problem. Many patients are reluctant to discuss the issue and unlikely to have undergone examination by their GP.

Pharmacological treatments do have their place, but patients need to be aware of common side effects and expected efficacy to make informed decisions.

RESOURCES

Further information and excellent resources for both patients and health professionals are available from the 'Continence Foundation of Australia' http://www.continence.org.au/.

National continence helpline 1800 33 00 66

Management guidelines for incontinence are available here http://www.continence.org.au/pages/management-guidelines.html

Financial assistance to help cover the costs of incontinence aids for people with permanent and severe incontinence is available from the Commonwealth Government via the Continence Aids Payment Scheme (CAPS) and the DVA Rehabilitation Appliances Program (RAP) for Department of Veteran's Affairs card holders.

Help services for incontinence care are also available from foundations supporting health conditions associated with incontinence e.g. Alzheimer's Australia, National Stroke Foundation, Parkinson's Australia etc. A list of these is available at http://www.continence.org.au/pages/useful-links.html.

The Australian Continence Exchange has a number of resources and networking options for health professionals involved in continence care http://www.continencexchange.org.au/

Advice on selection of continence aids is available at http://www.continenceproductadvisor.org/

THE LEADERSHIP PROCESS

Effective and successful leadership is about setting direction for the team, getting team members to do the right things and experiencing growth within oneself. Successful indicators are not just limited to team performance, achieving objectives or team cohesion. Being a journey of discovery, reflection and learning, long-term leadership is also measured by leadership growth over time. Leadership is a long-term process in which, in a very real and practical way, all actions have consequences.

Words | Robin Tang and Mark Lock

Learning Objectives

After completing this activity pharmacists should be able to:

- Describe leadership using the Leadership Process Model
- Discuss insights from the Leadership Process Model in long-term leadership development
- Apply practical tools from the Leadership Process Model in long-term leadership development.

2016 Competency standards addressed:

1.1, 1.2, 1.4, 1.5, 2.2, 2.3, 2.4

apc ACCREDITED CPD

Accreditation Number: A2204ITK2

Expires: 31/03/2024

This activity has been accredited for 0.75hrs of Group 1 CPD (or 0.75 CPD credits) suitable for inclusion in an individual pharmacist's CPD plan which can be converted to 0.75hrs of Group 2 CPD (or 1.5 CPD credits) upon successful completion of relevant assessment activities.

Introduction

There are many important leadership considerations, including the meaning and purpose behind leadership, contrasting differences and similarities between management and leadership, leadership styles and traits. To encapsulate the process and understanding of leadership, a visual and conceptual framework introduced by Dunham and Pierce helps us conceive why it is important to adopt a positive, relational and long-term approach to leadership (Dunham R.B. 1989). This article explores the Leadership Process Model and how it can be applied to your own situation.

The Leadership Process Model

Developed by Dunham and Pierce in their 1989 published book, Managing, the 'Leadership Process Model' is a complex, dynamic and continuous exchange between four key components in the entire leadership process (Dunham R.B. 1989). See Figure 1 for a simplified version. The complexity explains that successful leadership is not always dependent on the same factors. Invariably, even when all the right components are aligned, there is no guarantee of a successful outcome. Adding to that, the model highlights that leadership is an ongoing and evolving process; therefore, it is important to be flexible, depending on the context and outcomes and to invest continually in your relationship with your followers. Essentially, everything affects everything else. In a very real way, negative actions feed back to negatively affect future performance, and positive actions feed back to improve future performance.

The Leadership Process Model shows the relationship between four key factors that contribute to leadership success or failure. These are;

1. Leader
2. Followers
3. The Context or Situation
4. Outcomes

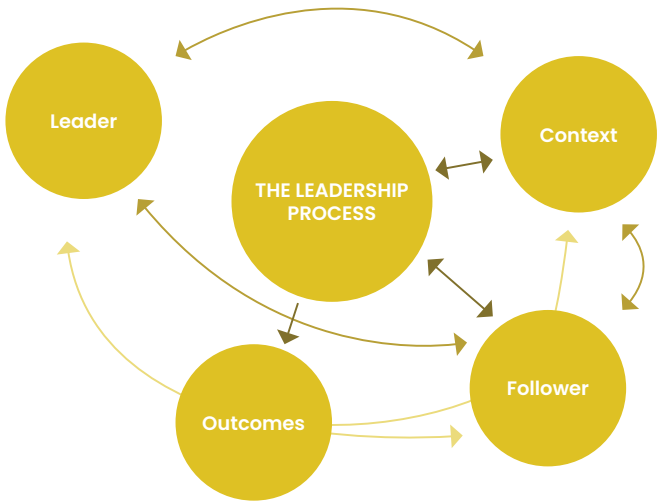


Figure 1: The Leadership Process Model

These are the results of the process. Outcomes could mean reaching a particular goal, developing a high-quality product or resolving a customer service issue; and could also include improved trust and respect between the leader and followers or higher team morale.

According to this model, an understanding of leadership and the leadership process necessitates the development and understanding of the leader, the followers, the context, the process and the resulting consequences (e.g., leader → follower or follower → leader), its relational impact on successful outcomes, future transactions, developmental opportunities etc. From this conceptual framework, Pierce and Newstrom highlighted several ways that you can apply the insights from this framework to your own development as a leader and to the development of your people (Pierce J.L. 2000).

These include:

01 Ethical and transformational leadership

This model illustrates the relationship between leader and followers. If this relationship is built on mutual trust and respect, then the context and outcomes will mostly eventuate on a positive note. However, if the relationship is based on animosity, resentment or even fear, the effect on context and outcomes will likely be negative. Your people need and deserve a leader they can trust and look up to. For this reason, it is important to be an ethical leader. Ethical leaders set and define the standard and put that into practice consistently. Clearly identifying, defining and setting ethical standards in your organisation are the first steps in permeating ethical stances deep within the team and organisational culture (Brown M.E. 2005). These are the questions you should ask:

1. What are the important behaviours and values to my organisation and why are they important?
2. What are the specific values that we should be working towards?
3. How do key stakeholders see me and how do they want to see me?

After clearly setting the tone and identifying the core values, an ethical leader leads by example, creating the right environment within the team to cultivate such values. Ethical leaders promote the aligned values and behaviour, and incentivise team members who consistently act accordingly (Resick C.J. 2006). Consequences should be established for team members who do not follow the set values with remedial actions taken to avoid future occurrence.

Importantly, team members need to understand, be interested in, and be intrinsically motivated to embrace these core values (Brown M.E. 2005). As a leader, be prepared to be challenged with ethical dilemmas. When challenged by these tough situations, listen to your core instincts, trust your core values, and always go back to basics. Leaders lead best by example, and actions speak louder than words.

When choosing a leadership style to follow, Transformational Leadership is highly desirable. Transformational leaders: (Bass B.M. 1994)

- Act with integrity
- Set clear goals
- Communicate well with their team members
- Inspire people with a shared vision of the future.

However,leaders occasionally need to adopt different leadership approaches to fit a particular follower,outcome or context. Therefore, it helps to be able to use other leadership styles when appropriate.

02 Provide and receive regular feedback

Probably the most important thing that the Leadership Process Model highlights is how important it is to provide 'good' feedback so that your team can grow and develop. When you give feedback to your team, it influences the context and helps to improve the outcome. This then cycles back to influence you and your team in a positive way. Regular feedback also helps you take your people in the right direction as outcomes and the context change. A simple and logical tool to help frame, plan and prepare for a feedback session is the Feedback Matrix (Garber P.R. 2004). See Figure 2.

Figure 2: The feedback matrix

This matrix allows the scene to be set, it explains and provides a better understanding of the purpose and meaning of the feedback session. This allows a clear and simple way of communication, with the emphasis of keeping the session with one single idea or action, and not complicating the issue. Another important point is to address the problem, not the person. This effectively removes any possible tension caused by the feedback

Finally, focus the feedback on a joint effort. Engagement and involvement normally lead to acceptance and commitment, with the suggestions and recommendations to be actionable, measurable and accountable. As important as it is to give feedback, receiving feedback and appraisals forms an important role in self-evaluation and development as a leader. An important and often used tool is 360-degree feedback. Mostly used in organisations in administrative decisions related to pay and promotions, 360-degree feedback can also be useful in leadership self-evaluation and developmental purposes.

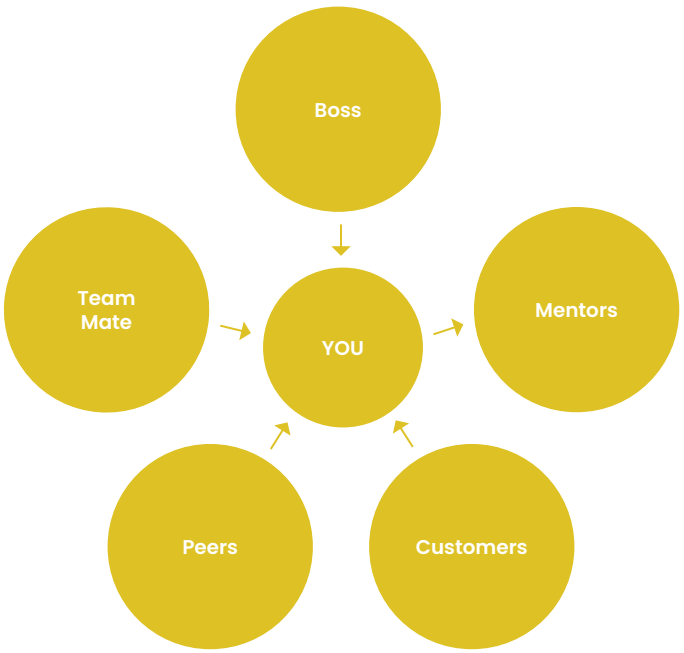


Figure 3: 360-degree feedback

The Linking Leader Profile (LLP) is a 360-degree feedback tool that provides the information to increase one's self-awareness (Margerison C.J. 1995). It is a powerful tool that allows you to receive feedback from various sources; thereby giving valuable insights into how others see you. From the multi-dimensional information received, this gives an honest and solid foundation to develop leadership and personal growth.

03 Develop self-awareness and personal development

Leaders often depend on their people more than team members depend on their leaders. Working relationships should therefore be built on trust, respect and transparency. The deeper the relationship a leader has with their team, the better a leader can be. Leaders should begin by developing emotional intelligence. People with high emotional intelligence are self-aware, manage their emotions and act according to ethics and values.

When people see their leader as empathic, they feel the leader is on their side and can see things from their perspective. This deepens the relationship the team has with the leader. Relationship development starts from powerful conversations that enable a deeper and mean ingful exploration of oneself. Gratton and Goshal term such conversations and engagement 'Creative Dialogue' (Gratton L. 2002). Based on research over five years in organisations around the world, Gratton and Goshal have created a dialogue matrix (Figure 4).

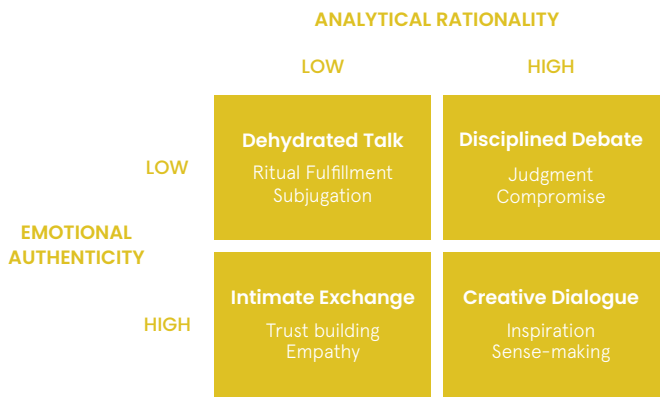


Figure 4: The 'Dialogue Matrix'

Creative Dialogue occurs when there is high level of analytical rationality and emotional authenticity. It is this kind of conversation and exchange that produces inspiration, sense making, trust, creativity and authenticity. Whenever there is Creative Dialogue, the topics and agenda are generally loose and relatively unformed, giving people the required space and energy to combine rationality and emotional engagement. Hindering factors include indifference and cynicism, both of which destroy the developmental opportunity in creating such exchanges.

04 Develop self-awareness and personal development

The Leadership Process model makes it clear that every action taken (whether these are decisions made, statements produced, verbal and non-verbal communication) will produce an impact and/or consequence/s. Every action has a reaction. Leaders, followers, the context and the outcome are all tied together in a dynamic relationship.

It is essential that leaders always keep this in mind. There will be consequences when leaders say something thoughtless or lash out at a team member, even if these consequences are not seen immediately. Consequences might include:

- Diminished performance
- Reduced morale
- Increased absenteeism
- Accelerated staff turnover.

Developing the skill of awareness takes time. However, there is a balance between awareness and 'overt awareness', which could create tension and reduce team confidence.

Therefore, it is important to develop self-mastery, both of thoughts and of actions. Bringing self-mastery to a more personal level, Peter Senge places considerable weight on the importance of Personal Mastery in the development of successful organisation (Senge P.M. 1990).

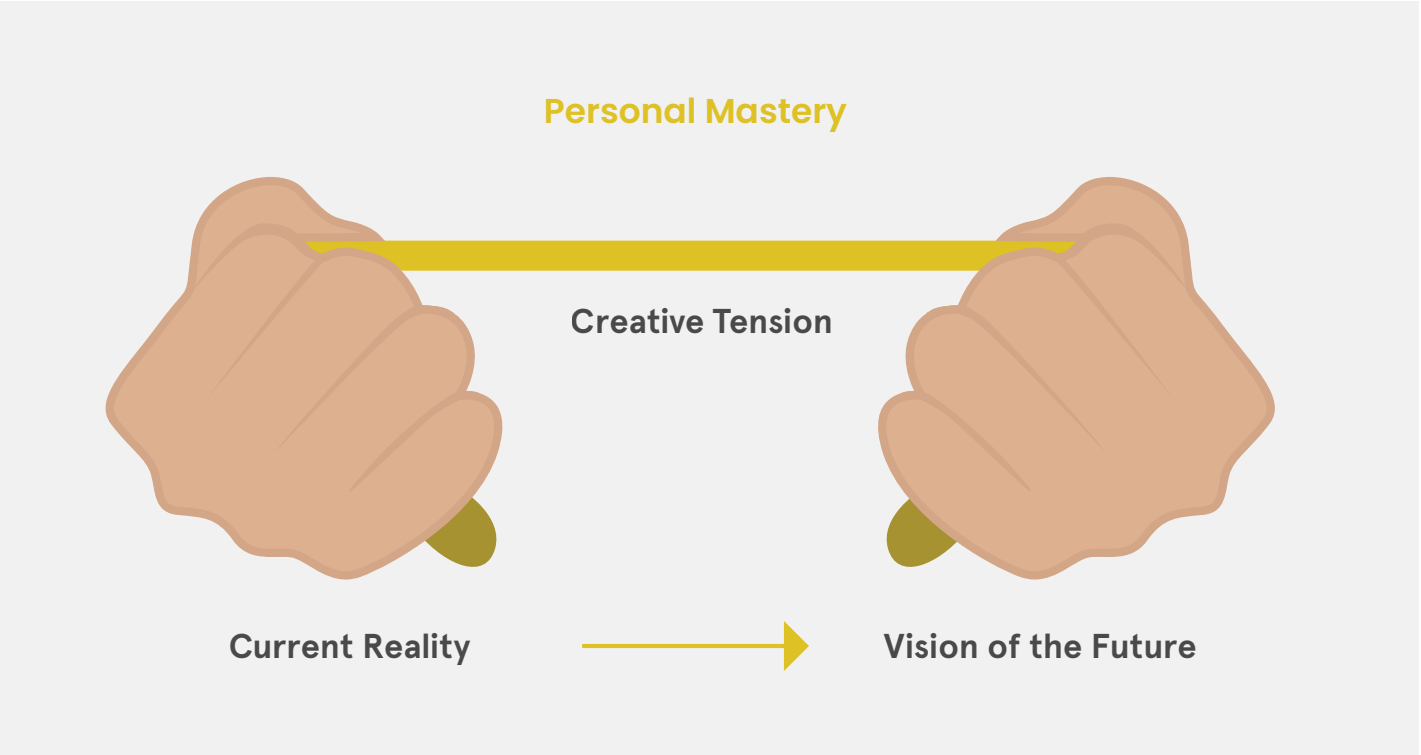


Figure 5: Personal Mastery (Source: Senge P. (1998) The Fifth Disciplie Fieldbook: Strategies and Tools for Building a Learning Organization)

Personal Mastery goes beyond mastery of competence and skills. When practised as a discipline, integrating self-mastery into our lives asks two questions:

1. What does our personal vision look like and what is really important for us?
2. What is our current reality?

Personal vision is not just goals and objectives. It operates at a higher level as a blueprint from which actions and goals can flow. A true and authentic personal vision requires having a clear view of how we would like our lives to be, which goes beyond specific wants and needs like promotions, new house, qualifications and so on. It is certainly not an instant process and it may take some time of reflection to clarify. Just as important, our vision may change according to time as we experience and learn new things.

The second step is to clearly articulate and hold a clear picture of the current reality. Our personal understanding of current reality is heavily dependent on self-reflection and through rich conversations with people who hold different perspectives from our own. What follows is the bringing together of the Current Reality and Personal Vision with Creative Tension. Senge claims that the essence of Personal Mastery is learning how to generate and sustain this Creative Tension in our lives. This is the juxtaposition of our vision, what we want, and a clear picture of where we are relative to what we want.

From here, we can use this as our source of energy that will enable us to achieve our vision. As suggested in Figure 5, there could be only two ways to resolve this tension: pulling towards the Current Reality or going in the other direction, through making small and measurable steps towards the Personal Vision.

Summary

The Leadership Process Model highlights the dynamic and long-term nature of leadership. The interrelationship between each of the key components produces the resulting impact known as the leadership outcome. As well as having an awareness and understanding of the model, there are lessons that can be learned to become a more effective leader. These are:

1. Lead ethically
2. Focus on developing relationships
3. Develop self-awareness and awareness in relation to others
4. Develop a personal growth plan
5. Receive feedback with a view to improve
6. Give feedback with future positive expectation
7. Lead by example

Overall, the Leadership Process Model demonstrates the interdependent nature of leadership and its effects on situations and outcomes. Leaders can use this framework to be aware of their actions and to deepen the relationships they have with their people.

REFERENCES

1. Bass B.M., A. B. J. (1994). Improving organizational effectiveness through transformational leadership. Thousand Oaks, Sage Publications.
2. Brown M.E., T. L. K., Harrison D.A. (2005). "Ethical Leadership: A social learning perspective for construct development and testing. Organizational Behaviour and Human Decision Processes."Organizational Behaviour and Human Decision Processes 97: 117-134.
3. Dunham R.B. , P. J. A. (1989). Management. Illinois, Scott Forseman.
4. Garber P.R. (2004). Giving and Receiving Performance Feedback. Amherst, HRD Press, Inc.
5. Gratton L., G. S. (2002). "Improving the quality of conversations "Organizational Dynamics 31 (3): 209-223.
6. Margerison C.J., M. D. J. (1995). Team Management: Practical New Approaches. London, Management Books 2000.
7. Pierce J.L. , N. J. W. (2000). Leaders and Leadership Process. Boston, McGraw-Hill.
8. Resick C.J., H. P. J., Dickson M.W., Mitchelson J.K. (2006). "A cross-cultural examination of the endorsement of ethica leadership "Journal of Business Ethics 63 (345-359).
9. Senge P.M. (1990). The Fifth Discipline: The Art and Practice of the Learning Organization. London, Random House.

Urinary and Faecal Incontinence

01 **Helen is a 42-year-old mum of four children and her youngest is 13 months. She is looking at the shelf with menstruation pads and comes over to ask you if there is anything more appropriate for urinary incontinence. She complains of urinating small amounts when she has to pick up her two youngest children, and while gardening and coughing. What type of urinary incontinence does she have?**

a) Urge
b) Stress
c) Overflow
d) Functional

02 **You direct Helen to patient information regarding non-pharmacological treatment but ask her what medicines she is taking. She is currently on Fluoxetine and prazosin for post-traumatic stress disorder, and Noriday™ and amlodipine for her hypertension. Which medicines have been associated with worsening incontinence?**

a) Fluoxetine
b) Prazosin
c) Noriday™
d) Amlodipine

03 **Overflow incontinence or urinary retention is ...**

a) Related to cognitive and/or mobility factors. There is no pathophysiological deficit in the lower urinary tract.
b) When the bladder contracts prematurely.
c) The over-activity of the urethral sphincter or weakened bladder detrusor muscle that will not sufficiently empty the bladder.
d) When the urethral sphincter is unable to resist the pressure (or stress) exerted by the bladder.

04 **You are undertaking a review of your aged care patients and note functional incontinence in Doreen; a 78-year-old with dementia. She has been on donepezil for 3 years and the family perceive it is effective. No medicines are prescribed for urinary incontinence and there are no new medicines in the last 3 months since your last review. What action would you take?**

a) None, it is not likely to be the donepezil. However, an appropriate continence aid may help manage the UI symptoms experienced by the patient.
b) Ask to cease the donepezil as this is the likely cause.
c) Suggest oxybutynin to manage the incontinence.
d) Suggest to cease the donepezil and add in oxybutynin.

05 **All opioids can slow the transit time of the colon and induce constipation, but why is loperamide preferred over other opioids such as codeine?**

a) It slows the colon transit time more than codeine.
b) It has a faster onset of action.
c) It has greater bioavailability.
d) There is very limited absorption, hence reducing the incidence of CNS side effects.

LEARNING OBJECTIVES

After completing this CPD activity, pharmacists should be able to:

- List the different classifications of urinary incontinence
- Briefly describe the pathophysiology of urinary incontience
- Discuss medicines and aids for the management of faecal and urinary incontience
- List medicines and other substances that can exacerbate incontinence

SUBMIT YOUR ANSWERS TO EARN CPD CREDITS

Answers can be submitted through GuildEd at guilded.guild.org.au. Australasian College of Pharmacy members can submit answers online at acp.edu.au in the CPD Library.

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The Leadership Process

01 According to the Leadership Process Model, the key components are:

a) Leader, Follower, Context, Leadership Style, Ethics.
b) Context, Leader, Leadership Processes, Outcomes.
c) Situation, leader, follower, outcomes
d) Context, leader, follower, outcomes, leadership processes

02 The Leadership Process Model highlights key lessons to be learned when it comes to becoming a more effective leader. They are:

a) Prepare to give and receive feedback, lead ethically, lead with examples and actions, use transactional leadership most of the time.
b) Lead with examples and actions, lead ethically, listen actively, deliver regular feedback, focus on developing long-term relationships.
c) Receive feedback with a view to improve, develop self-awareness, develop self-mastery, lead ethically only at appropriate times.
d) Focus on developing relationships, give feedback and receive feedback only when it is necessary, use a transformational leadership style.

03 Creative Dialogue occurs when there is:

a) Low emotional authenticity and high analytical rationality.
b) High emotional authenticity and low analytical rationality.
c) High emotional authenticity and high analytical rationality.
d) Low emotional authenticity and low analytical rationality.

04 Leaders need to focus more on developing long-term relationships with followers to establish trust, respect, and transparency, often in workplaces where there is a lack of motivation, emotional engagement and drive. Which of the following are suggestions to create authenticity, purpose, motivation and creativity within the workplace?

a) Promote short, sharp bursts of creative dialogue where topics and agenda are generally loose. Be prepared to engage in challenging dilemmas.
b) Engage in disciplined debates during discussion times and only use intimate exchanges during lunch breaks.
c) Focus on long and time-consuming discussions during staff meetings and reserve casual intimate exchanges during lunch breaks.
d) Focus on working within yourself and only rely on your teammates when necessary.

05 A personal leadership development plan plays an important role in Claire's journey in her role as a leader. After engaging with her selected stakeholders and organised feedback sessions for continual reflection and development, Claire has decided to use Peter Senge's concept of Personal Mastery to map out her future vision. It is important for Claire to consider:

a) Clarifying her current reality through self-analysis and 360-degree feedback through using the Leader Linking Profile.
b) Using creative tension by mapping out small incremental steps that are tangible, measurable and accountable to draw closer to her future vision.
c) Ensuring there is not too much tension (stress and burnout) and not too little tension (no improvement) by balancing her creative tension.
d) All of the above

LEARNING OBJECTIVES

After completing this CPD activity, pharmacists should be able to:

- Describe leadership using the Leadership Process Model
- Discuss insights from the Leadership Process Model in long-term leadership development
- Apply practical tools from the Leadership Process Model in long-term leadership development.

SUBMIT YOUR ANSWERS TO EARN CPD CREDITS

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