SUMMER 2017

MIMS matters

What a year – it's time for the Holiday Season!

Robert Best
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MIMS Australia Pty Ltd
MIMS New Zealand Ltd
eHealthWise Services Pty Ltd
Board Member – MSIA (Medical Software Industry Association) of Australia

I would like to welcome our readers, partners and customers to our final MIMS Matters for 2017 – our Summer Edition!

As we approach the end of another year, like all of us, it makes you stop and reflect on the last 12 months. I'm exceptionally proud of the MIMS and eHealthWise teams for all their efforts during 2017. This year has been our most exciting and rewarding – in fact, a historical best ever company performance across our group business, so a big thank you to all our staff, customers and partners for their ongoing support.

Throughout 2017, our core focus never wavered – to continue to be the leading brand and product of choice, used by thousands of healthcare professionals, who everyday make critical drug and medicine related decisions at the point of care. Accordingly, we ensure we attend, sponsor and participate across a large number of market leading Industry Conferences, Forums and Events covering Australia and New Zealand. We proudly supported Pharmacy Interns of the Year, participated in Industry Stakeholder sessions, and held constructive product design and roadmap workshops with both MIMS End Users and our numerous Medical Software Vendor partners. During the year, we also launched our new Content Management System (CMS) and we are now ready for all new TGA PI Reformatting initiatives that will come into play from 2018.

As we look towards 2018-2019, I am proud to have been nominated and selected to join the Board of the MSIA (Medical Software Industry Association), and to announce our MIMS Honorary Advisory Board and MIMS Alumni for 2018/19 (please refer to article on page 4). With our new Advisory Board members, our MIMS family has further diversified and extended to include some of Australia's top calibre healthcare professionals across a broader coverage of the Healthcare industry. We also welcome Gaurav Sood, our new Head of Product for Australia and New Zealand (please refer to article on back page) who is busy finalising our new 3 year strategic product roadmap to kick off in 2018.

In closing, I would like to take the opportunity to wish all of you a happy and safe holiday period, and we look forward to working with you during 2018, when we are back, energised and ready to kick off the new year!

MIMS Christmas Party

We celebrated the end of 2017 on our beautiful Sydney Harbour in "Christmas theme" style – spending time enjoying each other's company and bonding as colleagues and friends. Cruising Sydney Harbour during the twilight hours was truly an amazing experience, while sharing quality time talking through the past year and the exciting opportunities ahead of us in 2018.

This Issue...

The Search for Better Clinical Decision Support: Drug Interaction Alerts in Focus

It comes as no surprise that the drug interaction alert screen is, by far, the most frequently ignored screen in any clinical software. Doctors, pharmacists and nurses know it: our finger is already anxiously hovering over the 'Enter' key before this seemingly obnoxious screen displays. We bypass the drug interaction details before we could even process the content that flashed by. Yet statistics indicate that clinical errors within major hospitals could occur as frequently as one error per patient and that prescribing errors account for 2.5% of all medicine orders.[1,2] If so, why are we still ignoring these very important screens?

Alert fatigue appears to be the overriding culprit based on research. [1-6] Users are constantly bombarded with too many alerts containing information that is either irrelevant, unhelpful or both – a trend seen in prescribing and dispensing software across both primary and acute healthcare settings. [3,4] A multitude of assessment tools have been used in studies to analyse differences between alert display in different software applications and to compare alerts in common secondary references to those displayed in software applications. [1-6]

Many of these studies, however, have one common shortcoming: they look at individual interactions in terms of content, format and language but do not take into consideration factors surrounding drug interactions as a whole. This oversimplifies the problem and results in suggested solutions that may not necessarily be helpful. Alert fatigue does not occur as the result of one poorly displayed drug interaction. It is often the consequence of many contributing factors.

FACTORS CONTRIBUTING TO ALERT FATIGUE WITHIN INDIVIDUAL DRUG ALERTS

Severity filters

A study states that 'designers and vendors sharply limit the ability to modify system alerts because they fear being exposed to liability if they permit removal of warning that would prevent harmful prescribing errors' [4] whereas, in actual fact, many knowledge providers and software designers already provide such a feature to enable adjustment of severity filters. Rather, it is the users and organisations they work for who decide to minimally adjust filters. This is not a design issue but a question of liability – ultimately, no party wants to bear the burden of responsibility for a medication-related error. This instinctive nature is something that even the most advanced computer system can not change.

Content

Another study suggests that there is a 'lack of information on clinical effects and management advice'. [3] A step back from this observation reveals two possible causes: (1) limited research into the drug interaction of interest, and (2) failure of knowledge providers to maintain an up-to-date database of drug interactions reflective of current clinical recommendations. It is noteworthy that only the latter is a software issue. If the level of evidence remains limited for a particular drug interaction, then this is not a software design issue but a clinical question that the scientific community, as a whole, needs to answer.

Route of administration

Research argues that drug interaction alerts can be made more relevant by being more specific to the route of administration (e.g. if the offending medication is a topical preparation with negligible systemic absorption). [3,4] While this is true in a generic sense, it is important to consider situations that are more complex, such as:

- multiple interacting medications ordered at different prescribing levels (e.g. a doctor may wish to prescribe paracetamol and leave it to the nurse's discretion to nominate a suitable route depending on the patient's ability to swallow) or;
- extemporaneous preparations containing ingredients normally administered via a different route (e.g. interactions for an oral agent may not necessarily apply when it is added into topical preparation)

Moreover, in a software application designed for the hospital setting at an international scale, it is important to consider the fact that different drug databases may be used in different countries, and that not all drug databases provide drug interaction data at the same level. For example, First Data Bank and MIMS provide interactions data specific to the route of administration, where as Thesorimed and Farmadati provide interactions data at the generic level. This poses a challenge for software developers because the system's alert-triggering infrastructure needs to function seamlessly, despite differences within each data source. Route of administration is not as simple as it seems. We need to define what we want under all circumstances before jumping to a generic conclusion.

Discontinued medications

A study also recommends removal of drug interaction alerts for medications no longer taken by patient. [3] While this appears to be a logical suggestion for most situations, we need to consider outliers such as:

- drugs with a long half-life (e.g. MAOIs and fluoxetine where drug interactions may occur 14 days following cessation of the drug)
- antidepressant changeover periods (when it is important to acknowledge the risk of serotonin toxicity if the second antidepressant is initiated too closely to the first antidepressant which has been ceased)

The question of whether to exclude drug interactions for discontinued medications becomes a question of which drugs and for how long.

FACTORS AFFECTING DRUG INTERACTION ALERTS AS A WHOLE

Situations with >1 drug interaction

Current research provides valuable suggestions on improvements to the layout, format and content of single drug interaction alerts but provides very few (if any) recommendations on the display of multiple drug interaction alerts, despite the fact that alert fatigue is more likely to occur with multiple alerts compared to a single alert. Aspects to avoid when designing a screen for multiple drug interaction alerts include:

- unnecessary scrolling (because users never scroll)
- additional clicking (which will impede workflow)
- displaying everything on the same screen (information overload)

Yet, if we look at this list carefully, one might ask what other ways there are to display information when screen space is limited and we do not want to scroll, click or display all details at the same time? Screen design becomes an ultimate dilemma. It is a fine balance of many on-screen factors where nothing will be perfect regardless of what we decide on.

Other clinical alerts

Clinical decision support is not just about drug interactions. A myriad of other clinical alerts exist: duplicate therapy, drug allergy, drug-disease contraindications, pregnancy and lactation precautions and drug-dose thresholds. As healthcare professionals, we are trained to process and prioritise these clinical concerns within seconds of reviewing a patient's medicines list. Our clinical experience and professional judgement empowers us with the ability to filter across different clinical alert types to pinpoint and act on the most important concerns for the patient. Replicating this skill in a computer system is much more difficult. Within a drug database, each clinical alert type is contained within a different dataset with a different set of severity ratings (e.g. moderate drug interaction, Category X for pregnancy). We are yet to generate an algorithm that can prioritise across different clinical alert types. How do we build a system that can outsmart years of clinical experience combined with professional judgement?

Alerts at different stages of patient care (e.g. admission/inpatient/discharge), episodes and visits

Around half of hospital medication errors occur on admission, transfer and discharge. [1] Of these, about 30% have the potential to cause patient harm. [1] Medication reconciliation plays a large role in minimising these errors, and clinical decision support (which includes drug interaction alerts) is an important component of the medication reconciliation process. However, if we have so many different aspects to consider during the medication reconciliation process (e.g. changes to the medication, dose, strength, timing of administration, associated vital signs and laboratory results, progressive changes to the patient's condition, other relevant clinical aspects), how do we reduce the amount of information and number of alerts displayed when all the details are important, just for different patients and to different users at different times under different circumstances? How do we build a system that caters for everyone without making incorrect assumptions about what they know (and don't know) by removing 'insignificant' and 'irrelevant' drug interaction alerts?

WHERE TO FROM HERE?

There is a clear need for guidelines to regulate the on-screen display of drug interaction alerts. [1-6] We are, however, far from reaching this target: questions still exist around the display of individual drug interaction alerts; research has not yet evaluated the effectiveness of screen display for multiple drug interaction alerts. It took years of speculation before the Australian Commission on Safety and Quality in Healthcare developed national guidelines for on-screen display of clinical medicine information in January 2016. Considering the complexity of issues around clinical decision support, it may take years before regulatory guidelines are developed for the on-screen display of drug interaction alerts.

This makes it even more important for us to take a proactive approach. Organisations such as MSIA are in the perfect position to start a conversation among knowledge bases, software developers and users. Our knowledge and understanding needs to be shared vertically amongst different parties, as well as horizontally between competing parties.

Only through collaboration can we match the needs of users with what knowledge bases and software developers can realistically provide. Only through collaboration can we excel clinical decision support to the next level.

About the Author

Susan Cheng is a registered pharmacist, currently working as an eMedication Management Specialist at Intersystems. Her areas of specialty include drug databases and clinical decision support.

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MIMS Honorary Advisory Board and MIMS Alumni

In October 2017, MIMS Australia put out a Call for Expressions of Interest to join a new MIMS Honorary Advisory Board. The role of the Board is to offer timely and appropriate advice and consultation on MIMS content and product development. It is intended to represent the MIMS user community and the contributions of the Board have had a profound influence on the theoretical and practical development of the MIMS suite of products in the past.

MIMS received over 100 expressions of interest from professionals representing many specialty healthcare areas. The process was extremely competitive and the selection committee was humbled by the diversity and calibre of the applicants that were interested in contributing to the future development of MIMS.

We are pleased to announce that the 2018-2019 Board will comprise a combination of returning and newly appointed members. They are:

Dr Debra Deasey

Debbie is a Nurse Practitioner based at Port Macquarie Base Hospital. She specialises in caring for the aged.

Associate Professor Deborah Rigby

Debbie is an Adjunct Associate Professor, University of Queensland and a Visiting Fellow, Queensland University of Technology. She regularly writes for the Australian Journal of Pharmacy, is currently Director of NPS Medicine Wise and Clinical Reference Lead for the Australian Digital Health Agency.

Associate Professor Fenton O'Leary

Fenton is the Clinical Associate Professor, University of Sydney Medical School. He is a consultant Emergency Physician and the Director of Emergency Medicine Training at The Children's Hospital, Westmead. He is also Associate Editor for Social Media Journal of Paediatrics and Child Health.

Professor Gregory Peterson

A community pharmacist, Gregory is also Deputy Dean, Faculty of Health and Professor of Pharmacy at the University of Tasmania. Additionally, he is Co-Director of Health Services Innovation Tasmania.

Dr Hanan Khalil

Hanan is Editor in Chief of the International Journal of Evidence based Health Care and Director of the Centre for Chronic Diseases Management, Joanna Briggs Institute. An experienced pharmacy practitioner, she has published articles in the areas of medication management, chronic diseases and evidence based health care.

Associate Professor Jeremy Shapiro

Jeremy is a Consultant Medical Oncologist, Cabrini Hospital and Adjunct Associate Professor, Monash University Department of Medicine (Alfred Hospital).

Dr John Ainge

John is a practising GP with extensive experience in design, distribution and support of practice management and clinical systems. His previous projects include concept development, and design of award winning consumer health website: myDr.com.au.

Professor John Ziegler

John heads the Department of Immunology and Infectious Diseases, Sydney Children's Hospital and is Professor of Paediatrics (conjoint), School of Women's and Children's Health, University of NSW. He is also a member of the Advisory Committee on Prescription Medicines.

Professor Richard Harvey

Richard is a psychiatrist in private practice specialising in telepsychiatry. He is also the clinical advisor on Psychiatry for the Australian Healthcare Regulatory Authority and Clinical Professor, School of Medicine, Deakin University.

Dr Robin Mann

Robin's background is in Health Informatics, but he also has experience in clinical medicine and academia. He is currently National Chief of Innovation, Little Company of Mary Healthcare (Calvary).

Stephen Wiblin

A nurse practitioner, Steve is currently the Head of Clinical Strategy and Development Allity Aged Care.

Dr Thomas Shafee

A biochemist and bioinformatician focusing on protein engineering, Thomas is extensively published and is also on the editorial board of the WikiJournal of Medicine.

MIMS Australia would also like to recognise the contribution made by three of our previous Board members by announcing them as the first to be named on the list of MIMS Alumni. They are:

Chris Wills

A registered Pharmacist, Chris was publisher and managing director of the MIMS Australia and New Zealand business from 1973 to 2007. He served on the MIMS Advisory Board from 2007 to 2017, and his advice will continue to be sought as the business moves into 2018.

Professor Ken Fitch

Ken is a sports and exercise physician at the School of Human Sciences, University of Western Australia. A member of the Medical Commission of the International Olympic Committee from 1985 to 2012, he has served on the MIMS Editorial Board since 1991 and has been instrumental in helping MIMS Australia successfully classify drugs in the MIMS database with respect to their status in sport. He will continue to provide regular advice to MIMS in this regard.

Professor Peter Carroll

Peter is Professor and Head of Pharmacology, School of Medicine, University of Notre Dame, Sydney and Honorary Professor of Pharmacology, Sydney Medical School, University of Sydney. He is also President, NSW Branch of the Pharmaceutical Society of Australia and a practising Pharmacist. Peter has served on the MIMS Editorial Board since it's inception and as the Chairperson from 1995 to 2017.

MIMS Australia would like to thank everyone that expressed an interest in serving on the 2018-2019 MIMS Honorary Editorial Board, and congratulate both new and returning members on their selection.

Medical Software Industry Association and MIMS

Dr Andrew Maginnis & Dinah Graham

The MSIA goal is to power a vibrant and successful medical software industry and promote the value of technology to improve health outcomes. MIMS shares this goal and our database powers the majority of clinical software used in Australia and South East Asia.

This shared goal has seen MIMS be a member of this organisation since the early 2000s and in all that time a MIMS representative has been a member of the Board.

The MSIA is governed by a volunteer Board elected by the Members. The Board is accountable to members and stakeholders for MSIA performance and is responsible for the development of strategies and policies that shape future direction and service delivery, whilst maintaining and developing MSIA values and ensuring these values are reflected in organisational behaviour and practice.

In November this year Robert Best our CEO was voted onto the Board by the Members at the AGM – happily the tradition continues.

Being a Member of the MSIA is of enormous value to MIMS and has helped the team gain a deep understanding of the issues faced by our partners and allows us to work with those partners to influence efficient delivery of healthcare services and overall health outcomes. The MSIA has representatives on many Government and Industry working groups. In 2017 Dinah Graham our Business Director, Primary Care has participated in the Australian Digital Health Agency Medicines Safety Program Steering Group Meeting as the MSIA representative and together with other members has been able to highlight the problems the clinical software providers are experiencing when using the Australian Medicines Terminology (AMT) codes.

Dinah has been on the MSIA Board for five years, three of those as Secretary. Retiring from the Board in November Dinah was asked to Chair a new Alumni made up of ex Board Members and will continue to have an active role participating in working groups and, together with the other Alumni, working with the Board throughout the year.

Each year, prior to the AGM, the MSIA members nominate and then vote for a person, from a Member Company, who has shown "above average leadership and service in the health software industry". Dinah was the 2017 recipient of the Andrew Maginnis Award.

The MIMS Team are thrilled to see Dinah's work within the health software industry recognised. And, amazed to see her speechless for the first time in all those years when the Award was announced!

Excellence and patient impact

Resident of the Year awards at MM2017

Jimmy Young, Sheridan Briggs accepting on behalf of Sarah Marsh and Peter Fowler

Jimmy Young, Amanda Horiniak & Peter Fowler

Two early career pharmacists were given top honours at Medicines Management 2017, the 43rd SHPA National Conference on the weekend, with the presentation of the inaugural SHPA Resident of the Year Award, supported by MIMS.

Peter Fowler, Chair, SHPA's Residency Committee and Jimmy Young, Business Development Director - Acute Care at MIMS, bestowed the award on Amanda Horiniak, resident pharmacist at Alfred Health.

As a resident undertaking the SHPA Residency Program, Ms Horiniak was recognised for excellence in practice and professional improvement through residency.

In addition, Sarah Marsh, resident pharmacist at Tamworth Rural Referral Hospital was Highly Commended for her professional practice improvement.

Andrew Matthews, SHPA General Manager Workforce Transformation said the judging panel had a tough task deciding a winner, given the high standard of all nominations.

'We wanted the award to reflect the values of SHPA Residency; a professional development program focused on practice-based experiential training in which evaluation, feedback, and reflection are integral components.

'Both Amanda and Sarah's nominations demonstrated their application of performance evaluation and preceptor feedback to improving their clinical practice and their impact on patient care.'

Ms Horiniak said she was truly honoured to receive the SHPA Resident of the Year Award.

'The SHPA Residency Program has provided a training infrastructure that has fast-tracked my professional development. I want to thank my colleagues at Alfred Health for implementing the program and supporting me in my clinical practice.'

Sheridan Briggs, Director of Pharmacy at Tamworth Rural Referral Hospital accepted the Highly Commended award on behalf of Sarah Marsh.

'Rural services don't have the same breadth of resources as in metropolitan hospitals. But Sarah's award shows the dedication and commitment of quality staff supporting training and development ensures high standards are achieved,' said Ms Briggs.

'We've challenged Sarah to excel and she's grasped these challenges and opportunities with enthusiasm.'

The SHPA Resident of the Year Award will be granted annually and continues the tradition of MIMS supporting the pharmacy profession by encouraging innovation and excellence in quality health services to patients.

QLD Health signs new 3 year User Agreement with eHealthWise

eHealthWise

Sydney, Australia, November 27th 2017. QLD Health has signed a 3 year ICT Services Agreement with eHealthWise Services for the provision of electronic claiming for the Child Dental Benefits Scheme (CDBS).

eHealthWise is a wholly owned subsidiary of MIMS Australia – a leading Healthcare provider of medicines information, clinical decision support and knowledge for over 50 years to the majority of Australian Healthcare Professionals . "MIMS and eHealthWise provide a range of integration options to in excess of 80 different IT Vendor Partners" said Robert Best, Executive Director and CEO of MIMS Australia, New Zealand and eHealthWise Services Pty Ltd. "The growing need for more customers to engage with our range of products and services, whether it be to drive billing and e-claiming efficiency, or to minimise patient risk at the point of care, continues to increase. We are delighted to be working with QLD Health and look forward to implementing efficiencies that they will gain from our solution."

"A successful pilot of the THELMA platform implementation in two of Queensland's Hospital and Health Services (HHSs) has resulted in a large number of other HHSs signing up for the service, for implementation in early 2018," said Warren Dunlop, Manager, Clinical Information and Analysis at the Office of the Chief Dental Officer, Department of Health.

"We are excited to be working with the Office of the Chief Dental Officer for QLD Health, in order to implement an electronic hospital claiming solution that has been developed specifically for the Child Dental Benefits Scheme." said Stuart Davies, Business Development Director of eHealthWise. "QLD Health identified a need for electronic claiming to the CDBS to replace manual claims. eHealthWise were able to rapidly integrate with the Department's existing ISOH platform to enable electronic claiming for CDBS patients. eHealthWise's award winning THELMA platform enables QLD Health to replace labour intensive manual claiming processes, thus helping to drive billing efficiencies for the Department across the State."

About eHealthWise

eHealthWise Services is a wholly owned subsidiary of MIMS Australia. Since 2001, eHealthWise has been the provider of THELMA Services - a highly secure, cloud based, low cost electronic health administration transaction solution designed to simplify the healthcare revenue cycle and payments processing. eHealthWise's solutions enable clients to improve efficiency, cash flow and free up staff time to improve the quality of patient care and can be interfaced to any Patient Management System. Throughout 2016, we processed in excess of AUD$830 million of claims value and were awarded NSW Winners of the 2013 ICT iAwards in the Health Industry. Since 2006, we have been an Accredited Medicare Integration Partner, offering our innovative intelligence built into THELMA and have been facilitating the exchange of real-time information and business transactions between health industry partners including: hospitals, health funds, Medicare Australia, medical practitioners and diagnostic providers. For more information visit **www.ehealthwise.com.au**

Black triangle to promote adverse event reporting

The Therapeutic Goods Administration (TGA) is implementing a Black Triangle Scheme.

Commencing January 2018, the scheme is designed to help health professionals and patients to identify certain types of new prescription medicines, and to encourage the reporting of adverse events associated with their use. A similar scheme currently operates throughout the member states of the European Union, including the United Kingdom.

When a medicine or vaccine is first registered and made available in Australia, information about its safety and efficacy is usually available only from clinical trials. Clinical trials generally have strict inclusion criteria and relatively limited numbers of participants. This means it is common for new adverse events to be identified after new medicines are used more broadly in the population.

Accompanying text for PI: 'This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information in Australia. Healthcare professionals are asked to report any suspected adverse events at **www.tga.gov.au/reporting-problems**.'

The black triangle symbol, and accompanying text, will appear on Product Information (PI) and Consumer Medicines Information (CMI) documents of newly registered prescription medicines (with the exception of biosimilar medicines, generic versions of already-approved prescription medicines and seasonal influenza vaccines). It will also be used for all provisionally registered medicines, including those with a provisionally approved indication.

Additionally, other medicines may be included following approval of an extension of indication that is for:

- a significantly different condition; and/or
- use in a significantly different patient population.

The black triangle will also appear in TGA-related material, such as **Australian Public Assessment Reports for prescription medicines (AusPARs)**. Future work will be conducted to include the black triangle in other sources of medicine information.

For medicines included in the scheme, the black triangle will appear on the PI and CMI for five years, starting from the date of first supply.

For provisionally-registered medicines, the black triangle symbol will appear for a period of not less than five years. This will include the entire period of provisional registration, and may include a period of time following full registration. The duration following full registration will be determined during the evaluation of data to support full registration.

The black triangle does not denote that there are known safety problems, just that the TGA is encouraging adverse event reporting to help us build up the full picture of a medicine's safety profile more quickly. Adverse event reporting remains important for all products, including those without a black triangle.

For further information about the TGA's Black Triangle Scheme visit **www.tga.gov.au/black-triangle-scheme**.

Product Information documents to be updated to make clinical information easier to find

A Product Information document (PI) provides health professionals with a summary of the scientific information relevant to the safe and effective use of a particular medicine.

However, sometimes the current format of PI documents in Australia can make the most useful information for health professionals harder to find than it should be.

The primary function of a PI is as a risk-minimisation tool. The PI informs health professionals of the approved indication(s), dosing regimen(s) including dose adjustment, appropriate patient selection (contraindications), important precautions for use and known adverse effects.

The current PI format requires information on a medicine's pharmacology and clinical trials data to be presented ahead of information relating to the clinical use of the medicine. The critical information for health professionals includes the indications, dosage and administration instructions, contraindications, precautions and adverse events information. In current PIs, much of this information is located in the middle or towards the end of the PI, which can frequently be 20 or more pages long. The planned changes will bring this important information to the front of the PI document, making it more readily accessible to health professionals.

TGA has developed the new format in consultation with health professionals, and relevant professional bodies have expressed their support for the changes. In addition, the new format has been developed to align with the formatting requirements of other international regulators, specifically the New Zealand medicines regulator Medsafe and the European Medicines Agency.

The key changes are:

- the content of the PI is being re-ordered to bring critical clinical information together at the front of the document.
- the headings and subheadings have been updated to align with headings used internationally.

Some new subheadings have been added to facilitate harmonisation of the format with that used in New Zealand and Europe. Many currently approved PIs already include content that relates to these headings, for example the effects of the medicine on a person's ability to drive and use machines. For these medicines, this information will now be located in a standardised place in the PI.

The new PI format will be introduced for new medicines approved after 1 January 2018. Existing PI documents will be updated to the new format during a three-year transition period.

Codeine rescheduling for 1 February 2018

From 1 February 2018, all medicines containing codeine will no longer be available without a prescription. This includes over the counter (OTC) codeine-containing combination analgesics (for example Panadeine, Mersyndol and Nurofen Plus), and codeine-containing cough, cold and flu products (for example Codral and Demazin).

The TGA decision has been based predominantly on safety concerns and abuse potential. Medicines available without prescription should be substantially safe and not subject to abuse; this is not the case for codeine. Codeine, like other opioids including morphine, has been linked to opioid tolerance, dependence, toxicity and death.

Some consumers regularly taking medicines containing codeine, for example for chronic pain, have become addicted to codeine without realising. Some of the codeine withdrawal symptoms, such as headache and muscle ache, resemble the symptoms that low-dose codeine products are commonly used to treat, leading consumers to incorrectly continue taking the medicine for longer periods and/or in higher doses. These risks are too high for use of codeine without management by a doctor.

Codeine toxicity is attributable to both accidental and intentional deaths in Australia. Codeine may produce respiratory depression and reduced level of consciousness in overdose. OTC codeine products are combined with other analgesics, such as paracetamol or ibuprofen. Long-term use of high dose paracetamol may result in liver damage, while long-term use of high dose ibuprofen may lead to gastrointestinal bleeding, kidney failure and heart attack.

Codeine functions as an analgesic by conversion to morphine in the body. Genetic variations between individuals cause significant differences in the rate of codeine metabolism, making it harder to predict therapeutic analgesic doses in individual patients. More effective opioid and non-opioid analgesics are available to relieve severe acute pain and cancer pain, and doses of these products are more easily titrated to meet individual requirements.

For mild to moderate acute pain, products containing paracetamol or a nonsteroidal anti-inflammatory drug, such as ibuprofen, or the two products in combination, may provide adequate relief. A pharmacist should be consulted if there are comorbidities, such as stomach, kidney, liver or heart problems. There are also safer and more effective medicines targeted to relieve symptoms of cough, cold and flu without the requirement of codeine.

In common with Australia, a prescription for codeine-containing products is required in the United States, Japan, Russia and many European countries. People with ongoing pain should consult their doctor or other healthcare provider for assessment of their condition, and treatment with the best available options.

MIMS will update the poison schedule of all OTC codeine-containing product listings to prescription only from 1 February 2018.

Information on codeine rescheduling is available from the TGA on the Codeine information hub. **https://www.tga.gov.au/codeine-info-hub**

PSA-MIMS Intern Pharmacist of the Year award 2017

MIMS
100% pure knowledge

Being nominated for, and jointly winning the prestigious PSA-MIMS Intern Pharmacist of the Year award for 2017 was nothing short of inspiring. The award itself recognises the contributions interns make to pharmacy in such a short period of time, and to be sponsored by MIMS –the leading supplier of quality medicines information to Australian healthcare professionals –is truly amazing.

Throughout my intern year, my preceptor provided me with endless opportunities for growth and development. The delivery of professional services was a key aspect of my intern year, and the two programs I championed were smoking cessation and sleep apnoea. Communicating with both customers in my community and staff members in the pharmacy during the initial phase of service delivery, I could see that there was a knowledge gap, and an obvious need for programs like these in my community. There is no doubt that pharmacists are the most accessible healthcare professionals and offering services like these in a community pharmacy setting is leading to better patient outcomes. Additionally, seeing my work directly contribute to the viability of the business was very rewarding.

Since receiving the national award, my commitment to the profession and goals of improving the overall health outcomes of customers in my community has increased. I now work for the Therapeutic Goods Administration in addition to working as a community pharmacist. I also hold a position on the Pharmaceutical Society of Australia's ACT branch committee and am an active member of Rise Above – Capital Region Cancer Relief. I love being involved in so many different aspects of pharmacy and am a firm believer that a career in pharmacy has endless opportunities.

I would strongly encourage anyone thinking about nominating for this prestigious award to enter; with MIMS Australia as the exclusive partner of this award, the opportunities to network are endless and to have your contributions recognised nationally is truly amazing.

Seema Khiani

PSA-MIMS Intern of the Year – A Gateway to Going Far in Pharmacy

Joe Foster M.Pharm MPS

In November 2014, I finished my Masters at Curtin University and embarked on a new adventure; leaving the comfort, familiarity and unrelenting summer heat of Perth and moving to the regional town of Albany in West Australia. I completed my intern year at Brooks Garden Chemmart Pharmacy, a service orientated and friendly Pharmacy that aligned with my values as a recent graduate. What was a one year experiment turned into a three-year adventure, going from an Intern to dispensary manager. What a journey it has been!

In my intern year, I outlined the idea of a more defined Pharmacy triage service; with the goal of providing timely, accessible and accountable referral pathways for Pharmacists to use.

At the end of the year, my preceptor, Brad Smithson, entered me into the PSA WA Intern Pharmacist of the Year (IOTY) award. It was an honour, but it quickly moved to the back of my mind when I passed my final oral exam and was registered as a Pharmacist. In February 2016, I received a call to inform me that I had won, and travelled up to Perth to accept it at the West Australian PSA awards night. It was an incredibly humbling experience being in the same room as Pharmacists who had achieved so much in their careers.

Winning WA IOTY awarded me flights, accommodation and conference fees to PSAs flagship annual conference in Sydney. It was my first experience at a national conference and the buzz was infectious; it was amazing to be in the company of so many Pharmacists who were so passionate about the profession we share. I took the stage with the IOTY winners from other states and territories, and looked on in shock when it was announced that I had won the national award. It was a huge honour, and has shaped my career in Pharmacy in many new and exciting ways.

Winning the national award gave me a $4000 education grant, sponsored by MIMS. The grant allowed me to visit South Korea for FIP Congress in September this year, the prominent international conference for Pharmacists. I spent a week in South Korea learning, connecting and networking with colleagues from all over the world. I have fostered new friendships in Pharmacy, and I hope to return to the congress in 2018 when it lands in Glasgow, Scotland.

Prize money aside, another value of the IOTY award is the connections that it creates. I have been fortunate enough to return to university to teach, as well as be a guest speaker at the National Pharmacy Students Association congress this year in Perth. It has also resulted in my involvement in the PSA WA Early Career Pharmacists working group. I am currently in the newly created R3ECP group, designed to provide a voice to rural, regional and remote early career pharmacists in West Australia. I also have some exciting work coming up in accredited pharmacy with the AACP.

I have always believed my ideal career would be a blended mix of workplaces with varying roles, and winning the IOTY I have been able to realise that ambition, and go far in Pharmacy. I would urge any Intern Pharmacists to reflect on their achievements during the year, and ask their preceptor to pen a submission – that is all it takes to be in the running for a career-changing award!

MIMS Staff Profile

Gaurav Sood
Head of Product
Australia and New Zealand

What is your role at MIMS?

I'm Head of Product for Australia and New Zealand, based out of the Sydney office, but working with a distributed team across APAC. My role involves developing our strategy and innovation capability across all existing and future products. I will be working across the business to develop our roadmap to manage product lines, implement best practice processes and technologies, and develop products to gear MIMS for growth. Reporting to Robert Best, CEO of MIMS Australia, I am aligned with his vision to develop MIMS into the leading industry provider of health knowledge and solutions.

My focus is on delivering increasing value to our customers that enables better delivery of healthcare. As a product lead, I will be working closely with our customers, partners and users to envisage, design and launch our products.

What is your background?

I've had an interest in healthcare since an early age when I wanted to be a cardiologist. I hold a B. Engineering (Telecoms Hons) and B. IT from The Australian National University. My first role was at the Bionic Ear Institute, where I worked on a project to enable volume calibration for infants with cochlear implants that was tested with a person.

My career transitioned to enterprise software and finance platforms where I developed web and integration solutions for global banks, working in Sydney and London. As my passion lay in strategic technology and innovation management, I decided to undertake a MBA from a leading business school to learn how the best companies innovate. IE Business School (Madrid, Spain), is ranked 8th globally by Financial Times, and is recognised for innovation and entrepreneurship. This experience gave me a unique perspective on business strategy based on the latest thinking from industry leaders.

On return to Australia, I worked at a leading pharma analytics company named Prospection as a product manager, providing drug trend, and patient and prescribing behaviour reporting. Since 2013, I've led a health technology innovation community with 1200 members, hosting nearly 30 events and speaking at conferences. I also mentor several startups.

What do you enjoy most about role?

The cross-functional nature of my role involves wearing many hats and thinking through customer, business and technology problems. This gives real exposure to the heartbeat of an organisation and its customers, to create ideas that are differentiated and valuable. The role gives me exposure to keep learning from others with deep expertise, and asking questions to shed light on opportunities to create impact. It is very satisfying when all these concerns line up and you are able to create a product that is loved by customers and generates value for the company.

My philosophy is that success comes from great multi-disciplinary teams, so I like to share my knowledge so that the combination of all ideas will be most optimal. I enjoy these interactions, building diverse and talented teams, and creating valuable products.

What do you enjoy outside the office?

I love tennis, running, yoga and scuba diving. I enjoy getting to a Grand Slam when possible to soak up the rich intercultural, athletic and historical atmosphere, seeing great sportsmen and women at their peak. I've been to Wimbledon, US Open and Australian Open. I like reading a lot of strategy and technology books to keep updated in the latest thinking in innovation, human behaviour, leadership, healthcare and venture capital. I am also a fan of great food, wine and travel. I like to listen to music, cook, and watch films to relax.

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