# GP LINK Lunches | Megan Tremlett

**Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.**

Megan Tremlett

Dr Ken McCroary

**Ken McCroary – An undisputable silver lining from our pandemic has been an increase in collaboration and cooperation, in my opinion, between the various professionals working in Australian healthcare. I've been fortunate enough to have the opportunity to work with non-GP members of the healthcare team as well striving to achieve common goals and positive outcomes for our local South Western Sydney community and wider patient healthcare.**

**Despite ongoing controversies GP link continues to have great relationships with organisations such as the Pharmaceutical Society of Australia and the South Western Sydney Primary Health Network. Most recently we have been collaborating on a project to deliver the Core Palliative care Medicines – Building Collaborative Partnerships with Community Pharmacists project. The aim of this project is to support palliative care in the community across South Western Sydney by increasing timely access to essential medicines for people who wish to die at home or in an aged care setting.**

**One of the goals of this project is to increase collaboration between GPs and our pharmacy colleagues. Working together to develop and deliver palliative care education resources for both pharmacists and general practitioners in South Western Sydney. This will include providing webinar based educational resources for pharmacists and general practitioners particularly regarding the use of the core palliative care medicines list for NSW community pharmacy.**

**I thought I'd explore this project more deeply and I'm lucky to be joined by Megan Tremlett, a senior consulting pharmacist with the Pharmaceutical Society of Australia. Megan works for the Pharmaceutical Society of Australia as a senior pharmacist in the consulting team. PSA is the Australian Government recognised peak national pharmacy organisation championing all of Australia's 36 000 pharmacists working in all sectors and locations. Megan has more than 25 years experience working as a pharmacist across public and private hospital (in Australia and overseas), community pharmacy, consultancy, project management and research. On behalf of PSA Megan has managed a number of palliative care projects at Primary Health Networks and state level in recent years and is currently leading the delivery of the South Western Sydney PHNs project Core Palliative Care Medicines – Building Collaborative Partnerships with Community Pharmacists.**

**Ken McCroary: Thanks Megan, really appreciate you being here. Now we talked about the Expert Advisory Group PSA for core palliative care medicines, building the collaborative partnership with community and pharmacists, can you tell me a bit about that?**

**Megan Tremlett:** Yes thanks so much Ken, it's a great opportunity to have a bit of a yarn about the project. So this particular project is supported by the Australian Government through the South Western Sydney Primary Health Network and it falls under the Greater Choice For At Home Palliative Care Measure and it actually flows on really well from some of the previous palliative work I know you have been involved with yourself Ken, the Peace of Mind project. This particular project has a pharmacy focus and we're about at the mid-point now. It started July last year and will wrap up at the end this year. The primary aim of the project is to support palliative care across South Western Sydney by increasing access to the essential medicines for people who may wish to die at home either in their own private home or in an aged home or facility, so I guess that's the guts of it Ken. Do you want me to go into some detail?

**Ken McCroary: I'll probably go into some detail in a minute but just to clarify, one of my goals is always to increase collaboration in primary health care particularly GPs and pharmacists, because I don't think we collaborate as much as we could to the detriment of our patients, so just for our readers today you are from the PSA yeah, what is PSA and can you give us some background for people who aren't familiar?**

**Megan Tremlett:** PSA is the Pharmaceutical Society of Australia, commonly known as PSA. We're the peak body for all pharmacists nationally regardless of practice setting, pharmacists spread across the country and we're a registered training organisation as well so we're the guardian of the professional practice standard guidelines for pharmacists nationally. There are a number of other bodies in the pharmacy world that represent the owners of community pharmacies or hospital pharmacists, but I guess just to clarify PSA is the peak body of pharmacists regardless of practice setting.

**Ken McCroary: Yeah so there's a difference between the PSA and say The Pharmacy Guild of Australia and the Pharmacy Council of NSW isn't there?**

**Megan Tremlett:** Yes absolutely. So as I said the PSA works at a national level across all practice settings whereas say the Pharmacy Guild their brief is community pharmacy and in particular supporting the needs of community pharmacy and their owners to ensure it is sustainable and viable in a model of care or service provision in the community and then the Society of Hospital Pharmacists of Australia as well is another body that represents pharmacists working in hospitals. It's pretty self-explanatory so I guess PSA is a bit more broad sweeping you might say.

**Ken McCroary: Excellent and thanks. So just returning to the partnership with community pharmacists and the palliative care meds now we're talking about increasing timely access to medications. Any input on that you can share with us?**

**Megan Tremlett:** Yeah sure so I guess to set the scene going back to about 2018, the NSW Clinical Excellence Commission released a core palliative care medicines list for NSW community pharmacy so it was a list of five injectable palliative care medicines that aimed to address the predominate symptoms the majority of people may experience in their last days of life.

The list was developed really considering the efficacy of those medicines in symptom management and also things like cost consideration certainly to the patient and their family or caregiver in terms of the PBS and also I guess a little bit about the costs to pharmacies to routinely stock those items on the shelf. So that list of five core medicines was devised back in 2018 and that list at the moment the injectables include clonazepam, metoclopramide, hyoscine, morphine and haloperidol. For anyone working in the palliative care space they're a pretty good common denominator for the majority of symptoms in palliative care.

The idea of the core medicines list wasn't to dictate to prescribers a list of that's all that could be prescribed, the intent was to get some direction to community pharmacy as to what would be a good baseline, one box of each to keep on the shelves at all times, so that should someone's health deteriorate at short notice and timely access was needed there would be a greater chance of those pharmacies actually holding those medicines on the shelf should a prescription be written.

Of course, that needs to be paired with prescribing and in particular anticipatory prescribing from specialists as well. What we do know from some work done in other states with core medicines listed, it did actually help to increase the number of community pharmacies that routinely stocked that list of medicines and then by socialising that I guess with medical colleagues as prescribers they were understanding of what medicines were likely to be stocked should they be needed at short notice, understanding that within 24 hours they may wish to personalise the care and the prescribing for an individual persons needs and that stock ordered in by the pharmacy as soon as possible. So, the overarching aim is to really enable people who wish to die at home to be able to do so and not end up with an unwanted hospital admission if that is not their preference.

**Ken McCroary: Yeah which is what we sort of want to do, look after our patients and give them, well I've always considered a good death our job as a life journey in general practice, without distress, without pain and you know if you choose to die at home then we want to be doing our best to do that and I think your project is really going to assist with that. One of the things I'm interested in is education and I think it's one of the goals of the project too is to educate GPs and pharmacists about the core medicines list and availability, is that correct?**

**Megan Tremlett:** Absolutely, so across the 12 months of the project there's three webinars developed and delivered. The first one of those was held in November last year and it was designed just for pharmacists. We had a community pharmacist speaker, who is also an educator, and with a passion for palliative care and educating in terms of pharmacy students in palliative care and how they could assist in the community pharmacy setting. And we had another speaker who was a clinician, a palliative care medicine specialist from within the South Western Sydney region as well for some clinical content too. So that was the first webinar and that was really well attended by pharmacists. We ended up with about 55 pharmacists joining that event on the night. We also recorded that and made that available on PSA's learning platform which is incredibly familiar and well recognised by pharmacists so people who weren't able to make the viewing could go back and still register to watch that recorded webinar and undertake the assessment. So that was webinar number one. So there was some basic likely emergent symptoms in palliative care and the common medicines that are used to help manage those, a little bit of focus on the NSW Clinical Excellence Commission core list explaining to pharmacists why or the value in them routinely stocking those medicines as well and then, as you mentioned Ken, it's incredibly important to have that collaboration with the care from pharmacists and GPs and other members of the local palliative care community based teams as well. So webinar one has been held.

The next one is with a GP focus so that will be specifically for GPs in South Western Sydney covering clinical aspects of palliative care and to put some case studies in there to be able to see that knowledge in practice, noting too that the GP workforce does the majority of palliative care in the community, and then also again just tying that in with the core medicines that pharmacy in the region are being encouraged to stock. So we tie all that in by trying to build confidence in GPs in anticipatory prescribing even if it is the core list of medicines they become familiar with either to do that under their own direction or whilst awaiting some specialist input.

The final webinar, the third one in the series is going to be held 28 May. These are going to be evening webinars so after the majority of people's practice days and the final one is going to have a multidisciplinary approach. It will be hosted by PSA but it doesn't need to be pharmacists only who register for that one, we would also like to invite GPs and community nurses, palliative care nurses as well to that one with a more multidisciplinary approach to really focus on how we might be better able to coordinate healthcare as a community across South Western Sydney.

**Ken McCroary: Excellent. You're doing my job for me. The next question was about the core palliative medications list for NSW but we already mentioned clonazepam, haloperidol, hyoscine, metoclopramide and morphine so thanks for doing that. I've always had issues with engaging our colleagues particularly in difficult spaces like aged and palliative care. So engaging GPs and pharmacists, improving our awareness in this space, how are we going to do that?**

**Megan Tremlett:** Hopefully the webinars will go part of the way for that but also as part of this particular project we are developing some resources to assist both at consumer level, pharmacy level and general practice level and in that care coordination space. One of the examples will be a drafted template that might be an email communication, not many of us rely on physical communication these days, so it will be in a digital format but really to encourage communication I'd say from the pharmacy to reach to their local network of GPs.

Often pharmacists have at least a great awareness if not a great relationship with their local GP workforce for them to reach out and say we are actually making a commitment to stock these five core injectable medicines as recommended by the NSW CEC. If you have any prescribing preferences yourself, where you would like us to stock something different routinely because it's your preference, let's have a conversation about it. So I guess that kind of thing initially.

Another activity flowing through this project is seeking from community pharmacies across South Western Sydney a non-legally binding commitment to stocking those core medicines and it doesn't mean that any pharmacy would be held accountable if a prescription is presented and on that particular day they didn't have stock of that medicine, there could be various reasons for that, but the plan in seeking that commitment from pharmacies is we actually then post them on an interactive mapping of the region, sort of a dot point or a mapping, an interactive google map or something similar of the pharmacies that have made that commitment for stocking the core medicines. That's in no way intended to say this pharmacy is better than any other or to engage in any channeling to any particular pharmacy because its open to all 200+ community pharmacies across the region but should they wish to have their contact detail posted on that map it just means the link to that map can be shared with prescribers across the region.

It may be done say by the South Western Sydney HealthPathways, there are a number of ways that link to the map could be disseminated but the idea then is that a prescriber or indeed a family carer or consumer can actually have a look at that map. They know where they live, they can identify then a pharmacy with a drop pinpoint on that map, click on that then they can actually see the name, address, contact hours, phone number of that pharmacy knowing they have made a commitment to more likely than not have those five regular medicines or anticipated medicines on the shelf at all times. So that is part of that way of trying to bridge the connection there so that pharmacies are making that commitment, prescribers can see which pharmacies have made that commitment as well and then sharing that, making that something that is shareable between pharmacy and general practice as well.

**Ken McCroary: Yeah, I think that's a really great initiative. I struggle every Christmas season with the shutdown with the holidays and public holidays accessing palliative care medications and I guess if that is like a live map and we know whose working and whose not it's going to be quite helpful.**

**Megan Tremlett:** Indeed the aim is it for to be used by pharmacies themselves, as much as they often have a well-developed relationship with their community and client base it may well be that on a given day they simply haven't been able to access metoclopramide injection for instance and they might want to pop into that interactive map and rather than doing a ring around on the persons behalf they will be able to use the interactive mapping to go oh okay I suspect this pharmacy may well have it and give them a quick call. So the idea really is reduce care giver distress as well in the time that it takes to chase around for medicines that their loved ones may need in their last days of life, obviously at a time when their feeling extremely overwhelmed, exhausted and vulnerable and they want to obviously be at home next to their loved one rather than doing a drive around the neighbourhood or countryside seeking the medicines that have been prescribed so we're hoping that the interactive map works on a number of different levels.

**Ken McCroary: Yeah I'm looking forward to seeing it. Now you did touch on anticipatory prescribing a little bit earlier can you just explain that term in case any of our readers are unaware please?**

**Megan Tremlett:** Yeah sure so I guess the word anticipate is the key there in that once it has been recognised a person is getting closer to their last days it's an opportunity there to think okay the likely the symptoms I might see may include of cause pain, shortness of breath, potentially nausea, noisy breathing and some anxiety or terminal restlessness. So knowing in advance they are the common symptoms experienced by a lot of people in their last days of life or as they are dying its taking measures in advance to write prescriptions for the range of medicines that can help to manage those symptoms effectively.

So anticipatory prescribing is quite simply writing prescriptions in advance in anticipation of common symptoms that may emerge so it may be that those prescriptions are never dispensed. It might be the person doesn't actually have a need for those medicines but it's one thing for the pharmacies to be encouraged to hold these five medicines or something slightly different that is locally preferred but keeping the medicines on the shelf is part of a solution but the next step is actually making sure prescriptions are actually written in a timely manner to allow access to those medicines to be used at home or the aged care home setting. So it's really advanced planning at its finest with the person's last days of life in mind should their preference be to die at home in their own home or in an aged care facility.

**Ken McCroary: Yeah and I think you're exactly right we don't want to be writing this stuff up on the last day, we don't want the family running around trying to source medications on the last day of life do we, we want to be prepared?**

**Megan Tremlett:** Absolutely. Of course these are injectable medicines so there does need to be a connection in the community, palliative nursing teams, or otherwise who are maybe either educating a family member or caregiver if they have the health literacy and willingness and ability to administer medicines in the last days of life they can receive instructions to do so with the medicines that are available on hand. Otherwise, it may be having the medicines available within the home for community nurses or other people attending the patient in their last days of life, whether its attending to a continuous subcutaneous infusion device, if the medicines available when that person turns up to minimise delay and I guess loss of symptom control or symptom management.

**Ken McCroary: Excellent. Thank you. Now we were talking about increasing collaboration around the end of life care, you mentioned the community nurses, pharmacists, GPs and I think that's another commendable part of the project, working together for patient outcome is really important and there's some webinars planned. Any other ways you think we can improve collaboration?**

**Megan Tremlett:** I think thinking from the primary health network's perspective, HealthPathways and to be perfectly honest I am not across the uptake of HealthPathways by GPs in South Western Sydney and, in my experience, in similar projects we have done with other primary health networks there is a variable connection between GPs and primary health networks so indeed other clinicians that may be supporting palliative care in the community. I think there is definitely potential for pharmacists to better connect in with the community health pathways to better understand who are the local service providers, what are the referral points as well. In a similar vein there's probably not enough information in most primary health network HealthPathways about the role of pharmacists, both supporting the person diagnosed with a life-limiting illness and their care givers and the role that could be expected of pharmacists, community pharmacists in particular, to support people as well so supporting the prescribers, supporting the nursing colleagues in the community and supporting individual patients and their carers. HealthPathways is certainly one of those ways, there probably are more as well we are exploring through this project. I think any and all suggestions would be welcomed as well.

At the moment I'm running some focus groups to try and better understand that connection and where the gaps are in that connection as well. We have done local palliative care contact lists in the past and shared those with community pharmacy but I think that's a two way street between prescribers and pharmacies and pharmacy and prescribers and community nurses too. There is definite room for improvement and acknowledging that, sometimes unfortunately we can all work in a bit of a professional silo where we do what we do everyday but not necessarily aligning that with what our other health professional colleagues are doing too.

**Ken McCroary: Thank you. I was wondering if you have some information about experience of pharmacy and palliative care pharmacy in South Western Sydney. I know you've worked as a pharmacist yourself, are you getting feedback from the local pharmacists about the issues in our region?**

**Megan Tremlett:** Yeah I think again I've probably got two answers to that. A little bit at a more broad sweeping level having worked with a number of other primary health networks so at some state based palliative care there has been a fair bit of research into the barriers of community pharmacies to stocking palliative care medicines. One of them has been anecdotally the expense of stocking core medicines. So we've asking pharmacies to stock these five medicines, a box of each on the shelf at all times, if that expires then as a business that needs to be sustainable that represents a loss of money for them but we have well and truly identified that that really is a little bit of a myth to stock one box of each of these core five medicines, a full box of each on the shelves at all times, at the wholesaler buying price it comes in at under $100 so expense is not necessarily a barrier. Some pharmacies would say we don't necessarily do that because a much bigger pharmacy just up the road we know focuses on this so we would just reach to them or refer to them if we need to so there is some information around from a research perspective around that.

But what we do know from the research is that where another health professional involved in palliative care notifies a community pharmacist that one of their patients has been diagnosed with a life-limiting illness, the pharmacy is way more likely to make sure they routinely stock the core medicines on the shelf. So we know the value in that professional communication.

It's fabulous also if the patient and/or their caregiver let the pharmacist know but also wonderful if that information is shared at the professional level as well. I think the response to the webinar, knowing that it was a South Western Sydney pharmacy focused webinar in November last year, was actually really speaking to the unmet need for that information.

We also know that nationally a knowledge gap exists across the pharmacists when it comes to palliative care. The vast majority of pharmacists have not engaged in any additional palliative care education beyond their undergraduate course. For me that was more than 20 years ago but personally I have engaged in more, but four out of five pharmacists have not. And what they did learn in their undergraduate course varies. There are about 18 pharmacy schools across the country and what they teach in the way of palliative care is highly variable between schools so we know that there's a knowledge gap. And pharmacists do identify that sometimes it's an area they may see as a bit confronting professionally and I guess emotionally where there is a bit of a tendency to go 'this is something we'll leave to the specialist', 'palliative care is a specialist area we'd rather leave that to the specialists'. What we would really aim to do is bring up the baseline, the nuts and bolts of palliative care knowledge, to as many pharmacists as possible to build their confidence in having conversations with prescribers as well as patients and their carers.

**Ken McCroary: Yeah because it's like in medicine most palliative care is still looked after by primary care physicians not by palliative specialists because there isn't enough and I think community pharmacists there's a role for them isn't there not leaving it to the specialists?**

**Megan Tremlett:** Absolutely yes and I'm literally nodding which is not helpful when I'm at a distance to you but I'm nodding profusely because pharmacists are highly accessible in the community. Community pharmacists on average Australians visit their community pharmacy about 18 times a year without an appointment necessary most of the time depending on what it is they are seeking when they come into the pharmacy. So I think the accessibility of pharmacists means they are very well positioned, provided they have some knowledge in palliative care, to provide support and if they feel it's beyond their knowledge base or comfort zone then they refer to someone else in the community to assist that particular person or to seek an answer to the query, so I think building that knowledge base is extremely important in the first instance.

Again having medicines on the shelf or knowing what a core medicines list is does not equate to being able to answer or find solutions to the issues people are having literally in their home environment whether it's around swallowing difficulties or the crushability of the medicine. Pharmacists are pretty good at understanding availability issues when it comes to medicines. A prescription may arrive and there has been a supply issue with the Maxalon brand of Metoclopramide injection in recent times which can be problematic in the palliative care space, pharmacists are well placed to know what actually is available through the wholesaler so I think there's a lot of information that is part of the day to day skill set of pharmacists but it's just building that understanding of common symptoms and their management in the palliative care space.

**Ken McCroary: Yeah, very good. I'm just going to broaden out a bit here and talk about sharing knowledge in terms of life as a pharmacist particularly as a community pharmacist out this region. So can you tell us about life as a pharmacist really? Like what sort of pressures are you guys facing? What sort of local needs we have? Relationships with GPs, teamwork? You know all that sort of stuff.**

**Megan Tremlett:** Yeah absolutely so I guess very similar to general practice there are workforce pressures on pharmacists as well in terms of in some regions there being an unavailability of pharmacists which puts pressure on the pharmacists that are available on the roster.

I think that certainly, I won't go into the political landscape Ken I think that's outside the scope of this conversation, but I think it's fair to say that pharmacists are busy, hundreds of scripts a day, working very hard to keep up with the counselling and dispensing aspect of care but also providing now days a lot of additional clinical services whether it be providing immunisations or health checks or otherwise too so there's a lot of workload pressure on community pharmacy it would be fair to say.

It also escalates at certain times of the year and across the Christmas/New Year period is one of those time examples where we are getting to the very end of the PBS safety net time of the year that I guess reaches its peak before 31 December each year, staff going on holidays, people migrating around if they are on their own family holidays so it's a very busy place to be in community pharmacy. Having said that community pharmacists tend to develop quite a rapport if they're in a particular pharmacy and I guess not working in a locum or relief capacity, but a pharmacist who is working regular hours in a pharmacy by nature will start to see the same people a lot if they have multi morbid conditions or they are older or particularly if they are supporting someone with palliative care needs. It is an opportunity for them to know that person more on a personal level and maybe recognise when things aren't going as well as they could be and it might be that the person is simply presenting in a way, in a more exhausted way or that particular individual is expressing they are having difficulty managing at home either with their own health or with the care of a loved one. So I think those regular brief interventions in a busy community pharmacy can be quite insightful and is information that can then be shared more broadly with the person's GP and care team. Is there opportunity for that collaboration to happen more? Absolutely but I think that pharmacists are well placed to recognise when things might be deteriorating or further support is needed or potentially looking at collaborating with a change in medicine.

**Ken McCroary: Thank you for that. What about the future of pharmacy and community pharmacy? What are the major issues facing you guys, what do you think is around the corner?**

**Megan Tremlett:** I guess again I would probably parallel that with some of the challenges being in general practice which is funding mechanisms. We have the advent of 60 day dispensing and other fee for service models that are coming through community pharmacy. We will start to see in the second half of this year a funded program for pharmacists to be able to working on site in aged care facilities as well that's likely to be facilitated at least partially if not majority through community pharmacy as well. So I think workforce is going to continue to be a pinch point for community pharmacy as well as the renumeration that is available for the services support, the sustainability of community pharmacy and for them to employ their support staff as well.

As I say I'm not a political beast Ken I wouldn't like to speak into the nitty gritty of that other than the broader level of understanding that there are some pressure points for community pharmacy that have existed to some extent for a long, long time perhaps a little bit ramped up at the moment just with some of the broader system changes that impact community pharmacy. I guess that's the most broad sweeping way I would answer that question Ken. All pharmacists need to keep continuing their continuing professional development each year and to undertake opportunities to upskill and undertake education in areas that are of interest and professional relevance. I'm talking a little bias having worked in the palliative care project space for a while but I think palliative care should be a bread and butter basics upskilling opportunity for each pharmacist so yeah I would absolutely point them to these opportunities, education supported by the primary health network, they would be wise to undertake that.

**Ken McCroary: That's cool. I'm happy to leave the politics out of it but as a pharmacist and as member of the profession with all the prescribing and trials this year going on around the country how are you guys feeling about that? Are you feeling it's a great challenge to improve our profession and allow us to contribute more as a professional in this field? How are you feeling about that?**

**Megan Tremlett:** I think as a professional the team I work with in PSA for instance you know we are looking at ways the medicines expertise of pharmacists can be utilised in pretty much in any setting medicine is spoken about or dispensed or used and ways. For instance, going back about six years I came to PSA to help manage a project that was as a government funded trial looking at the role of pharmacists working in Aboriginal controlled community health services. So that was a project that was PSA led in conjunction with NACHO as the national body representing Australia's Aboriginal community control health services and also with James Cook University. We undertook that trial over about two-and-a-half years to explore that role. Prior to that there were some pharmacists working in NACHOs but certainly not many and NACHO themselves had identified the need to get some extra data to support and back up the role that pharmacists could do to apply their medicines expertise provided that was done in a culturally safe way but in a NACHO setting.

So following on from that as the wheels of change move slowly, just in the first half of 2023, the Medical Services Advisory Committee, it took about three years but they took their time to consider the findings from that particular trial, it was called the IPACs trial and in the end they did make a positive recommendation to government to support public funding of pharmacists in NACHO settings. Of course that doesn't equate to funding, actual funding, but it does equate to a positive recommendation for funding. NACHO and PSA are now sort of working together to advocate for an actual secure funding stream to support that model of care for pharmacists working in NACHOs. It is very much a thing that the Aboriginal community control sector are wanting to see happen so I guess the wheels of change move slowly.

Our pharmacists immunising, you know that was probably until about six or seven years ago that was something that hadn't necessarily been considered now fast forward from immunisation we now have pharmacists through legislation able to actually administer medicines via injection for injections that are other than for vaccination. It might be say, long acting injectable buprenorphine to try and provide another avenue to support people with opioid treatment programs as well. So I guess from my perspective, the wheels of change, there needs to be a demonstrated need or gap that the expertise of pharmacists could help to fill with appropriate training and education and credentialling. So I think a lot of things need to line up for pharmacists to be, I guess recognised to work. I guess this just means different ways that pharmacists expertise and skills can be aligned with legislative change to fill a gap that is perhaps unmet at this point in time in the care of people in the community. That might be a bit of a long-winded answer but I hope that gets to the guts of your question.

**Ken McCroary: No appreciate that that was excellent. Thank you. Now obviously you're really busy you're doing a lot, you are passionate about what you are doing, how do you tend to balance the pressures with being aware and looking after self? We're pretty big on wellbeing in our organisation as well, do you have any advice?**

**Megan Tremlett:** With my community pharmacist hat on Ken or as me working at the PSA doing what I do from day to day?

**Ken McCroary: Both, you do a lot and we're busy people and any positive or helpful feedback may well be well received by someone who's struggling at the moment.**

**Megan Tremlett:** Yeah sure, I guess if we were to think in the palliative care space there is definitely a professional, clinician personal burden when it comes to supporting the palliative care individuals and their carers. We did look at that as part of another PHN-funded project that was looking at supporting people with grief, pharmacists supporting people with grief and bereavement also building into that an element that is actually self-care for pharmacists as health professionals as well and I guess some direction around self-care.

The PSA has also developed some education in the palliative care space that's an essential continuing professional education activity and that is something that's a deeper dive into a particular area. In this case its palliative care so we have had one that has been available for two years that is now being updated and will be made available again in a few months time to pharmacists nationally so I think you know it really is important to provide some guidance for pharmacists but taking that on board ourselves. I guess I'm thinking from a PSA perspective as well as taking the advice that we are disseminating to pharmacists as well who are really focused on looking at the opportunities to take some time out and focus on self-care and stop and think what are the things that I actually enjoy doing that take my mind off my professional life and some of potentially, the emotionally challenging parts of that as well.

So the PSA last year applied for and was very happy to receive a National Palliative Care projects grant as part of the $60 odd million dollars of the Australian Government's Department of Health and Aged Care's National Palliative Care Projects Grants Program and we will be developing a national multimodal palliative care foundation level training program available for all pharmacists nationally as well. So again that's trying to build the base level of palliative care knowledge amongst pharmacists at a national level but we're dedicating an entire model to grief, bereavement and self-care as well that we are going to have created by someone who actually specialises in mental health and that social work element of grief and bereavement as well, so really looking for opportunities where we can share that with pharmacists nationally and encourage their uptake but take on the content of that very much ourselves as individual health professionals.

Ken McCroary: Sounds excellent and I commend you on the efforts you are putting in with your profession. I don't think we do enough collaboration between pharmacists and general practitioners so it was really good to talk to you.

**Megan Tremlett:** It's my pleasure thank you very much for the opportunity Ken.

**Remember if you're not a member of GP Link already or you would like to learn more log onto our website at https://sswgp.link/.**