FACILITATORS AND BARRIERS TO PERFORMING COMPREHENSIVE MEDICATION REVIEWS AND FOLLOW-UP IN OLDER HOSPITALISED PATIENTS

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Background

There is a lack of knowledge about factors that influence the performance of comprehensive medication reviews (CMRs) and post-discharge follow-up by multiprofessional ward teams including a clinical pharmacist. A better understanding of these factors is needed to support implementation and sustainability of CMRs or similar hospital services.

Objective

To explore the facilitators and barriers for performing CMRs and post-discharge follow-up in older hospitalised patients.

Methods

Semi-structured interviews were conducted with 16 physicians and 7 pharmacists recruited from an ongoing trial at 8 internal medicine or geriatric wards at in total 4 hospitals in Sweden. The interviews were audio-recorded, transcribed verbatim and thematically analysed using the Consolidated Framework for Implementation Research.

Results

Six main themes with in total 21 facilitators and 25 barriers were identified, of which frequent recurring factors are depicted here:

”Yes, it can take time […] but I think it saves more time than what it takes, so it’s well-invested time.” - physician

Facilitators	**Main themes**	Barriers
	CMRs and follow-up are needed, but not in all patients	
• Patients need and appreciate CMRs		• Not all patients want, need or feasible for CMR
	General belief in positive effects of CMRs and follow-up	
• Pharmacist's work is relevant and appreciated by physicians		• Insufficient quality of and communication about post-discharge follow-up by primary care
	Pharmacists’ knowledge and skills are valuable, but they need more clinical competence	
• Pharmacist is reliable and has broad pharmaceutical competence		• Pharmacist lacks or needs more clinical competence
	Compatibility of CMRs with hospital practice is challenging, and roles and responsibilities of ward-based pharmacists are unclear	
• CMR or pharmacist is well-adapted to hospital practice		• Hard to fit CMR in hospital practice • Primary care or others responsible and suited for CMR • Pharmacist is not fully integrated in the ward team • Unclear role of the pharmacist
	Personal contact at the ward is essential for physician-pharmacist collaboration	
• Positive experience by physicians with pharmacist collaboration • Pharmacist participates in medical rounds or meetings		• Pharmacist is not always present at the ward • Physicians can feel criticised by the pharmacist • Frequent rotation of healthcare professionals at the ward
	Lack of resources is an issue, although the performance of CMRs may save time	
• CMR or pharmacist may save time and costs • Availability of shared electronic medical record		• Lack of time among healthcare professionals • Phone calls and check upon discharge for all patients is not time efficient

“It is important to understand that not everything is relevant to address, and that some things don’t have to be changed right now. Just focus on what’s most relevant.” - pharmacist

Conclusion

Multiple facilitators and barriers for performing CMRs and post-discharge follow-up in older hospitalised patients exist. These factors should be addressed in future initiatives with similar interventions by multiprofessional teams including a clinical pharmacist to ensure successful implementation and sustainability in hospital practice.

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