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Original Research

Barriers and facilitators of medication reconciliation processes for recently discharged patients from community pharmacists' perspectives

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Abstract

Background: Community pharmacists play a vital part in reconciling medications for patients transitioning from hospital to community care, yet their roles have not been fully examined in the extant literature.
Objectives: The objectives of this study were to: 1) examine the barriers and facilitators community pharmacists face when reconciling medications for recently discharged patients; and 2) identify pharmacists' preferred content and modes of information transfer regarding updated medication information for recently discharged patients.
Methods: Community pharmacists were purposively and conveniently sampled from the Wisconsin (U.S. state) pharmacist-based research network, Pharmacy Practice Enhancement and Action Research Link (PEARL Rx). Community pharmacists were interviewed face-to-face, and transcriptions from audio recordings were analyzed using directed content analysis. The Theory of Planned Behavior (TPB) guided the development of questions for the semi-structured interviews.
Results: Interviewed community pharmacists ($N = 10$) described the medication reconciliation process to be difficult and time-consuming for recently discharged patients. In the context of the TPB, more barriers than facilitators of reconciling medications were revealed. Themes were categorized as organizational and individual-level themes. Major organizational-level factors affecting the medication reconciliation process included: pharmacy resources, discharge communication, and hospital resources. Major individual-level factors affecting the medication reconciliation process included: pharmacists' perceived responsibility, relationships, patient perception of pharmacist, and patient characteristics. Interviewed pharmacists consistently responded that several pieces of information items would be helpful when reconciling medications for recently discharged patients, including the hospital medication discharge list and stop-orders for discontinued medications.

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Conclusions: The TPB was useful for identifying barriers and facilitators of medication reconciliation for recently discharged patients from community pharmacists' perspectives. The elucidation of these specific facilitators and barriers suggest promising avenues for future research interventions to improve exchange of medication information between the community pharmacy, hospitals, and patients.
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Keywords: Community pharmacy; Medication reconciliation; Transitions of care; Qualitative methods

Background

The transition from hospital to community care is a vulnerable time during a patient's health care delivery.[1] As patients transition from hospital to community care settings, they often experience discontinuity in their care as responsibility for their care shifts from one set of providers to another.[2] As a result, patients often are the only link between inpatient and outpatient health care settings since most providers restrict their practice to one setting.

Medication discrepancies are common for patients who transition from hospital to community care.[3,4] To help address poor care coordination upon discharge, hospitals are utilizing hospital-to-home transitional care programs to facilitate the care coordination for patients post-discharge. However, community pharmacies are not always included in these transitional care programs[1,5] despite many patients receiving their medications from community pharmacies while in the outpatient setting.[6] According to The Joint Commission (TJC), medication reconciliation is the process of comparing and resolving discrepancies, or differences, between a patient's medication orders for all of the medications a patient is using to their new medication orders.[7,8] TJC has made medication reconciliation a national priority and requires medication reconciliation processes to be implemented at all their accredited institutions.[9,10] To date, however, there are no regulations[11] in place to ensure that community pharmacies receive complete, updated patient medication information after a hospital discharge. Not receiving up-to-date information on medications complicates the community pharmacist's role to reconcile medications and prevent medication errors that place the patient at risk of obtaining incorrect medications. If a pharmacist does not know about a change in a patient's medication, the pharmacist will not be able to dispense the updated correct medications and provide appropriate consultation. Therefore, research that elucidates mechanisms by which the patient is at risk of receiving incorrect medications post-discharge from their community pharmacy is needed.

Previous research has documented the barriers and facilitators that community pharmacists encounter with implementing cognitive pharmaceutical services generally,[12] but research examining medication reconciliation processes in the community pharmacy setting for recently discharged patients is scarce.[13] In other health care settings, a recent systematic review by Chhabra et al (2012) evaluated medication reconciliation interventions in patients who transition to and from long-term care nursing facilities. The authors reported that clinical pharmacists were effective in these settings by assuming specialized responsibilities during the medication reconciliation processes.[14] Similarly, community pharmacists play a critical role in medication reconciliation processes when patients transition between hospital to home, underscoring the need for attention to be directed at the community pharmacist.

To advance the understanding of conditions affecting medication reconciliation processes in the community pharmacy setting, it is necessary to systematically examine the barriers and facilitators faced by community pharmacists when reconciling medications and pharmacists' preferred content and format for communications. By understanding these facets, pharmacists also may adopt specialized roles and interventions may be tailored to improve medication reconciliation processes which will ultimately increase the quality of patient care. Therefore, the goal of this study was to examine community pharmacists' perspectives through a theoretical lens regarding the barriers and facilitators of medication reconciliation processes for recently discharged patients. This goal was accomplished through a qualitative inquiry[15] that analyzed detailed community pharmacist narratives through one-on-one semi-structured interviews. The Theory of Planned Behavior (TPB)[16,17] provided the theoretical framework to structure the interviews, focusing on the barriers and facilitators of