## Data extraction tables

## Table 1: Study characteristics of included research studies (full data extraction table)

Study ID	Study	Setting	Intervention	Key findings	Authors' conclusions	Study
	design/sample					strengths/limitations
	size					
Alharthi	Secondary	Care homes	Integration of	Factors that acted as both	PiPs' involvement in care homes	Strengths: Diverse
2023[18]	analysis of	in England	PIPs into care	enablers and barriers were PIP	is influenced by numerous	PIP contexts and
	qualitative	and	homes to	relationship with General	barriers and enablers that can	perspectives on
	interview data	Scotland	improve	Practitioner (GP), care home	be addressed to improve	deprescribing;
			medication	staff and residents/families,	intervention effectiveness	theory-informed
	11 pharmacist		management	awareness of the PIP role and		analysis using
	independent			family trust in PIPs'		Theoretical Domains
	prescribers			deprescribing activities (social		Framework to
	(PIPs) who			<i>influences</i> ); PIPs' independent		identify barriers and
	participated in			prescribing confidence, previous		enablers
	a cluster			experience and ability dealing		
	randomised			with residents' medications		Limitations: Only PIP
	trial			(beliefs about capabilities);		perspective
				understanding of PIP role and		considered; analysis
				PIP confidence in their role as an		used data from
				independent prescriber		interviews focused
				(social/professional role and		on the whole
				identity); access to residents'		intervention process
				records, deprescribing decision		rather than
				support, regular follow-up from		exclusively on
				care home staff, resident		deprescribing
				difficulties with medications,		

				teamwork, and time restraints (environmental context and resources). Belief that the negatives of deprescribing outweigh benefits regarding certain medications (beliefs about consequences) acted as a barrier.		
Alves 2019[19]	Service evaluation 10,405 patient reviews over 5 years	Care homes in Somerset	Medication review by primary care pharmacists linked to GP practices	Pharmacists made 23,955 interventions (mean 2.3 per patient) from the 10,405 patient reviews undertaken. 16.1% of interventions were related to safety. Potential drug cost savings were estimated at £812,441 over 5 years, of which £431, 493 (53%) was attributed to deprescribing	Medication reviews undertaken by primary care pharmacists in care homes generate a wide range of interventions, commonly involving deprescribing. The service contributes to the continuous optimisation of prescribing and monitoring of medicines and offers potential drug cost savings.	Strengths: Collection of data from 'real world' implementation of intervention over 5 years Limitations: No control group, cost saving estimates not based on full economic evaluation
Baqir 2017[20]	Retrospective evaluation of quality improvement project 422 residents in 20 care homes	Care homes in two CCG areas in North East England	Medicines optimisation by a pharmacist acting independently or jointly with a GP. Shared decision making with the patient or their advocate	Of the 422 patients reviewed, 298 (70.6%) had at least one medicine deprescribed with 704 medicines (19.5%) being stopped. There was no statistically significant difference between pharmacist only and pharmacist plus GP in terms of deprescribing. Assuming that each medicine stopped would have been taken for another year, annualised cost savings were estimated at £65,471	Medicines optimisation reviews can lead to a reduction in polypharmacy for care home residents through a deprescribing process. Patients' medicine regimens were simplified and optimised while making financial savings for the NHS	Strengths: Compares two approaches to delivering medication review Limitations: Short- term uncontrolled study; intervention quality/fidelity not measured

Birt	Miyod	Care homes	Integration of	All stakeholders reported some	The intervention was generally	Strengths: Involved
2021[21]	methods	in England	DIDs into caro	henefits from DIPs having	implemented as intended and	three LIK nations with
2021[21]	methous	III Eligialiu,	PIPS IIILO Care		implemented as intended, and	differing health same
	process	Scotland	nomes to	responsibility for medicine	well-received by most	differing nealthcare
	evaluation of	and	assume	management and identified no	stakeholders.	systems; used study
	cluster RCT	Northern	central	safety concerns. PIPs reported	Whilst there was widespread	records to
		Ireland	responsibility	an increase in their knowledge	deprescribing, contextual factors	supplement
	Intervention		for medicines	and identified the value of	effected PIP engagement.	qualitative data
	arm comprised		management	having time to engage with care	Implementation was most	
	25 triads: Care			home staff and residents during	effective when communication	Limitations: Interview
	homes (staff			reviews. PIPs recorded 566	pathways between PIP and GP	participants may not
	and up to 24			clinical interventions, many	had been	be representative;
	residents),			involving deprescribing; 93.8%	previously established.	limited access to care
	GP and			of changes were sustained at 6		home residents
	pharmacist			months. For 284 (50.2%)		
	Independent			residents a medicine was		
	Prescriber			stopped, and for a quarter of		
	(PIP); 22 PIPs			residents, changes involved a		
	contributed			medicine linked to increased		
	data			falls risk. Qualitative data		
				indicated participants noted		
				increased medication safety and		
				improved resident quality of life.		
				Contextual barriers to		
				implementation were apparent		
				in the few triads where PIP was		
				not known to the GP and care		
				home before the trial in three		
				triads DIDs did not doliver the		
				intervention		
Howard	Dragoss	Conoral	Dharmanist lad	Dearmanista judged 72% (05% Cl	Decommondations from the	Strangthe Lleas data
	Process	General	Pharmacist-led	Pharmacists judged 72% (95% Cl	Recommendations from the	Strengths: Uses data
2014[11]	evaluation of	practice	i enabled	70, 74; 1463/2026) of cases of	pharmacists were broadly	from a large cluster
	data from	surgeries in	intervention	nazardous medicines		KCI
	cluster RCT	an 80 km	(PINCER).	management to be clinically		

	radius	Patients	relevant. Pharmacists	acceptable to GPs and led to	Limitations:
36	around	potentially at	recommended 2105	ameliorative action in the	Pharmacists did not
intervention	Manchester	risk from	interventions in 74% (95% CI 73.	maiority of cases. It seems	record detailed
and 36 control	and	hazardous	76; 1516/2038) of cases and	likely that the approach used by	reasons for their
practices; 1946	Nottingham	medicines	1685 actions were taken in 61%	the PINCER pharmacists could	judgements and
patients	-	management	(95% CI 59, 63; 1246/2038) of	be employed by	these were not peer
identified as at		were	cases; 66% (95% CI 64, 68;	other practice pharmacists	reviewed
risk in		identified	1383/2105) of interventions	following appropriate training.	
intervention		using Quest	recommended by pharmacists		
practices		Browser	were completed and 5% were		
		software to	accepted by GPs but not		
		search GP	completed at the end of the		
		electronic	pharmacists' placement; the		
		records.	remaining recommendations		
		Intervention	were rejected or considered not		
		practices were	relevant by GPs.		
		assigned a			
		pharmacist			
		who educated			
		practice staff			
		about			
		medication			
		management			
		and			
		recommended			
		improvements			
		to practice.			
		Pharmacists			
		also reviewed			
		cases of			
		potentially			
		hazardous			
		medication			

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			and recommended interventions to GPs			
Jeffries	Qualitative	CCG in the	Electronic	Effective use of the EMOS	The use of an electronic	Strengths: Realist
2017[13]	realist evaluation Interviews: 3 GPs, 2 CCG pharmacists; Focus groups: 2 GPs, 4 community pharmacists, 4 patients, 4 practice managers	South of England	Medicines Optimisation System (EMOS). The EMOS is intended to facilitate clinical audits of prescribing activity to identify patients at risk of adverse drug events	depended upon engagement with the system, the flow of information between different health professionals centrally placed at the CCG and those locally placed at individual general practices, and upon adaptation of work practices to facilitate the use of the system. The use of the system was undermined by perceptions of ownership, lack of access, lack of knowledge and awareness, and time pressures.	medicines optimisation system may improve medication safety in primary care settings by identifying those patients at risk of an ADE. To fully realise the potential benefits there needs to be better utilisation across primary care and with a wider range of stakeholders. Engaging with all potential stakeholders and users prior to implementation might allay perceptions that the system is owned centrally and	strengths: Realist methodology enabled detailed examination of how the EMOS was used and its potential effects Limitations: Study involved only one CCG so may not be representative
					potential benefits.	
Jeffries 2018[12]	Qualitative process evaluation 28 staff members from 23 general practices (9 GPs, 12 pharmacists, 7 other GP staff)	43 general practices in Salford, Greater Manchester	Electronic audit and feedback surveillance dashboard to identify patients potentially at risk of hazardous prescribing or	Engagement with the dashboard involved a process of 'sense- making' by pharmacists. The intervention helped to build respect, improve trust and develop relationships between pharmacists and GPs. Collaboration and communication between pharmacists and clinicians was primarily initiated by	Medicine optimisation in primary care may be enhanced by the implementation of a pharmacist-led electronic audit and feedback system. This intervention established a rapid learning health system that enabled data from electronic health records to be used to make changes in practice to improve patient care.	Strengths: Use of Normalization Process Theory as a framework to understand implementation Limitations: Evaluation team also developed the intervention; number of follow-up

			monitoring of medicines	pharmacists and was important for establishing the intervention.		interviews was limited
Lane 2020[22]	Qualitative focus groups and interviews 85 (72 in focus groups and 13 in semi- structured interviews)	Care homes (4 sites in England (2), Scotland and Northern Ireland)	Integration of PIPs into care homes to take responsibility for medicines management	A PIP service was seen as offering benefits for residents, care homes and doctors but stakeholders raised challenges including agreement on areas where PIPs might prescribe, contextual barriers in chronic disease management, PIPs' knowledge of older people's medicine, and implementation barriers in integrated team- working and ensuring role clarity. Introducing a PIP was welcomed in principle but conditional on: a clearly defined PIP role communicated to stakeholders; collaboration between doctors, PIPs and care- home staff; and dialogue about developing the service with residents and relatives	The overarching theme from this research was that everyone must "understand each other's systems". In particular, PIPs need to understand care homes' systems in advance of implementing a new service	Strengths: Purposively selected sample; use of TDF as a framework to analyse data Limitations: Data relate to proposed service model in advance of implementation
Madden 2022[14]	Qualitative interview study 10 newly appointed pharmacists working in primary care	General practice in England	Structured medication review (SMR) for people at risk of harm or medication- related problems	SMR implementation was largely delegated to individual pharmacists. Established pharmacists appeared more ready for implementation than newly appointed staff. New pharmacists were learning about working in primary care settings and tended to follow procedures	Early implementation of SMRs did not match the intention of providing patients with a holistic review and shared decision- making. The authors identified an important opportunity cost of SMR implementation without prior adequate skills	Strengths: based on detailed, in-depth interviews Limitations: Authors note interviews need to be complemented by data on actual

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	networks (PCNs) in Northern England; 10 established pharmacists working in GP practices in other PCNs			with which they were already familiar, particularly when they lacked patient-facing expertise. Implementation was affected by ongoing backlogs and workforce issues in general practices	development, testing, and refining	practice and longer term follow-up
Peek 2020[15]	Interrupted time series 43 general practices covering 235,595 people in Salford, Greater Manchester	General practice in England	Pharmacist-led Safety Medication dASHboard (SMASH). SMASH involved (1) training of clinical pharmacists to deliver the intervention; (2) a web- based dashboard providing actionable, patient-level feedback; and (3) pharmacists reviewing individual at- risk patients,	The study used an interrupted time series analysis of rates (prevalence) of potentially hazardous prescribing and inadequate blood-test monitoring, comparing observed rates post-intervention to extrapolations from a 24-month pre-intervention trend. At baseline, 95% of practices had rates of potentially hazardous prescribing (composite of 10 indicators) between 0.88% and 6.19%. The prevalence of potentially hazardous prescribing reduced by 27.9% (95% CI 20.3% to 36.8%, $p <$ 0.001) at 24 weeks and by 40.7% (95% CI 29.1% to 54.2%, $p <$ 0.001) at 12 months after introduction of SMASH. The rate of inadequate blood-test monitoring (composite of 2 indicators) reduced by 22.0%	The SMASH intervention was associated with reduced rates of potentially hazardous prescribing and inadequate blood-test monitoring in general practices. This reduction was sustained over 12 months for prescribing but not for monitoring of medication. There was a marked reduction in the variation in rates of hazardous prescribing between practices.	Strengths: Authors noted pragmatic design, evaluation of clinically relevant outcomes and large number of practices taking part Limitations: Not a randomised study so possibility of unrecognised confounding cannot be excluded

			and initiating remedial actions or advising GPs on doing so.	(95% CI 0.2% to 50.7%, $p =$ 0.046) at 24 weeks; the change at 12 months (23.5%) was no longer significant (95% CI –4.5% to 61.6%, $p =$ 0.127). After 12 months, 95% of practices had rates of potentially hazardous prescribing between 0.74% and 3.02%.		
Rodgers 2022[16]	Multiple interrupted time series 393 general practices covering approximately 3 million patients	General practice in the East Midlands region of England	Pharmacist-led IT intervention to reduce hazardous prescribing (PINCER)	Successive groups of general practices received the PINCER intervention between September 2015 and April 2017. Eleven prescribing safety indicators were used to identify potentially hazardous prescribing and data were collected over a maximum of 16 quarterly time periods. PINCER was implemented in 370 (94.1%) of 393 general practices; data were successfully extracted from 343 (92.7%) of these practices. For the primary composite outcome, the PINCER intervention was associated with a decrease in the rate of hazardous prescribing of 16.7% (adjusted odds ratio (aOR) 0.83, 95% confidence interval (CI) 0.80 to 0.86) at 6	The PINCER intervention, when rolled out at scale in routine clinical practice, was associated with a reduction in hazardous prescribing by 17% and 15% at 6 and 12 months post- intervention. The greatest reductions in hazardous prescribing were for indicators associated with risk of GI bleeding. These findings support the wider national rollout of PINCER in England.	Strengths: Suggests intervention was implemented successfully in routine practice and was associated with significant reductions in hazardous prescribing Limitations: The authors adjusted for calendar time and practice, but since this was an observational study, the findings may have been influenced by unknown confounding factors or behavioural changes unrelated to

				months and 15.3% (aOR 0.85, 95% CI 0.80 to 0.90) at 12 months post-intervention. The unadjusted rate of hazardous prescribing reduced from 26.4% to 20.1% at 6 months and 19.1% at 12 months. The greatest reduction was for hazardous prescribing indicators related to GI bleeding		the PINCER intervention. Data were also not collected for all practices at 6 and 12 months post- intervention
Syafhan 2021[17]	Individual RCT 356 patients at risk of medication- related problems (MRPs) from 8 GP practices	General practice in England (6 practices) and Northern Ireland (2)	Medicines optimisation with shared decision- making and agreed treatment goals. Intervention repeated at 2 and 4 months, building on progress towards agreed goals	Median number of MRPs per intervention patient at 6 months was reduced from 3 to 0.5 ( <i>p</i> < 0.001) in patients who received the full intervention schedule. Medication Appropriateness Index (MAI) scores were reduced (medications more appropriate) for the intervention group, but not for control group patients. Using the intention-to-treat (ITT) approach, the number of telephone consultations in intervention group patients was reduced and different from the control group. No significant differences between groups were found in unplanned hospital admissions, length of hospital stay, number of A&E attendances or outpatient visits. The mean overall healthcare	The pharmacist service reduced MRPs, inappropriateness of medications and telephone consultations in general practice in a cost-effective manner	Strengths: Pragmatic randomised design Limitations: Sample smaller than planned; high loss to follow-up; MRP analysis only covered patients who attended 3 appointments

Thayer 2021[23]	Service evaluation 160 care home residents with intellectual disabilities (ID)	Care homes for people with ID in the Wirral	Pharmacist review of residents' medicines and lifestyle risk factors between November 2019 and May 2020.	cost per intervention patient fell from £1041.7 ± 1446.7 to £859.1 ± 1235.2 ( $p$ = 0.032). Cost utility analysis showed an incremental cost per patient of – £229.0 (95% CI – 594.6, 128.2) and a mean QALY gained of 0.024 (95% CI – 0.021 to 0.065), indicative of a health status gain at a reduced cost (2016/2017). The 160 residents were prescribed 1207 medicines, 74% were prescribed ≥5 medicines and 507 interventions/recommendations were made, averaging 3.3 per resident. The highest proportion (30.4%) were lifestyle risk related, while changing and stopping medicines accounted for 17.9% and 12.8%, respectively. Of the recommendations discussed with GPs/psychiatrists, 86% were accepted.	There was considerable polypharmacy among the residents and a high level of pharmacists' interventions/recommendations about medicines and lifestyle risk, most of which were accepted by GPs/psychiatrists. Wider adoption of collaborative pharmacist review models could have benefits for residential populations with ID and potentially reduce pressure on other health services	Strengths: Drew on skills of pharmacists from different sectors to address wide range of care needs; recommendations addressed national priorities Limitations: Study limited to one CCG area; limited access to patient records; observational study with no control/comparator arm Strengths: Large
2015[24]	evaluation	pharmacies in England	Medicines (FOMM) support	(71.1%) completed the 6-month study period. Pharmacists made 142	the age of 65 years with four or more medicines, community pharmacists can improve	sample of patients and providers; use of

620 patients	service.	recommendations to prescribers	medicine adherence and patient	validated outcome
(aged over 65	Patients were	in 110 patients, largely centred	quality of life.	measures
years and	invited to	on potentially inappropriate		
prescribed $\geq 4$	participate in	prescribing of		Limitations: No
medications)	the service by	NSAIDs, PPIs or duplication of		control/comparator
	the	therapy. At follow-up, there was		group; authors note
	community	a significant decrease		some patients were
	pharmacy	in the total number of falls		probably reviewed
	team. The	experienced and a significant		independently by
	pharmacist	increase in medicine adherence		their GP during the
	held regular	and quality of life. Cost per		study period;
	consultations	quality-adjusted life		relatively high
	with the	year estimates ranged from£11		attrition rate
	patient and	885 to £32 466 depending on		
	discussed	the assumptions made.		
	risk of falls,			
	pain			
	management,			
	adherence and			
	general health.			
	They also			
	reviewed the			
	patient's			
	medication			
	using			
	STOPP/START			
	criteria. Data			
	were analysed			
	for the first 6			
	months of			
	participation			
	in the service.			

## Appendix Table 2: TIDieR Lite for UK pharmacist studies

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		supplying community pharmacy and study team			
Care home medication reviews Alves 2019[19]	Primary care pharmacists and GPs in Somerset CCG area and CCG staff	Medicines optimisation visits to care homes. Primary care pharmacists visited homes on behalf of GP practices; GPs could participate in visits or hold discussions with pharmacists prior to the visit; screening of safety interventions was done by CCG pharmacist leads	Care homes with and without nursing in Somerset	The time and level of support allocated for the service was agreed with the respective CCG Locality Pharmacist Manager and influenced by a number of factors such as engagement from GP practices; primary care pharmacists' availability; skills and confidence; number of care home patients registered with each GP practice; and geographic area covered by the prescribing support pharmacists	The aim of the programme was to offer at least one visit to as many care homes as possible (appears to be one visit per year but not explicitly stated)
Shine Medication Optimisation Project Baqir 2017[20]	Pharmacists together with care home nurses and other members of the multi-disciplinary team (MDT), including GPs and mental health professionals as needed. Two different models: pharmacists made prescribing decisions (as part of shared decision- making) independently or in conjunction with GPs	A notes based, pharmacist-led review of medicines, where the Northumbria 3Q approach was applied to each medicine, that is, was there an indication, was the indication appropriate and was it safe?. Additionally, medicines missing that could be beneficial (eg, START medicines) were identified. This was followed by a MDT meeting where the information from the pharmacist-led review was discussed and an action plan was formulated. Whenever possible, the final decisions were made with patients and their families. After the review,	Care homes in North East England	Intensity of intervention not reported. Prescribing decisions could be made by pharmacists alone or in conjunction with GPs	Once, as a funded quality improvement (QI) project

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		the project database was updated to show medicines taken before review, medicines stopped, started or changed and any other interventions made.			
PINCER Howard 2014[11]; Rodgers 2022[16]	Pharmacists specifically trained to deliver the intervention; GPs, other practice staff and pharmacy technicians involved in implementation	Computer systems of general practices are searched to identify patients at risk of potentially hazardous prescribing using a set of prescribing safety indicators. Pharmacists then provide an educational outreach intervention where they meet with GPs and other practice staff to: • Discuss the search results and highlight the importance of the hazardous prescribing identified using brief educational materials. These feedback sessions were to be held straight after running the searches and then at regular intervals. • Agree on an action plan, retained within the practice, for	General practices	When PINCER was rolled out in the East Midlands, time spent by pharmacists delivering the intervention varied by CCG depending on the resourcing level of the local Medicines Optimisation Team	Data collected quarterly up to 12 months after starting the intervention[16]

		reviewing patients identified as high risk and improving prescribing and medication monitoring systems using root cause analysis Pharmacists (sometimes supported by pharmacy technicians) then work with, and support, general practice staff to implement the agreed action plan, sometimes making the necessary changes themselves			
Eclipse Live (electronic medicines optimisation system (EMOS)) Jeffries 2017[13]	Developed by a private company (Eclipse Solutions) and made available to stakeholders (including doctors, pharmacists, practice managers and patients) by a CCG in the South of England	Web-based user interface which securely extracts patient data from general practice patient records. Accessed separately from the GPs' clinical systems, it allows different stakeholders access to real time anonymized patient data including medical histories of diagnoses, prescribed medications and test results. The EMOS is intended to facilitate clinical audits of prescribing activity to identify patients at risk of ADEs, or not appropriately monitored.	General practices covered by the participating CCG	Not reported (qualitative study)	Not reported (qualitative study)

		Patients can access the system through a "Patient Passport"			
Safety Medication dASHboard (SMASH) Jeffries 2018[12]; Peek 2020[15]; Jeffries 2020[26]	Clinical pharmacists working in general practices and other general practice staff	Pharmacists were trained to deliver the intervention and apply root cause analysis techniques to identify, explore, resolve, and prevent medication errors in partnership with general practice staff. Pharmacists and practice staff were given access to a web-based, interactive dashboard that provided feedback on 12 indicators of potentially hazardous prescribing. The dashboard also provided practice-level summary data as well as educational material.	General practices covered by the participating CCG	Practices interacted with the dashboard a median of 12.0 (interquartile range, 5.0–15.2) times per month during the first quarter of use. Over time, dashboard use transitioned towards regular but less frequent (median of 5.5 [3.5–7.9] times per month) checks to identify and resolve new cases. The frequency of dashboard use was higher in practices with a larger number of at-risk patients.	Dashboard was updated daily. Frequency of use varied by practice and over time (see previous column)
Structured Medication Review (SMR) Madden 2022[14]; Stewart 2021[27]	Clinical pharmacists within general practice primary care networks (PCNs)	Invited, personalised, holistic review of all medicines and their benefits to health for people at risk of harm or medicine-related problems	General practices	Reviews are recommended to be scheduled for at least 30 minutes to allow time for shared decision-making	Once
Medicines optimisation intervention	GP practice-based pharmacists operating as part of the wider primary care team	Each pharmacist received 2 days of intensive specialist training	Eight general practices in four regions of the UK	Initial meeting with further appointments available at 2 and 4 months building on patient progress towards agreed goals	Once per patient (up to three appointments)

Syafhan	on medicines ontimisation		
2021[17]	(including training on		
2021[17]			
	interviewing) The intervention		
	interviewing). The intervention		
	Included: review of patient		
	records prior to meeting;		
	medication history; individual		
	medicines optimisation plan		
	that could include		
	recommending/making		
	changes to medication		
	regimens (in collaboration with		
	GPs), personalised		
	education and counselling on		
	medication management, the		
	correct use of medication		
	administration devices and		
	lifestyle factors; and an agreed		
	list of treatment goals.		
	Pharmacists could also refer		
	patients to another health		
	professional within the		
	practice.		
	Having completed the		
	intervention, the pharmacist		
	produced a short report for the		
	patient's GP outlining		
	actions taken and any further		
	recommendations requiring GP		
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Collaborative pharmacist review	Community and specialist mental health pharmacists	Medicine review using a structured framework based on recommendations of the 2018	Care homes for people with	507 interventions/recommendations for 160 residents reviewed (3.3 per resident)	Once
		Learning Disability Mortality	Intellectual		
Thayer		Review (LeDeR) report.	disabilities		
2021[23]		Pharmacists visited care nomes			
		to conduct the reviews using			
		individual residents' care home			
		records. The specialist mental			
		health pharmacist also had			
		access to the care record held			
		by the Specialist Mental Health			
		Trust, if the resident was under			
		the Trust's care, and remote			
		access to the local data			
		sharing platform.			
		Assessments included			
		medicines adherence and			
		burden (particularly the			
		anticholinergic burden),			
		respiratory care, vaccination			
		status, constipation risk, sepsis			
		prevention, dysphagia risk and			
		lifestyle risk issues, especially			
		smoking. Finally, pharmacists			
		were asked to detail actions			
		taken/advice provided, any			
		recommendations made and			
		make referrals, as necessary.			
		Following the review, GP			
		surgeries and psychiatrists were			
		contacted by the pharmacists			
		to arrange a review of their			

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	recommendations. As the pharmacists were not prescribers, decisions on accepting recommendations were made by the resident's GP/psychiatrist (after reviewing the resident's full clinical record) in consultation with the pharmacists			
Four or More Medicines (FOMM) pharmacists and pharmacy team support service Twigg 2015[24]	<ul> <li>Pharmacists were trained via distance learning and face to face, which included how to use the various different tools and assessments. Training was then cascaded to other pharmacy members.</li> <li>Patients were invited to participate in the service by the community pharmacy team. The pharmacist held regular consultations with the patient and discussed risk of falls, pain management, adherence and general health. They also reviewed the patient's medication using</li> </ul>	Participating community pharmacies	Pharmacist time estimated at 25 minutes for initial consultation, 10 minutes for monthly review and 11 minutes for quarterly review	After the first consultation, patients met with the pharmacist on a regular basis depending on when they collected their repeat medication or they felt a need.