Reviewer's report

Title: Determinants of intentions to monitor antihypertensive medication adherence in Irish community pharmacy: a factorial survey

Version: 0 Date: 25 Nov 2018

Reviewer: Joanna McLaughlin

Reviewer's report:

Thank you for the invitation to review this manuscript. The paper addresses the barriers and facilitators to pharmacists undertaking adherence interventions for antihypertensive medication in the community pharmacy setting. In providing a quantitative assessment of the role of various factors in a large sample it offers valuable insight into the next steps required to address implementation of adherence intervention programmes.

Well done on what is an overall thorough approach to the methodology and analysis of the work undertaken. I have some suggestions and points to clarify as follows:

Introduction

A short section giving the estimated prevalence and impact of poor adherence to antihypertensive medication would be useful to frame the importance of the study question.

Page 4 Line 40: "most patients with hypertension attend a pharmacy at least once a month" Additional comment is needed to clarify here whether this represents patients with diagnosed hypertension/ patients prescribed antihypertensive medication / all hypertensive individuals.

Methods

Page 6 Line 13: the sample size is listed as n=1,543 though the results section states that only 1,153 invitations were sent.

Page 6-7 section on Survey Design: The language here is difficult to follow. I would suggest wording similar to the following may offer improved readability:

"[…] including those of pharmacists [24, 29, 30]."
Items from pre-existing questionnaires and informal qualitative discussions with academic pharmacists experienced in community pharmacy practice were used to inform the survey content. (ref the existing questionnaires here). The TPB framework served as a guide to ensure the survey content would adequately assess all important constructs potentially influencing behaviour.

The TPB is useful in examining behavioural intention and clinical behaviour; however social, organisational, political and economic factors [32] must also be included in theoretical models that seek to evaluate the feasibility of implementing a new clinical service such as an adherence intervention in community pharmacy."

[section ends]

Make it clearer that Table 1 and Fig 2 are related as figure 2 is difficult to interpret when referred to in isolation.

Page 10 Line 39: change "recommend" to "recommended"

Page 11 Line 51: explanation for the difference in number between addresses requested and provided? Depending on the reason there may be reflection required on bias introduced here.

Page 12 Line 26: change "respondent directly access" to "respondent to directly access"

Page 12 Line 36: explanation for the difference in number between addresses received and invitations emailed? The power calculation indicated that 2,315 pharmacists should be invited therefore it's not clear why some email addresses weren't used to get closer to this figure. Depending on the reason there may be reflection required on bias introduced here.

Results

Page 15 Line 3: unclear what is meant by "less true" - that the response was still positive but less strongly so?

Discussion

Principal findings: The finding that pharmacists reported being more likely than not to perform each of the three intervention activities is a little lost in the way the principal findings are presented. Clarify that this was the case and then discuss the differences between each intervention. The current format makes it unclear whether the 'moderately positive attitudes' are implied from the MMAM score alone or from the specific responses to each intervention in the vignettes used.
Strengths and limitations: where social desirability bias is discussed there would be value in commenting on whether this is thought to affect respondents differently dependent on their demographics e.g. newly qualified or by gender.

See comments above on disparities between email address numbers requested, received and emailed with invitations. Discussion of any potential resultant bias will be necessary.

Discuss the relatively high number of surveys (n=72) that were left incomplete - if this was due to busier pharmacists being unable to fulfil them in which case information pertinent to time-pressures may have been lost. If this was due to technical issues or difficulty in pharmacists interpreting what was needed then this should be commented on. Could the partial information have been incorporated into the analyses.

Practice and research implications: Comment on what the actual contractual and professional expectations and responsibilities are for pharmacists in this setting regarding adherence interventions. It is not made clear whether the pharmacists have formal requirements to offer these types of interventions at present and what their awareness is of this aspect on their behaviour. Were any of the pharmacists working in settings where there is an organisational policy requiring action along the lines of these interventions already?

The assertion that the association between offering ABPM and lower likelihood of intervention can be explained by additional time pressure on pharmacists does not seem robust. This would be worth exploring further.

Very little is made of the fact that the study examines only behavioural intentions towards patients aged 65+. Provide explanation on why this decision was made and also the resultant impact on generalisability for the study.
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
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Yes

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Please indicate the quality of language in the manuscript:

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