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Improving Medication Reconciliation at Discharge: A Cross-Sectional Survey

New evidence from RNs' perspectives has invaluable practice implications.

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Despite decades of concerted effort, medication reconciliation remains one of the most persistent patient safety-related challenges in health care, particularly during hospital discharge. Such care transitions are known to be periods of heightened patient vulnerability, as discrepancies in medication lists can lead to adverse drug events (ADEs), preventable readmissions, and poor continuity of care.¹⁻⁴ A recent systematic review by Alqenae and colleagues found that across 11 studies, a median of 50% of adult patients experienced at least one unintentional postdischarge medication discrepancy.⁵ Another recent study by Accomando and colleagues reported that even with pharmacist review, discrepancies were found in 57% of the medications among 89% of patients.⁶

Medication reconciliation has been defined as the systematic process of identifying and maintaining an accurate list of a patient's current medications and using it consistently across care settings.^{4,7} This includes obtaining a complete medication history, verifying the list during hospitalization, and updating it at discharge. Yet despite national mandates from accrediting bodies such as The Joint Commission, hospitals continue to face significant obstacles that compromise the accuracy and timeliness of this process.^{2,7,8} Prior studies have identified multiple barriers, most notably role ambiguity, workflow fragmentation, time constraints, and limited communication among interdisciplinary team members.^{2,7,8} For example, Lee and colleagues found that physicians, nurses, and pharmacists often held differing views regarding who is responsible for completing and verifying medication lists, and that good interdisciplinary communication was sometimes lacking.⁸ Although electronic health records have improved the accessibility of medication information, inconsistent documentation practices

and poor integration across systems continue to create confusion for both clinicians and patients.^{8,9}

Nurses have a central role in preparing patients for hospital discharge, and they are crucial to preventing medication discrepancies. They often serve as the final checkpoint before discharge, reinforcing the patient's understanding of new prescriptions, any discontinued medications, and follow-up care. Yet nurses have reported challenges in verifying the accuracy of medication lists, especially when updates occur late in a hospitalization or when after-visit or discharge summaries are incomplete.¹ In addition to the aforementioned barriers, nurses often name the after-visit summary (AVS) as a vulnerable component, particularly when multiple clinical teams contribute to medication decisions and updates aren't immediately entered in real time.^{1,4,5} (The AVS is the patient-facing discharge document used to educate patients and families, whereas the discharge summary is the clinician-facing medical record used to communicate with outpatient providers.) Such lapses can undermine nurses' ability to provide accurate patient education and contribute to preventable postdischarge confusion, ADEs, and readmissions.

For an illustrative example, see *The Case of Mr. J.: Challenges in Medication Reconciliation at Discharge*.

Study purpose. This study aimed to explore RNs' perspectives of medication reconciliation during hospital discharge, focusing on barriers, communication patterns, and opportunities for system improvement. We hope that the survey findings serve to inform recommendations that will strengthen interdisciplinary collaboration and support safer patient transitions from hospital to home. This work builds on our prior study, a broader quality improvement initiative examining nurses' perspectives on discharge processes and care transitions, which identified medication reconciliation as one of the most recurrent challenges affecting safe patient discharge.¹

METHODS

Design and setting. This study used a cross-sectional survey design to examine nurses' perspectives on discharge medication reconciliation and communication processes. The survey was conducted at Ronald Reagan UCLA Medical Center, a 520-bed quaternary academic teaching hospital in Los Angeles. Data were collected from bedside RNs working on medical telemetry, cardiac observation, short-stay, and general observation units between March 21 and April 30, 2022. At this institution, which

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ABSTRACT

Background: Medication discrepancies remain a persistent patient safety concern despite decades of quality improvement efforts. Research indicates that about half of hospitalized adults experience at least one such discrepancy after discharge, often stemming from unclear clinician roles and poor communication among nurses, physicians, and pharmacists. Understanding nurses' perspectives is critical to designing interventions that will improve medication reconciliation and enhance patient safety at discharge.

Purpose: This study aimed to explore RNs' perspectives of medication reconciliation during hospital discharge, focusing on barriers, communication patterns, and opportunities for system improvement.

Methods: A cross-sectional survey was administered to nursing staff across medical telemetry, cardiac observation, short-stay, and general observation units at a large quaternary academic teaching hospital between March 21 and April 30, 2022. The survey assessed nurses' comfort with patient education, perceived role responsibilities, and collaboration with other disciplines. Quantitative responses were summarized descriptively, and open-ended responses were analyzed using inductive content analysis to identify recurring themes.

Results: Of the 217 nurses invited to participate, 108 completed the survey. Most nurses reported high comfort levels in using teach-back methods (93.5%) and reviewing reconciled medication lists with patients (87%). Responsibility for medication-related discharge tasks was most often viewed as shared, including medication teaching and schedule review as well as communicating medication changes made during hospitalization. Collaboration with pharmacists received the most favorable evaluations, with a majority (60.1%) rating it good or excellent. In contrast, a majority rated as average or worse collaboration with physicians (54.6%), case managers (68.5%), and social workers (63.9%). Free-text responses to open-ended items added further insights.

Conclusions: The study findings indicate that while nurses generally feel confident about their ability to provide patient education, their ability to deliver accurate medication information is hindered by incomplete or inconsistent documentation, role ambiguity, and lapses in interdisciplinary communication. Addressing these issues will require targeted educational interventions, improved interprofessional collaboration, and expanded pharmacy integration. Embedding technological tools such as automated notifications into discharge planning workflows could further improve medication reconciliation and ensure safe care transitions. To achieve these goals, nurses must have accurate medication information, role clarity, and integrated interdisciplinary support.

Keywords: care transition, hospital discharge, interdisciplinary communication, medication reconciliation, nursing, patient safety, pharmacist collaboration

uses the Epic electronic health record system, physicians complete discharge medication reconciliation, pharmacists provide counseling for selected patients, and bedside nurses review the AVS and reinforce discharge education.

This analysis represents a focused secondary examination of data collected during the aforementioned prior study.¹ That study identified several common challenges in discharge planning and provided nurses' recommendations for ways to improve care transitions and patient safety. The present study builds on those findings by examining medication reconciliation as a distinct and recurrent challenge within hospital discharge processes. Per the UCLA institutional review board, the study

met quality improvement criteria and did not require formal human-subjects approval.

Sample. All bedside RNs who were working on the selected units were invited to participate, as they are directly involved in discharge education and coordination. Nurse managers and nurses working in non-bedside administrative roles were not eligible. Participation was voluntary and anonymous.

Each unit identified a nurse champion who posted recruitment flyers in staff areas, announced the study during huddles, and encouraged participation. Unit managers also promoted the study during staff meetings. An invitation email containing a link to the survey, which was hosted on the Qualtrics platform, was

The Case of Mr. J.: Challenges in Medication Reconciliation at Discharge

Mr. J. was a 68-year-old man admitted to the hospital with acute decompensated heart failure. (This is a composite case based on the primary investigator's clinical experience, relevant cases referred to peer review, and themes identified from the open-ended survey responses.) During the course of his five-day stay, the inpatient health care team made multiple changes to his medication regimen, including discontinuing the diuretic he took at home, starting a β -blocker, and adjusting his anticoagulant dosage regimen based on his renal function. Although updates were entered into the hospital electronic health record (EHR), the after-visit summary (AVS) printed at discharge contained outdated information, reintroducing medications that had been stopped during hospitalization.

The discharge nurse, though generally confident in her ability to provide patient education, struggled to determine which medication instructions were accurate. With contradictory documentation and delayed communication from the team physi-

cian, she was unable to answer Mr. J.'s daughter's questions about which medications to resume and which to stop. Moreover, Mr. J.'s AVS gave a vague follow-up plan: "See primary care provider and cardiologist within seven days." But no appointments had been scheduled, and it was unclear whether the patient's primary care provider had received a copy of the discharge summary. Because the cardiologist used a different EHR system, the inpatient team assumed that this outpatient provider would retrieve records manually.

After returning home, Mr. J. and his daughter contacted the primary care provider's office because they weren't sure which medications to continue. Reconciling the discrepancies required additional phone calls among the outpatient clinic, pharmacy, and hospital teams. Although the errors were corrected before serious harm occurred, this case illustrates how communication and workflow gaps during care transitions can delay care, increase clinician workloads, and place patients at unnecessary risk following hospital discharge.

Table 1. Participant Characteristics (N = 108)

Characteristic	No. (%)
Age in years	
≤34	30 (27.8)
35-44	34 (31.5)
45-54	25 (23.1)
≥55	11 (10.2)
Prefer not to answer	8 (7.4)
Gender identity	
Female	86 (79.6)
Male	12 (11.1)
Transgender female	1 (0.9)
Nonbinary	2 (1.9)
Prefer not to answer	7 (6.5)
Race/ethnicity	
Asian	48 (44.4)
Black/African American	6 (5.6)
Hispanic/Latino	9 (8.3)
Native Hawaiian or other Pacific Islander	4 (3.7)
White	20 (18.5)
Other	4 (3.7)
Prefer not to answer	17 (15.7)
English as primary language	
Yes	80 (74.1)
No	28 (25.9)
Highest educational level	
Associate degree	5 (4.6)
Bachelor's degree	76 (70.4)
Master's or doctoral degree	27 (25.0)
Years of RN experience	
<5	21 (19.4)
5-10	22 (20.4)
10-20	44 (40.7)
>20	21 (19.4)

Note: Because of rounding, percentages may not sum to 100.

distributed via the nursing listserv and by the unit champions, with one reminder email sent midway through the active survey period. Two \$50 Amazon gift cards were raffled off among participants who opted to provide their contact information in a separate, unlinked form.

Survey instrument. The survey instrument was developed in 2022 for our prior study¹ and was informed by the Agency for Healthcare Research and Quality's *Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook*.¹⁰ The survey comprised multiple-choice items, items that used a Likert-type response scale, and open-ended items, and addressed a range of discharge planning and care transition topics that included communication, patient education, role clarity, and interdisciplinary collaboration during hospital discharge. Demographic data were also collected. Content validity was supported through

review by hospital medicine physicians and nursing leadership and by pilot testing prior to distribution.

Data analysis. As noted, findings from the full survey have been published previously.¹ The present study involved a focused secondary data analysis, examining medication reconciliation as a distinct discharge challenge. This analysis covered survey responses to 12 closed-ended items and two optional open-ended items spanning four domains relevant to the discharge planning workflow: patient and family engagement in discharge education, discharge-related communication challenges, perceived responsibility for medication-related tasks at discharge, and interdisciplinary collaboration in discharge planning. Most of the closed-ended items used a 4- or 5-point Likert-type response scale to rate the respondent's perceptions regarding patient and family engagement in discharge education, discharge-related communication challenges, quality of interdisciplinary collaboration, and frequency of discharge planning discussions during nurse–physician rounding. Some of these items also included a not applicable option. Perceived responsibility for medication-related tasks at discharge was assessed using multiple-choice options. For items using Likert-type response scales to assess positive constructs (such as comfort with patient education), higher scores indicate more favorable perceptions. For negatively worded items (for example, “Changes in medication lists are not clearly communicated”), higher scores indicate greater levels of perceived problems.

Quantitative responses were summarized descriptively. Open-ended responses were analyzed using inductive content analysis to identify recurring themes that contextualized quantitative findings.

RESULTS

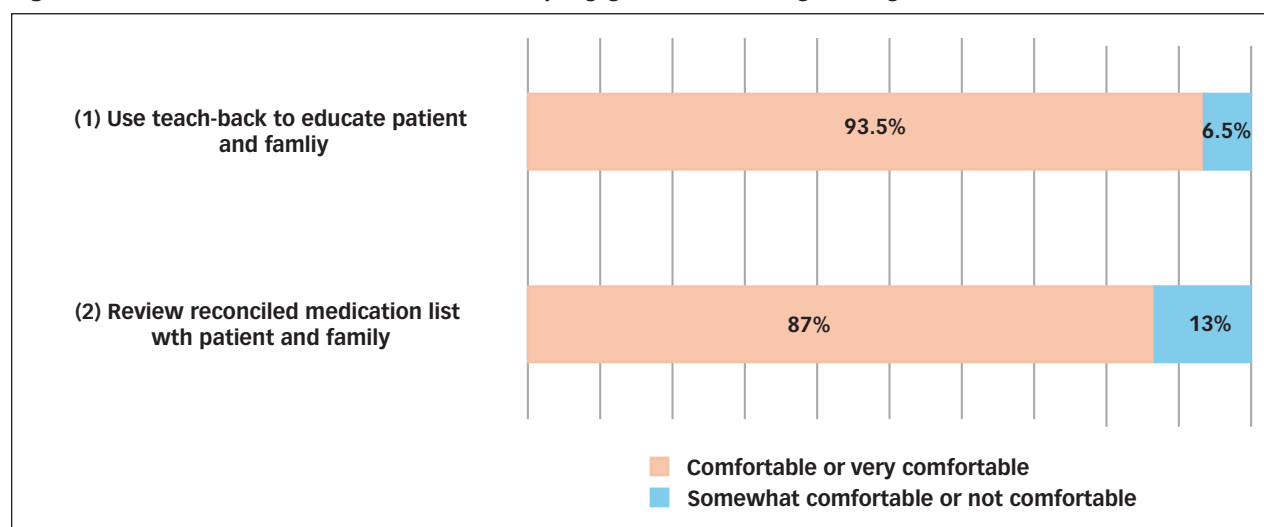
A total of 108 RNs completed the survey out of the 217 invited to participate (a 50% response rate). The majority (79.6%) identified as female. The largest age group consisted of nurses ages 35 to 44 years (31.5%), followed by nurses ages 34 years and younger (27.8%). Almost all nurses (95.4%) had a bachelor's degree or higher, and most (80.5%) reported having five or more years of RN experience. For more detailed participant characteristics, see Table 1.

All respondents completed the closed-ended items included in this analysis. Optional open-ended responses were provided by 26 nurses (24.1%) to the prompt “Please provide any feedback or comments regarding the above questions [on patient and family engagement]”; and by 31 nurses (28.7%) to the prompt asking for more details from respondents rating interdisciplinary collaboration as “poor” or “terrible.”

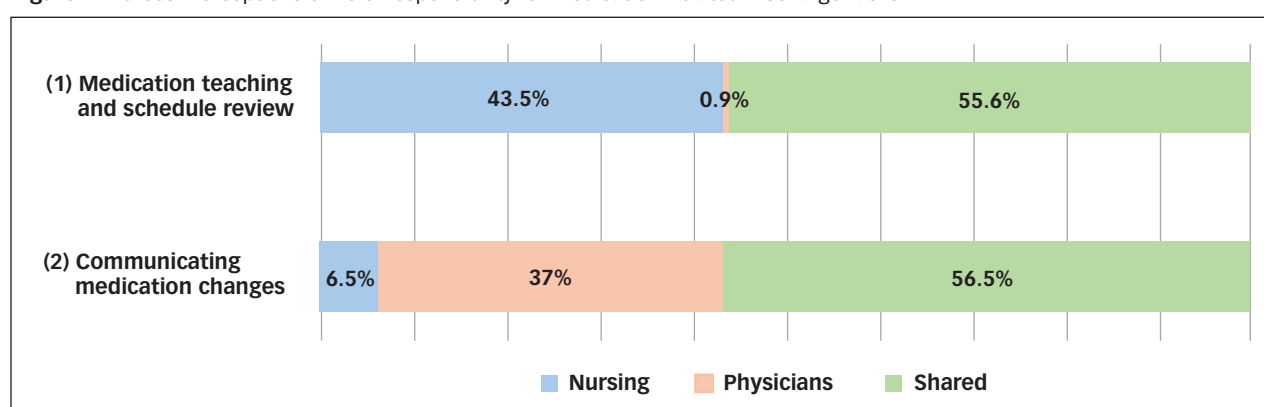
Quantitative findings are presented below, along with illustrative comments to the open-ended items.

Patient and family engagement in discharge education.

Most respondents expressed strong confidence in their ability to engage with and educate patients and families during the discharge process. Of the 108 respondents, 101 (93.5%) reported being comfortable or very comfortable using teach-back to educate the patient and family on the patient's condition and to explain medications, and 94 (87%) reported being comfortable or very comfortable reviewing the reconciled medication list with the patient and family on the day of discharge (see Figure 1). However, open-ended responses to the first prompt cited above revealed ongoing concerns about the reliability of the medication information provided to patients. Among the 26 nurses who submitted comments to that prompt, many described frustration

Figure 1. Nurses' Comfort Level with Patient and Family Engagement Tasks During Discharge

Nurses rated their comfort performing each of two patient and family engagement tasks during the discharge process: (1) using teach-back to explain the patient's condition and medications, and (2) reviewing the reconciled medication list with the patient and family. Bars represent the percentage of respondents reporting being "comfortable" or "very comfortable" versus "somewhat comfortable" or "not comfortable" for each task.

Figure 2. Nurses' Perceptions of Role Responsibility for Medication-Related Discharge Tasks

Nurses were asked to indicate who has primary responsibility (nursing, physician, or shared) for each of two medication-related discharge tasks: (1) medication teaching and schedule review, and (2) communicating medication changes made during hospitalization. Bars represent the percentage of respondents selecting each response option for each task.

with unreconciled or outdated medications appearing on the AVS, which created confusion for patients and families about which medications to continue at home. One nurse explained,

Medication reconciliation [is] not updated by the team, and it can be difficult to know if the patient should continue taking certain meds at home that they stopped taking in the hospital.

Discharge-related communication challenges. Survey responses reflected the respondents' persistent concerns about physician–nurse communication. Fifty-eight respondents (53.7%) indicated that greater physician input was needed to ensure the accuracy of medication information, and 69 (63.9%) somewhat or strongly agreed that changes to medication lists were not clearly communicated. Open-ended responses to the first prompt cited

above reinforced these findings. Nurses frequently described time-consuming efforts to clarify or correct AVS content. One nurse noted that "the nurse spends a lot of time going back and forth with the MD to fix problems [with the AVS]," while another noted that inaccuracies "cause confusion for the patient and family." Communication challenges extended beyond medication-related tasks, with 57 (52.8%) respondents reporting that discharge planning was not consistently discussed during nurse–physician rounding.

Perceived responsibility for medication-related tasks at discharge. The respondents expressed mixed views regarding responsibility for these tasks. Sixty respondents (55.6%) identified medication teaching and schedule review as a shared responsibility of nurses and physicians, while 47 (43.5%) viewed this as primarily a nursing responsibility; only one respondent (0.9%) identified it as primarily a physician responsibility. Similar perceptions were held regarding responsibility for communicating medication

changes made during hospitalization. Sixty-one respondents (56.5%) viewed this as a shared responsibility, 40 (37%) assigned primary responsibility to physicians, and seven (6.5%) assigned primary responsibility to nurses. (See Figure 2.)

Interdisciplinary collaboration in discharge planning.

Respondents' perceptions of the quality of interdisciplinary collaboration varied across professional groups, with pharmacists receiving the most favorable evaluations. Sixty-five nurses (60.1%) rated their collaboration with pharmacists as good or excellent. In contrast, just 49 nurses (45.4%) rated their collaboration with physicians as good or excellent, while 59 (54.6%) rated it as average, poor, or terrible. Collaboration with case managers and with social workers was rated as average, poor, or terrible by 74 respondents (68.5%) and 69 respondents (63.9%), respectively. (See Figure 3.)

Collaboration challenges were also evident across care settings. Sixty-five respondents (60.1%) reported inadequate communication between inpatient and outpatient providers. Among the 31 nurses who provided open-ended responses to the prompt asking for details about collaborations they rated as poor or terrible, many described a lack of direct communication, delayed discharge planning, and an overreliance on nurses as intermediaries between teams. One nurse wrote,

Outpatient and inpatient providers rarely talk if at all. Inpatient should alert outpatient providers about the course and [discharge] plan. However, there are not enough staff to do this. More providers or care liaisons need to be hired to do this well.

For a summary of the analyzed survey items and corresponding response options, see Table 2.

DISCUSSION

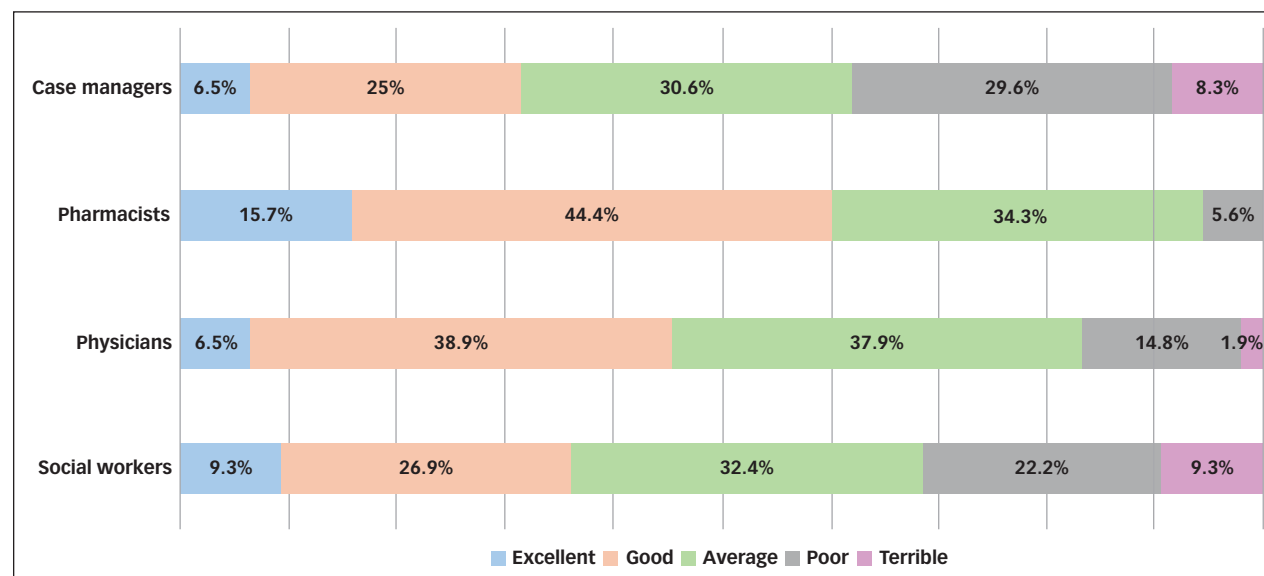
The findings from this survey reveal persistent systemic and interprofessional communication issues that afflict medication

reconciliation during the hospital discharge process. They highlight gaps in the discharge planning workflow that can contribute to medication discrepancies and fragmented follow-up after discharge. Three interrelated themes were identified across the data. First, nurses reported high confidence in their patient and family education skills but low confidence in the accuracy of discharge medication information. Second, the nurses held varying perceptions of role responsibility for medication-related tasks even as they indicated that physician communication was too limited. Third, nurses reported that interdisciplinary collaboration varied widely by professional group, with notable gaps in communication between inpatient and outpatient providers. Taken together, these findings underscore the need for coordinated, team-based solutions that strengthen communication, clarify roles, and support accurate, patient-centered care transitions.

Theme 1. High confidence in teaching skills, low confidence in information reliability. Most survey respondents reported high levels of comfort with using the teach-back method and with reviewing medication lists with patients and families, yet their confidence was often overshadowed by frustration. Respondents described frequently finding inconsistencies between physician orders and the AVS, including discontinued medications reappearing, late updates to orders, and unclear documentation of medication changes. These issues created confusion and made it difficult for nurses to answer patients' questions.

These findings suggest that skillful patient education alone may be insufficient when medication information is inaccurate or incomplete, a troubling indication given previous studies demonstrating that medication discrepancies at discharge remain common and contribute to postdischarge ADEs.^{5,11} In our study, the AVS, which is intended to serve as a clear and comprehensive discharge guide for patients and families, instead emerged as a point of vulnerability as a result of delayed or late updates, fragmented workflows, and inadequate communication across clinical roles and teams. For nurses to engage effectively with patients and

Figure 3. Nurses' Ratings of Interdisciplinary Collaboration During Discharge



Nurses rated the quality of their collaboration with case managers, pharmacists, physicians, and social workers during the discharge process, using a 5-point Likert-type scale (range, excellent to terrible). Bars represent the percentage of respondents selecting each rating category for each discipline.

Table 2. Summary of Survey Items Included in the Secondary Analysis

Survey Items Analyzed	Response Options
Patient and family engagement: Below is a list of suggested practices from the AHRQ that improve the discharge process involvement of patients and their families throughout the hospital stay. Please indicate your comfort level in performing the following practices.	
Daily during hospital stay: Use teach-back to educate the patient and family on the patient's condition and explain medications to them.	4-point Likert-type scale: not comfortable, somewhat comfortable, comfortable, very comfortable; N/A
On the day of discharge: Review the reconciled medication list with the patient and family.	4-point Likert-type scale: not comfortable, somewhat comfortable, comfortable, very comfortable; N/A
Please feel free to provide any feedback or comments regarding the above [patient and family engagement] questions.	Free-text response
Discharge-related challenges: Below are some challenges in providing high-quality care as patients leave the hospital. These challenges have been adapted from the AHRQ's IDEAL Discharge Planning Implementation Handbook. To what extent do you agree with the following statements?	
There is lack of communication between inpatient and outpatient providers.	5-point Likert-type scale: strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree
Changes in medication lists are not clearly communicated.	5-point Likert-type scale: strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree
The primary team physician does not effectively communicate discharge planning to nursing.	5-point Likert-type scale: strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree
Perceived responsibilities for discharge education and communication: Below is a list of patient education discharge items. These challenges have been adapted from the AHRQ's IDEAL Discharge Planning Implementation Handbook. Is the item primarily a nursing, physician, or shared responsibility?	
Medication teaching and schedule	Nursing, physician, shared responsibility
Communicate changes in medication regimen made during hospitalization.	Nursing, physician, shared responsibility
If you answered nursing or shared, is more input needed from physicians in order to successfully fulfill this responsibility?	Yes, no, unsure
Interprofessional collaboration: How would you rate nursing collaboration with the following professionals regarding discharge?	
Case managers	5-point Likert-type scale: terrible, poor, average, good, excellent; N/A
Pharmacists	5-point Likert-type scale: terrible, poor, average, good, excellent; N/A
Physicians	5-point Likert-type scale: terrible, poor, average, good, excellent; N/A
Social workers	5-point Likert-type scale: terrible, poor, average, good, excellent; N/A
If you answered "terrible" or "poor" for any of the above, please explain why and indicate which professionals you are referring to.	Free-text response
Tools and interventions	
How often is discharge planning discussed during physician/nurse rounding?	5-point Likert-type scale: never, rarely, about half the time, most of the time, always

AHRQ = Agency for Healthcare Research and Quality; N/A = not applicable.

Note: Items are organized according to their original survey sections rather than analytic themes. The two open-ended questions were included to capture contextual explanations related to patient engagement and "terrible" or "poor" interprofessional collaboration. Perceived responsibility responses were analyzed descriptively.

families, they must have timely access to accurate and fully reconciled medication information. Without this, the final step of discharge teaching, when patient understanding is solidified, becomes compromised despite nurses' strong communication skills.

Theme 2. Role ambiguity and interdisciplinary communication issues. The data revealed uncertainty regarding which clinicians are responsible for specific components of discharge medication reconciliation. The respondents frequently noted misalignment between their expectations and the level of physician engagement in updating medication lists, documenting discharge instructions, and communicating changes. This is consistent with literature that has described persistent role ambiguity in medication reconciliation workflows.^{3,4} When responsibilities are unclear or inconsistently executed, nurses may be forced to "fill in the gaps," contributing to workflow delays, unnecessary task duplications, and frustration.

Educational interventions have shown promise in reducing role ambiguity. At one California hospital, an interdisciplinary

educational program aimed at clarifying medication reconciliation responsibilities increased completed reconciliation rates from 64.7% to 81.3%.¹² Another study, conducted at a medical center in South Carolina, found that implementing pharmacist-led education for nursing and medical staff led to improved medication history accuracy and identification of medication discrepancies.¹³ At academic medical centers, where resident physicians and other clinical trainees often complete discharge orders, embedding standardized medication reconciliation training into graduate medical and nursing education curricula is especially important. Early clarification of roles and responsibilities, followed by reinforcement through interprofessional feedback, may reduce errors downstream and strengthen shared accountability.

Theme 3. Interdisciplinary collaboration and communication gaps across settings. The survey respondents identified collaboration and communication gaps, both within the inpatient health care team and between inpatient and outpatient

providers, as significant barriers to effective medication reconciliation. They described difficulties in reaching physicians for clarification, inconsistent communication with case managers and social workers, and delays in addressing medication changes. These findings are in keeping with the literature, which has linked such gaps to patients receiving incorrect or confusing medication instructions, increased risk of readmission, and increased risk of postdischarge ADEs.^{5,14}

In the present study, respondents identified pharmacists as a critical but underutilized resource and expressed their desire for greater pharmacist involvement. This is supported by prior studies, which found that pharmacists identified medication discrepancies more effectively than did other clinicians.^{6,9} Moreover, when pharmacists provided medication-related counseling at discharge to patients with low health literacy, the rate of unplanned postdischarge health care utilization was lowered.¹⁵ Pharmacist-led interventions targeting patients at higher risk for readmission have been shown to reduce 30-day readmission rates by pairing comprehensive medication reconciliation with proactive follow-up.¹⁶

The findings revealed persistent gaps in role clarity, interdisciplinary collaboration, and inpatient–outpatient provider communication.

Lapses in communication between inpatient and outpatient providers further threaten safe care transitions. In the present study, respondents emphasized that discharge summaries and medication lists were not consistently transmitted to primary care providers, resulting in delayed continuity of care and incomplete follow-up plans. One potential solution to such lapses was tested in a study by Smith and colleagues, which demonstrated that sending automated electronic notifications to primary care providers reduced medication errors and improved postdischarge outcomes.¹⁷ Similarly, the RightRx system, which automates the integration of community-based pharmacy records into hospital medication reconciliation workflows, has shown potential for reducing discrepancies and improving communication across settings.¹⁸

In short, ensuring the completion of accurate medication reconciliation, improving role clarity, promoting interdisciplinary collaboration, and strengthening communication across care settings are essential to optimize the discharge planning workflow, prevent care fragmentation, and keep patients safe.

Implications for practice, technology, and systems design.

Findings from this study point to several opportunities for system-wide improvement. First, interprofessional education and clear role delineation are fundamental to reducing undesirable task variation and duplication in practice. Joint training sessions for nurses, physicians, pharmacists, and resident physicians and other clinical trainees can foster a shared understanding of responsibilities and improve medication-related communication during care transitions. Second, integrating pharmacists more effectively into the discharge process can support both

medication reconciliation accuracy and workflow efficiency. In settings with limited staffing, at least including pharmacists in the discharge process for high-risk or complex patients may significantly reduce medication discrepancies and prevent readmissions. Third, technology-enabled solutions should be embedded directly into discharge planning workflows. Through the use of automated provider notifications, real-time medication reconciliation dashboards, standardized AVS templates, and artificial intelligence–assisted medication verification tools, hospitals could potentially reduce manual errors, ensure timely information sharing, lessen clinicians' cognitive load, and strengthen communication across disciplines and settings. Such technologies are especially important given the myriad communication challenges identified by the study respondents. Together, these implications highlight the need for systemic approaches that combine education, interdisciplinary collaboration, and technological support to enhance the safety and reliability of medication reconciliation at discharge.

Limitations. This study was conducted at a single quaternary academic medical center, which may limit the findings' generalizability to other settings with different workflows or patient populations. The use of self-reported data may introduce response bias, particularly regarding respondents' perceptions of communication or responsibility. Because the survey gathered only nurses' perspectives and not those of physicians, pharmacists, case managers, social workers, or other clinicians, it could not fully assess interprofessional dynamics. Future research should incorporate multisite sampling and include multiple disciplines in order to guide the development of relevant interventions and evaluate their impact over time.

CONCLUSIONS

The study results provide new nursing insights into the system-level barriers affecting discharge medication reconciliation. While the surveyed nurses reported strong confidence in their ability to provide patient education, their ability to deliver accurate medication information at discharge was undermined by incomplete or inconsistent documentation, delayed updates, and lapses in communication with physicians and other team members. These findings revealed persistent gaps in role clarity, interdisciplinary collaboration, and inpatient–outpatient provider communication, all of which hinder safe, efficient care transitions.

Addressing these barriers will require targeted educational interventions, strengthened interprofessional collaboration, and expanded pharmacy integration. Embedding technological tools such as automated communication systems and medication reconciliation software into discharge planning workflows could further reduce medication discrepancies and improve care continuity across settings. Together, these strategies can enhance patient safety, reduce the risk of ADEs, and promote more reliable transitions from hospital to home. Ensuring that nurses have accurate information, role clarity, and integrated team support is essential to achieving these goals. ▼

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