What Patients Want: A Qualitative Study of Patients' Perspectives on Optimizing the Hospital Discharge Process

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ABSTRACT

Background: Poor discharge planning can lead to increases in adverse drug events, hospital readmissions, and costs. Prior research has identified the pharmacist as an integral part of the discharge process.

Objectives: To gain patients' perspectives on the discharge process and what they would like pharmacists to do to ensure a successful discharge.

Methods: Twenty patients discharged from tertiary care hospitals were interviewed after discharge. A phenomenological approach was used to conduct this qualitative study.

Results: Five main themes were identified from the patient interviews: interactions with health care professionals, importance of discharge documentation, importance of seamless care, comprehensive and patient-specific medication counselling, and patients' preference for involvement and communication at all stages of hospital stay.

Conclusions: Although participants generally reported positive interactions with health care providers at discharge, several areas for improvement were identified, particularly in terms of communication, discharge documentation, and continuity of care. A list of recommendations aligning with patient preferences is provided for clinicians.

Keywords: patient discharge, health service needs and demands, health knowledge, patients' attitudes, pharmacy practice, qualitative research

RÉSUMÉ

Contexte : Une mauvaise planification du congé hospitalier peut entraîner une augmentation des événements indésirables liés aux médicaments, des réadmissions et des coûts. Des recherches antérieures ont reconnu le pharmacien comme faisant partie intégrante du processus associé au congé de l'hôpital.

Objectifs : Recueillir le point de vue des patients sur le processus relatif au congé et sur ce qu'ils aimeraient que les pharmaciens fassent pour assurer la réussite de celui-ci.

Méthodologie : Vingt patients d'hôpitaux de soins tertiaires ont été interrogés après leur congé. Cette étude qualitative a été menée en adoptant une approche phénoménologique.

Résultats : Cinq thèmes principaux ont émergé à partir des entretiens avec les patients : les interactions avec les professionnels de la santé, l'importance de la documentation au moment du congé, l'importance de soins continus, des conseils complets et spécifiques au patient en matière de médication, et la préférence des patients pour l'implication et la communication à toutes les étapes de leur séjour à l'hôpital.

Conclusions : Bien que les participants aient généralement signalé des interactions positives avec les prestataires de soins de santé au moment de leur congé, plusieurs domaines d'amélioration ont été dépistés, notamment sur les plans de la communication, de la documentation au moment du congé et de la continuité des soins. Une liste de recommandations alignées sur les préférences des patients est fournie aux cliniciens.

Mots-clés : congé des patients, besoins et demandes en matière de services de santé, connaissances en matière de santé, attitudes des patients, pratique pharmaceutique, recherche qualitative

INTRODUCTION

Unplanned readmission within 30 days after discharge from acute care facilities is associated with increased risks of morbidity and mortality, as well as increased health care costs.[1,2] In British Columbia in the period 2021–2022, 15.7% of medical patients were readmitted following a discharge.[1] In Canada, the cost of hospital readmission is more than $1.8 billion per year.[3,4] Poor communication and poor planning have been cited as reasons for high hospital readmission rates.[4-6] In the current literature, poor planning during transitions of care has led to calls for action on the part of everyone working at all levels of the health care system, including clinicians, hospital administrators, and policy-makers.[3,6,7] Although professionals in many roles can contribute to optimizing the discharge process, the role of pharmacists is of particular interest because they are in an ideal position to reduce medication problems that may

arise from the discharge process.[7] Studies have shown that pre-discharge medication reconciliation by pharmacists leads to lower rates of prescribing of inappropriate medications and lower occurrence of adverse drug events within 30 days after discharge.[4,7]

Ladhar and others[8] explored the perspectives of hospital pharmacists in British Columbia concerning the discharge process. They found that pharmacists felt they could contribute significantly but were restricted by time and resources.[8] A follow-up survey revealed that less than 60% of patients in tertiary care hospitals received discharge interventions from pharmacists.[9] Medication reconciliation has been deemed the most critical intervention from the pharmacist's perspective.[8]

Although hospital pharmacists may perceive medication reconciliation as their most important contribution at discharge, it is important for health care providers, including pharmacists, to incorporate patients' views into the care that they are providing. Several studies have specifically examined patients' preferred interventions during the discharge process. In their systematic review, Ozavci and others[7] found that there is often a communication breakdown between hospital and community settings, leading to medication discrepancies and a decrease in patients' ability to self-manage their medications. Patients were disappointed by the lack of medication counselling and the lack of communication between the hospital and their primary care providers.[7] In another study, inadequate explanation about medications at discharge was commonly reported, which led to omission of medications, incorrect dosages, anxiety, and confusion.[10] Conversely, a systematic review of discharge interventions revealed that a customized discharge plan led to reductions in hospital length of stay and readmissions.[11] These studies employed various methodologies, were conducted in diverse patient settings, and focused on different outcomes, creating a challenge for pooling of relevant data. Therefore, a specific interest lies in investigating the experiences of patients in the current Canadian health care system.

The purpose of this study was to gain patients' perspectives on the discharge process and what they would like pharmacists to do to ensure a successful discharge.

METHODS

This qualitative study used key informant interviews. The methodology is grounded in phenomenology, which aims to understand the meaning that individuals ascribe to their lived experiences.[12]

Study Population and Recruitment

Patients were recruited from the general medicine wards of Vancouver General Hospital (VGH) and St Paul's Hospital (SPH) between December 2022 and February 2023. The investigators were not involved in the care of this patient population. These facilities are tertiary care teaching hospitals, with 700 acute care beds at VGH and 400 beds at SPH. At both hospitals, registered nurses designated as care management leaders coordinate discharge plans. The care management leaders at each hospital identified patients scheduled for discharge within 48 hours, and 4 of the investigators (S.[A.]L., K.D., J.K., J.H.) screened the patients for eligibility. Patients eligible for inclusion had to be cognitively intact, had to be taking 5 or more regularly scheduled medications, and had to have been admitted for at least 48 hours. The criterion related to number of medications was based on a similar qualitative study that aimed to capture moderate complexity in medication management.[8] Recruitment was stopped after 20 patients had been interviewed.

Patients who were eligible for the interview received a brochure about the study from their bedside nurse. The investigators returned 24 hours later to gauge interest and obtain informed consent. Post-discharge interviews were then scheduled, to be conducted by telephone or an online meeting platform (Zoom), according to each participant's preference. Patients were offered a $10 coffee gift card as an incentive to participate. Ethics approval for the project was obtained from the University of British Columbia Behavioural Research Ethics Board.

Data Collection

Each patient was contacted by one of the investigators (S.[A.]L.) within 5 days after their discharge. A total of 3 attempts were made to reach each patient. The interviews were conducted with either the participant alone or, for those not fluent in English, the participant and a caretaker, who acted as translator.

The interview questions were based on prior literature[7,13] and were reviewed by the research group and a patient partner, an individual with personal experience of the health care system who collaborates with researchers to provide insights. The interview questions focused on the discharge experience related to medications, with the aim of uncovering both successes and challenges during this process. The patient partner provided advice on the interview questions and how to improve recruitment. No repeat interviews were carried out. Field notes were not made during or after the interviews. Rather, the interviews were audio-recorded and transcribed verbatim into word-processing software (Microsoft Word) by the same investigator who conducted the interviews (S.[A.]L.). Transcripts were not returned to patients for comment.

Data Analysis

The transcripts were coded using NVivo version 1.7.1 qualitative data analysis software (QSR International). The codes were subsequently categorized into themes. Three of the

investigators (S.[A.]L., K.D, J.K.) met to discuss the initial codes for the first transcript. Subsequently, S.(A.)L. and J.K. independently coded the data and met 5 times to resolve discrepancies until consensus was reached. The full research group met an additional 3 times to discuss the codes and reach consensus on the identified themes. Participants were not asked to provide feedback on the findings.

RESULTS

The COREQ checklist was used to guide the reporting of this qualitative study.[14]

Of the 40 patients initially recruited, 2 withdrew, and 1 was ineligible because they were transferred to another hospital. In addition, the investigators were unable to reach 17 participants after initial recruitment. Interviews (lasting from 10 to 60 minutes) were conducted by telephone for the remaining 20 participants. On average, participants were 71 years old (Table 1). The median number of long-term medications was 9 before admission and 10 after discharge. Among all participants, 19 (95%) had a medication change and 12 (60%) used compliance aids provided by their community pharmacy for medication management.

Five main themes were identified from the interviews: interactions with health care professionals, importance of the discharge document, importance of seamless care, comprehensive and patient-specific medication counselling, and patients' preference for involvement and communication at all stages of the hospital stay.

Interactions with Health Care Professionals

During their hospital stay, the participants reported positive interactions with health care professionals, frequently characterizing these care providers as excellent and caring. Participants expressed a sense of trust and reliance on the health care team:

> I trust what they're saying. I trust what they're prescribing, and I trust what they think I should take moving forward. (Participant 1)

TABLE 1. Baseline Demographic Characteristics

Characteristic	Mean ± SD[a] (*n* = 20)
Age (years)	71 ± 13
Length of admission (days)	10 ± 9
No. of long-term medications	
Before admission	9 ± 3
During admission	12 ± 5
After discharge	10 ± 3
No. (%) with medication change at discharge	19 (95)

SD = standard deviation.
[a]Except where indicated otherwise.

Upon further inquiry, a substantial number of patients reported difficulty in recalling which health care professional had specifically communicated with them about medications, given that various individuals came into their room at different times.

> I really don't remember who spoke to me, if it was a doctor or nurse or a pharmacist. (Participant 35)

Nonetheless, 11 (55%) of the participants recalled speaking to a pharmacist.

Importance of the Discharge Document

At the time of discharge, patients were given a discharge document as part of the hospital's standard of care. This document included a summary of the patient's course in hospital and a list of medications, specifying what medications had changed and why.

> I really appreciate the list of the medications and it says how much, how, when, reason, next dose and additional instructions. (Participant 28)

Despite its utility, many patients encountered difficulties interpreting the contents of the discharge document, which led to confusion. More specifically, 10 (50%) of the participants reported some level of confusion with the discharge document. One participant was not aware, until she read through the discharge document, that she was to discontinue taking a certain medication and was disappointed that the reason for this change in her medication therapy was not detailed on the form:

> [Reading the discharge document] was how I found out I wasn't supposed to take some pills. If they're going to discharge people and not go over it, the discharge papers where it says, "don't take", and then "why not". The "why not" was not filled in. (Participant 22)

Several participants admitted to not reading the discharge document until after they had left the hospital, citing a lack of communication about or awareness of its significance. Another participant stated that the document was handed to them as they were walking out of the hospital; this observation ties into the lack of emphasis on discharge documentation exhibited by the health care team.

Importance of Seamless Care

Participants expressed a strong desire for optimal continuity of care after discharge, yet this desire was often not fulfilled. According to participants, quality continuity of care comprises several elements, the first of which is sending accurate prescription orders to the community pharmacy in a timely manner. An accurate prescription includes all details required for dispensing and aligns with clinical appropriateness. One participant recounted that their prescription

was sent to the wrong pharmacy, and another noted that the discharge prescription contained errors, which led to a delay in receiving treatment. One participant was unaware that his discharge package contained a prescription.

A second element of continuity of care involves explicit guidance on post-discharge follow-up appointments. One participant needed a follow-up appointment with a urologist, but this appointment was not scheduled or communicated with them at the time of discharge.

> We don't know yet where and when are we going to have the next appointment. (Participant 15)

Another participant reported receiving a list of doctors with whom to follow up, but the contact numbers were missing.

> How do I find these people? How do I get these phone numbers to make these appointments? (Participant 35)

Finally, many expressed a desire for continued contact with hospital staff after discharge, either through follow-up appointments or by having access to hospital staff if needed. They often felt disconnected from the health care system once discharged.

> I feel also that you're kind of on your own after you come out of hospital. There's no follow-up from any doctor, nothing. I wish there was more follow-up. They get busy with the existing patients, but it would be very nice to be able to follow up with the physician who has dealt with you. (Participant 2)

Comprehensive and Patient-Specific Medication Counselling

Patients desire medication counselling that is comprehensive and tailored to their specific needs. Although many participants in our study reported receiving medication counselling during their hospital stay, they often struggled to recall the information provided or found it unclear and incomplete. Many participants expressed a desire for more comprehensive and patient-specific medication counselling, which would include detailed information about the reasons for any changes made to their medication regimen, potential side effects, and interactions for which monitoring would be needed.

> It would have been helpful to have somebody give me more of an explanation on what medications are changing. Nobody really gave me a full explanation on it. (Participant 25)

> I'd like to know what each of the medications was, and I would like to know beyond what this medication is. (Participant 15)

Participants pointed out the importance of considering patient-specific factors when providing medication counselling. For some participants, medical conditions affecting cognition may limit their ability to remember verbal instructions. Some prefer that medication information be conveyed to their caregiver instead. A few highlighted the importance of considering their level of understanding of their own medical condition to decide the amount of detail needed in counselling. One participant suggested the following approach:

> [Provide a] verbal expression what the drug is, what the dose effects might be, how often to take it, and then if there was a handout to go with it, I would appreciate receiving that. (Participant 31)

Patients' Preference for Involvement and Communication at All Stages of the Hospital Stay

Patients desire consistent and frequent communication throughout all stages of their hospital stay, from admission to discharge. In particular, during the admission, they would like to be involved in planning all stages of their hospital stay.

> I complained to one person about, "let's make a plan here", because it seemed like no one was making a plan, […] There was none of that going on. It would have been nice. (Participant 28)

At the time of discharge, participants preferred early communication regarding their discharge plan to ensure they were adequately prepared to transition back home:

> Just to give me a heads-up going home and just give me a heads-up as to what's been going on and how it progressed or digressed, and I heard nothing. (Participant 1)

The pace at which discharge was carried out varied among the participants:

> Going home was very abrupt and caught me by surprise. (Participant 28)

Another participant shared an experience of being left uninformed about the expected pre-discharge wait duration:

> The whole discharge experience could be more rapidly exercised […] It was a whole day of waiting. (Participant 33)

Participants preferred that the discharge process be neither too rushed nor too prolonged, since each of these scenarios could cause undue stress.

DISCUSSION

In this study, we identified several subthemes relating to interactions with health care professionals, the importance of the discharge document and of seamless care, medication counselling, and communication during the hospital stay.

Although the majority of participants recalled positive interactions with health care professionals, there seemed to be difficulty in distinguishing the roles of various providers. Just over half (55%) of the participants recalled speaking to a pharmacist, which is similar to the finding of a prior Canadian study, which reported that 50% of patients or care providers recalled interacting with a pharmacist during the hospital stay.[15] We did not check the patients' charts to verify interactions with care team members, so there is a possibility of recall bias. Even so, this finding reveals that patients may not always be aware of the identities of the health care professionals with whom they interact.

The discharge document containing the medication list was highly appreciated by participants. This finding aligns with the results of a qualitative study conducted in the United Kingdom, in which most patients expressed the value of receiving a medication list.[16] However, we found that many participants were confused by the discharge document, and only half of them reported understanding its contents fully. Participants in our study mentioned technical terms and acronyms as barriers to understanding the document. The authors of the UK study suggested removing acronyms, jargon, and technical terms from discharge summaries as a potential solution.[16]

Participants also emphasized the importance of seamless care, which encompasses accurate prescriptions being faxed promptly to their community pharmacy, effective post-discharge follow-up, and ability to contact hospital staff after discharge. Pharmacist involvement in discharge medication reconciliation plays a crucial role in ensuring the accuracy of prescriptions, as evidenced by a prior study in which involvement of pharmacists led to a significant (57%) reduction in unintentional discrepancies.[17] However, the ability to fax prescriptions to community pharmacies may be hindered by staffing levels at each site.

Communicating the follow-up plan to patients can help to prevent dissatisfaction and omission of follow-up actions, as highlighted in the qualitative study conducted in the United Kingdom.[16] Additionally, participants in the current study expressed a desire to be able to connect with health care professionals from the hospital after discharge. Although ready access to providers after discharge may not always be feasible, this finding could prompt further investigation into the reasons behind patients' perceptions of disconnection from the health care system. Exploring the gaps in continuity of care that contribute to this desire for follow-up with hospital staff could offer valuable insights.

To address immediate post-discharge questions, a possible solution would be for hospitals to establish a dedicated phone line that patients could use if they have questions in the period shortly after discharge. Another effective solution would involve having a clinical pharmacist proactively follow up with patients after discharge. Odeh and others[18] found that telephone follow-up by clinical pharmacists significantly reduced hospital readmission rates, with positive effects on time to readmission, length of hospital stay upon readmission, health care costs, and patient satisfaction.

Additionally, participants in our study faced challenges in understanding and recalling medication-related information. Studies have shown that a significant proportion of medical information provided by health care professionals is forgotten, with estimates ranging from 40% to 80%.[19] Nonetheless, our participants expressed a preference for more comprehensive medication counselling, including an overview of their medications, indications, and side effects. A previous survey of patients at a New Brunswick hospital found that they wanted pharmacists to provide such information.[13] Pharmacists can enhance patients' understanding of their medications by providing repetitive and straightforward instructions during bedside visits over the course of the hospital stay. This approach would foster more comprehensive understanding, which could potentially improve patients' recall and understanding of medical information.

Patients' preferences for medication counselling may vary, influenced by factors such as difficulties associated with medical terminology, the mode of information delivery, and individual characteristics. Patients tend to prioritize diagnostic information over treatment instructions, which can lead to information gaps. To address these challenges, combining spoken information with written or visual materials is recommended; visual aids may be especially important for patients with low literacy.[19] Another method would be to conduct standardized health literacy assessment for patients, with a view to tailoring communications and tools to match each individual's health literacy.[20] Tailoring communication to a patient's physical, cognitive, and emotional state, their functional health literacy, and their preferences would also improve their understanding of medication information.

Finally, active patient involvement and effective communication throughout the hospital stay are crucial for increasing patient autonomy and engagement in the discharge process. Studies have shown that when patients feel involved in their own care, their satisfaction levels are higher.[21] For example, O'Leary and others[22] found that a significant number of hospitalized patients do not understand their care plan and may have misconceptions about the timing of their discharge. Uncertainty regarding discharge time and date have been reported by discharged patients in other studies as well.[10] To address these issues, early communication about the discharge plan, along with informative materials and clarification of key details, is crucial. By involving and communicating with patients throughout their hospital stay, health care providers can create a more positive and patient-centred experience.

The findings of our study can help inform health care leadership about areas for improvement in the discharge process and strategies to enhance the quality of care for

patients. Whereas previous research has focused on the perspectives of pharmacists, emphasizing the significance of medication reconciliation during the discharge process,[10,11] it is noteworthy that patients in this study articulated the importance of an accurate and comprehensive prescription document, which would be the direct result of successful medication reconciliation. Patients place great emphasis on effective communication and understanding of their care and medications, as well as on receiving a clear and easily comprehensible discharge document. These findings provide valuable insights for policy-makers and health care leaders, emphasizing a need to focus on patient-centred interventions that address patients' preferences during the discharge process. By aligning discharge practices with patient expectations, health care systems can enhance patient satisfaction, improve transitions of care, and ultimately optimize patient outcomes. Potential future research could delve deeper into the themes uncovered in this study, including avenues for enhancing the discharge document, implementing communication strategies to facilitate seamless care, and improving comprehension of discharge plans and medication changes.

Several recommendations have been developed as key takeaways from this study (Box 1). These are intended for clinicians involved in the care of patients, including pharmacists, nurses, and physicians.

Limitations

The study had several limitations. First, selection bias might have arisen from initial screening by the care management leaders, potentially favouring patients with positive experiences over those with negative ones. Second, underrepresentation of non-English-speakers and individuals with limited technical skills might have limited insights obtained from diverse groups. High loss to follow-up and stopping recruitment after 20 interviews (instead of continuing with interviews until data saturation was achieved) also raise concerns about incomplete representation of the study population. Repeat interviews were not carried out, which might have influenced the development of rapport between researcher and participant, thus affecting the richness of data collected. These limitations should be considered when interpreting the study results.

BOX 1. Recommendations for Clinicians

Introduce yourself to the patient and clarify your role.
Review the discharge document with the patient before discharge, and check for understanding.
Tailor medication counselling specific to the patient, with focus on reasons for change and monitoring.
Provide updates and early communications about discharge plans.
Ensure there is seamless care into the community after discharge.

CONCLUSION

Overall, we found that patients had generally positive interactions with health care professionals, although they may not always have been aware of the specific roles of the health care providers with whom they interacted. It is important to provide patients with easy-to-understand discharge summaries and to check their understanding of these documents. Aspects of seamless care that are important to patients include having accurate discharge prescriptions sent to the community pharmacy, clear communication of follow-up plans, and easy access to hospital staff after the discharge. Comprehensive and patient-specific medication counselling may be provided along with written or visual materials. This study also emphasizes the importance of involving patients in all stages of their hospital stay, particularly in the communication and understanding of their discharge plans. By addressing these preferences, health care providers can improve quality of care, promote patient engagement, and facilitate smoother transitions of care for patients.

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