Danger Ahead—You Are Being Discharged

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Transitions of care are potentially dangerous times for patients as they travel through the health care system. Nowhere is this more evident than on discharge from hospital. Over an 11-month period about a decade ago, the Canadian Institute for Health Information found that hospital readmission within 30 days of initial discharge was common (estimated at 8.5%), costly (at $1.8 billion), and preventable more than half of the time.[1] Medication-related issues have been identified as an important contributor to readmissions, with prescribing problems and adherence issues most frequently cited.[2]

Three papers in this issue highlight the discharge process, each emphasizing an important message. First, discharge planning needs to start early during hospital admission and should include a comprehensive medication review to prevent inappropriate prescribing on discharge, which in turn has the potential to reduce drug-related readmissions. Second, patient perspectives should be considered in discharge planning, something that is all too often neglected in our overwhelmed health care system these days. Finally, pharmacists need to critically think about how and when we perform evidence-based discharge activities.

The need for comprehensive medication review as a component of early discharge planning is demonstrated by Madey and others.[3] These authors identified prescribing issues that can arise for older, frail persons who receive antipsychotic agents during hospitalization. For one-third of the patients, these drugs were continued at discharge, with only 15% having a documented postdischarge antipsychotic follow-up plan and 40% still having an antipsychotic prescription at 180 days after discharge, putting them at risk of well-documented medication-related harms. While there are valid indications for antipsychotic use in older persons, these agents are not generally required over the long term when used for delirium, a common reason for prescribing antipsychotics during hospitalization. Moreover, when used for behaviours related to dementia, a plan for reassessment at 3 months should be in place.[4]

Madey and others[3] identify comprehensive medication review as one means to ensure that antipsychotics prescribed in hospital are not continued inappropriately on discharge. This approach is consistent with guidance from the World Health Organization, which has identified transitions of care as a priority area for medication safety, with comprehensive medication review as a key step.[5]

In the study by Yeh and others,[6] nonpharmacist team members identified performing discharge medication reconciliation and providing patient education—both of which have been shown to reduce 30-day readmission rates[7]—as the primary responsibilities of a pharmacist in the discharge process. However, the patient's perspective on the discharge process, as examined by Luo and others,[8] suggests that we reconsider when and how medication education takes place. Although patients had generally positive perceptions, they reported that medication counselling did not always meet their specific needs and should be more comprehensive, especially in relation to changes to their home medications. Furthermore, patients noted difficulty in recalling medication information provided to them and in interpreting discharge documents, including those related to drug therapy. These data support the need for a postdischarge medication follow-up to respond to patient questions, address difficulties in obtaining medications, and identify problematic side effects. Yet, despite demonstrated benefits in terms of readmission rates and patient satisfaction, such models of postdischarge care involving pharmacists are uncommon.[9]

An in-depth comparison of outcomes related to medication education provided before or after discharge is beyond the scope of this editorial, but consideration of this issue does raise the question of whether we should be rethinking when and how we deliver patient education. We also need to consider the potential for an expanded role for our community pharmacy colleagues, as established by the UK National Health Service (NHS). Recognizing patients' need for medication support after a hospital stay, the NHS Discharge Medicines Service aims to improve communication upon hospital discharge and thus reduce preventable medication-related harms.[10] I look forward to upcoming evaluations of this program and the potential for its adaptation to the Canadian health care system.

There is no question that pharmacists make hospital discharge safer, but patients still seem to fall through the cracks. Is it time to reflect more systematically on what the discharge process involves, when it should begin, and how to best deliver it?

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