

Medication Reconciliation during Transitions from Hospital to Home-Based Palliative Care: Nursing Roles and Implementation Challenges

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Abstract

Medication reconciliation during transition from hospital to home-based palliative care is often treated as a discharge task even though medication meaning, ownership, feasibility, and appropriateness continue to change at home. This conceptual article presents a transitional medication-safety framework integrating discrepancies, continuity, information transfer, patient and caregiver work, nursing surveillance, pharmacist and prescriber interfaces, and implementation conditions. Reliable reconciliation requires an interpretable medication state that is communicated, received, understood, supplied, enacted, reassessed, and corrected. The framework separates verification, responsibility transfer, early-home comparison, discrepancy interpretation, authorized resolution, and feedback. Nurses often detect mismatch after responsibility is distributed across services, while pharmacists, prescribers, patients, and caregivers contribute different knowledge and authority. Reconciliation is therefore a longitudinal function supported by both clinical accuracy and an operable system of responsibility.

Keywords: Medication reconciliation, Palliative care, Transitions of care, Home nursing, Medication safety, Continuity of care

Introduction

Medication management after hospital discharge is increasingly understood as a participatory process in which patients and families may need to interpret, question, organize, and enact treatment instructions, yet the degree of meaningful involvement varies substantially across transitional-care interventions [1]. Evaluation is also fragmented: studies of medication optimization at discharge use many different outcomes, limiting the extent to which “successful reconciliation” can be inferred from any single endpoint [2]. These problems are intensified in home-based palliative care, where family caregivers may assume unfamiliar responsibilities while simultaneously adapting to serious illness, symptom change, uncertainty, and new service arrangements [3].

Medication reconciliation is examined as a transitional implementation problem: how an intended regimen remains interpretable, available, executable, clinically appropriate, and correctable after responsibility shifts from hospital to home.

Conceptual approach

Transitional-care research describes effective hospital-to-home support as a combination of coordination, communication, continuity, education, follow-up, and collaboration rather than a single discharge event [4, 5]. For medication safety, this implies that reconciliation should be treated as a distributed process whose reliability depends on whether an intended regimen survives movement across organizational and temporal boundaries.

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The same transition may impose substantial work on informal carers. Reviews of older-adult transitional care identify informational, practical, relational, and service-access needs that can facilitate or constrain carers' participation [6]. In this article, transitional medication safety therefore refers to the preservation of an interpretable and clinically appropriate medication state while information, responsibility, and medication work shift across settings and actors. The concept is intentionally broader than list accuracy: a technically correct record has limited value when medicines are unavailable, instructions are misunderstood, responsibility is ambiguous, or emerging changes cannot be resolved.

Why hospital-to-home transition is a medication-safety vulnerability

Post-discharge medication error, unintentional discrepancy, and medication-related harm are recurrent findings across hospital-to-community studies [7]. Their significance lies partly in the fact that discharge simultaneously changes the location of care, the professionals immediately available, the documentation environment, and the person expected to execute the regimen.

Evidence from older hospitalized populations shows that unintentional discrepancies may arise before, during, or after discharge [8, 9]. The transition therefore cannot be evaluated from the final discharge list alone. **Table 1** distinguishes list accuracy, reconciliation, information continuity, medication ownership, and longitudinal medication safety.

Table 1. Analytical differentiation of medication-state concepts across the hospital-to-home palliative transition

Analytical unit	Central question	What constitutes apparent success	What can still fail despite apparent success	Relevance to home palliative care
Medication-list accuracy	Does the documented list correctly represent intended medicines at a particular time?	Medicines, doses, routes and frequencies are recorded as intended	Subsequent changes, supply problems, duplication, misunderstanding or non-use	Establishes a necessary starting medication state
Medication reconciliation	Have medication differences been identified, interpreted and intentionally resolved?	Differences are explained and an agreed regimen is documented	Responsibility for implementation or follow-up may remain unclear	Connects historical medication use with the intended transition regimen
Information continuity	Can downstream actors obtain and interpret the medication rationale?	Relevant medication information reaches the next setting	Receipt, comprehension or incorporation into local records may fail	Critical when hospital and community systems are separated
Medication ownership	Is it clear who must verify, monitor, clarify and authorize changes?	Functional responsibility is explicit	Several actors may participate without anyone accepting unresolved work	Particularly important when patients, caregivers, nurses, pharmacists and prescribers share tasks
Transitional medication safety	Does an accurate and appropriate regimen remain executable and correct across time?	Medication state, responsibility and follow-up remain coherent after discharge	Changes in symptoms, goals, supply, cognition or home capacity destabilize the regimen	Treats reconciliation as an ongoing transition function rather than a one-time checklist

Note: The table separates related constructs that can coexist but should not be treated as interchangeable. No single domain is sufficient to establish medication safety across the entire transition.

Transition theory and continuity of care

Direct studies of hospital-to-home palliative transitions show that patients and caregivers experience the move through interacting practical, informational, relational, and service-level enablers and barriers [10]. Continuity is therefore experienced through the usability of care arrangements, not simply the presence of a discharge document. Patient and caregiver accounts further indicate that continuity includes both reliable information and sustained relational connection across the hospital-home boundary [11].

A longitudinal study of palliative transitions also demonstrates that readiness, transition quality, and coping can change between the pre-discharge period and the first weeks at home [12]. This temporal variation matters for reconciliation because medication understanding that appears adequate before departure may become inadequate when symptoms change, the regimen is enacted without bedside support, or new questions emerge. The transition should therefore remain open to verification and correction after hospital discharge.

Pre-discharge medication reconciliation

Medication reconciliation can reduce medication errors compared with usual care, although effectiveness varies across settings and intervention designs [13]. Its hospital-side purpose is to create a defensible medication state before the patient leaves: previous medication use is compared with the intended discharge regimen, differences are interpreted, and intentional changes are distinguished from inadvertent discrepancies.

Pharmacists frequently perform important parts of this work, but pharmacist-led discharge reconciliation itself encompasses heterogeneous methods, tools, and service configurations [14]. The relevant conceptual unit is therefore the reconciliation function rather than a single profession. Implementation evidence from the MARQUIS2 programme similarly indicates that systematic tools can be strengthened by mentored implementation and local process redesign [15]. Pre-discharge accuracy is thus partly an organizational achievement. It creates the starting state for transition but does not establish that downstream actors will receive, understand, supply, or maintain the regimen.

Information transfer at discharge

Once the intended regimen is established, medication information must cross the organizational boundary in a form that remains clinically usable. A multifaceted discharge intervention incorporating medication reconciliation, documentation, and interprofessional work improved several handover-process measures in a pilot hospital study [16]. Such findings support attention to the quality and timeliness of transferred information, while remaining insufficient to establish downstream palliative outcomes.

A recent scoping review of hospital-to-primary-care information transfer found substantial variation in transfer practices and no clear consensus on an optimal approach [17]. Importantly, transmission is only one stage of continuity. Stakeholder research identifies delayed documentation, fragmented digital systems, incomplete information, and weak confirmation of receipt as recurring vulnerabilities [18]. A transition can therefore appear complete from the sending organization while remaining informationally incomplete for the receiving team. Medication handover should be evaluated according to availability, interpretability, receipt, and capacity for clarification.

Medication ownership and accountability

Medication information becomes clinically meaningful only when someone is able and expected to act on it. Co-design work involving hospital clinicians, community providers, patients, and carers shows that discharge handover can involve differentiated functions such as identifying higher-risk patients, improving medication documentation, preparing patients to ask questions, and coordinating follow-up [19]. Participation across several actors, however, does not itself establish accountability.

Qualitative synthesis of medication-management communication during care transitions similarly identifies information exchange, participation, and shared responsibility as interconnected processes [20]. For this article, medication ownership means functional accountability for a defined task: creating or verifying the medication state, communicating it, accepting it, monitoring its enactment, clarifying uncertainty, or authorizing modification. Ownership can be distributed, but each unresolved task still requires a credible route to an actor with the authority and capacity to complete it.

Early home transition

The early home period is analytically important because it is the first setting in which the discharge medication state is tested against actual use. Comparisons of medication records with medicines reported after return home can reveal omissions, additions, dose differences, and other forms of discordance [21]. Some differences are clinically intentional; others indicate that reconciliation or implementation remains unfinished.

Continuity also has a supply dimension. National pharmacy evidence demonstrates that transfer of medication information and continuity of medication access can remain problematic even where formal discharge requirements exist [22]. A correct list cannot be enacted when the medicine is unavailable, duplicated, or obtained under conflicting instructions.

Digital integration can improve part of this pathway. A randomized trial of shared digital medication information across hospital and primary care found fewer unintentional discrepancies in the intervention pathway [23]. Yet digital visibility cannot determine treatment appropriateness, assign responsibility, assess caregiver capability, or ensure that uncertainty is clinically resolved. Technology modifies the transition; it does not replace reconciliation.

Patient and caregiver medication work

At home, patients and caregivers become active components of medication-system performance. Home-visit research with family caregivers describes substantial work involved in interacting with health services, obtaining information, coordinating medication-related tasks, and compensating for system gaps [24]. These demands can remain largely invisible when reconciliation is evaluated only through professional documentation.

End-of-life care makes this work more consequential. Family caregivers may organize, prepare, administer, monitor, and interpret medicines while also managing distress, uncertainty, and changing relationships with professionals [25]. The medication state therefore needs to be executable by the person who will actually enact it. Patient participation can be supported before discharge. A feasibility trial of co-designed digital tools showed that structured medication information and question-prompting approaches can encourage participation, although feasibility and acceptability do not establish reduced medication harm [26]. The conceptual implication is

narrower: reconciliation should prepare patients and caregivers to recognize uncertainty and know how to obtain clarification [27].

Community nursing responsibilities

Community and home-care nurses often encounter the medication regimen after it has left the environment in which it was prescribed and reconciled. Qualitative research on nurses' discharge-reconciliation roles describes activities such as checking medication information, educating patients, coordinating with other professionals, and pursuing unresolved questions [28]. Nurses also report barriers related to guidance, training, confidence, workflow, and organizational support.

In home palliative care, this creates a distinctive role. The nurse may be the professional most likely to observe that the documented regimen, supplied medicines, patient behaviour, caregiver understanding, symptom trajectory, and current goals no longer align. This does not make nursing the default owner of every medication decision. It makes nursing a critical **continuity sensor**: identifying possible mismatch, establishing its clinical relevance, supporting safe enactment, and activating an appropriate clarification or escalation pathway when resolution lies outside nursing authority.

Pharmacist and prescriber interfaces

Pharmacists can provide a second layer of verification after discharge. Prospective evidence indicates that pharmacist-led reconciliation combined with counselling can reduce clinically important patient-generated medication discrepancies in the post-discharge period [29]. The contribution is especially relevant when home medication use differs from the intended regimen or when complex regimens require detailed review.

Palliative care introduces a further distinction between accuracy and appropriateness. International expert consensus on deprescribing in the last phase of life shows that continuation of a technically accurate medication list may still warrant reconsideration as prognosis, goals, treatment burden, or time-to-benefit change [30]. Reconciliation therefore cannot be reduced to reproducing prior prescriptions faithfully.

Cross-setting pharmacist services also depend on workable relationships with primary-care and prescribing systems [31]. Expertise has limited impact when recommendations cannot reach an authorized prescriber or responsibility for action is uncertain. **Table 2** maps these responsibility interfaces.

Table 2. Responsibility interactions during the early hospital-to-home medication transition

Medication-transition task	Patient or caregiver contribution	Community nursing contribution	Pharmacist contribution	Prescriber contribution	Characteristic unresolved state
Enacting the discharge regimen	Obtain, organize and administer medicines; report uncertainty or deviation	Assess whether the regimen is understood and practically executable	Clarify product, dose, duplication and supply issues	Confirm intended treatment where ambiguity concerns prescribing	Documented regimen cannot be reliably enacted at home
Comparing intended and actual medication use	Describe what is actually being taken and why	Identify visible mismatch between list, supply, use and clinical state	Perform detailed reconciliation and classify medication discrepancies	Determine whether a difference is clinically intended	Discrepancy identified but intentionality is unknown
Monitoring changing clinical context	Report symptoms, adverse effects and treatment burden	Observe symptom trajectory, function, adherence difficulty and caregiver capacity	Review medication-related causes and regimen complexity	Reassess therapeutic need, dose or continuation	Medication list is accurate but may no longer be appropriate
Clarifying discrepancies	Provide history and practical context	Gather information and contact appropriate professional	Reconstruct medication history and propose resolution	Authorize prescription-level changes where required	Several actors possess partial information but no definitive resolution
Maintaining a corrected medication state	Follow the updated plan and identify new divergence	Reinforce and verify updated instructions during subsequent contact	Update or communicate medication records within service capability	Confirm clinically authorized regimen	A correction occurs in one setting but is not propagated to others
Escalating unresolved risk	Seek help when instructions conflict or safe administration is uncertain	Triage urgency and activate clinical escalation	Escalate high-risk interaction, duplication, dose or supply concerns	Make or delegate time-sensitive treatment decisions	Uncertainty persists without an accountable escalation destination

Note: The allocation is functional rather than jurisdictional. Exact professional authority and staffing arrangements vary by health system, service design, and patient context.

Discrepancy detection and resolution

A discrepancy is not self-interpreting. Post-discharge evidence demonstrates that differences can arise from omission, duplication, dose change, altered frequency, new treatment, patient behaviour, documentation error, or legitimate clinical modification [7]. Stage-specific studies likewise show that the origin of a discrepancy may precede the final discharge event [8]. Persistent list discordance therefore requires classification before correction [9].

Early-home comparison offers an opportunity to distinguish the intended regimen from actual use [21]. Pharmacist-supported reconciliation can then reduce some patient-generated discrepancies [29]. The proposed transitional logic is consequently detection → interpretation → authorized resolution → propagation of the corrected medication state. Detection without interpretation risks reversing an intentional clinical change; interpretation without authorized action leaves the problem unresolved; correction without propagation creates another version discrepancy elsewhere in the care network.

Communication failures

Medication communication fails through more mechanisms than simple absence of information. Reviews of hospital-to-primary-care transfer identify inconsistency in what is sent, how it is transmitted, when it becomes available, and whether receipt is confirmed [17]. Stakeholders also describe fragmented systems, delayed discharge documentation, incompatible digital platforms, and communication problems spanning organizational, professional, and patient levels [18].

Shared medication responsibility can intensify this vulnerability when several actors participate but each assumes that another has completed the necessary follow-up [20]. Pharmacy-system evidence further shows that formal transfer requirements do not automatically guarantee practical continuity of information or medication supply [22].

The consequential failure is therefore not merely “poor communication.” It is unresolved informational asymmetry: one actor knows that a medication was stopped, altered, unavailable, poorly tolerated, misunderstood, or inconsistently taken, while another actor continues to work from an outdated representation. In home palliative care, where clinical circumstances may change rapidly, communication becomes safe only when uncertainty can travel back toward an accountable professional, receive a clinically authorized response, and return to the home as an updated, actionable medication state.

Organizational and technology barriers

Medication reconciliation can fail even when individual clinicians perform their tasks competently. Fragmented documentation, delayed discharge records, incompatible digital systems, uncertain receipt, and unclear cross-setting workflows can separate the medication state known in hospital from the state available to community clinicians [18]. Pharmacy-based transition research likewise shows that formal information-transfer requirements do not guarantee continuity of either information or medication supply [22].

Digital integration can reduce some discrepancies by making medication information more consistently available [23]. Its contribution remains bounded: technology cannot determine whether a regimen is still appropriate, whether a caregiver can execute it safely, or which professional should resolve disagreement. Nursing work is similarly shaped by access to guidance, training, time, and organizational support [28]. Medication safety is therefore partly a property of the surrounding implementation environment.

Implementation facilitators

Reliable transition processes require more than an instruction to “reconcile medications.” Implementation evidence supports structured workflows, risk identification, professional collaboration, timely documentation, and mechanisms for follow-up [15]. Pilot discharge interventions also suggest that coordinated reconciliation and handover can improve process performance when responsibilities are built into routine work [16].

Co-design research indicates that implementation is strengthened when patients, clinicians, and downstream services help shape the transition process [19]. More recent feasibility evidence similarly shows that multidisciplinary medication-handover interventions can be acceptable and operationally workable while still experiencing variable adoption across professional teams [32]. Accordingly, implementation success should be judged by whether the system repeatedly produces an interpretable medication state and a credible route for unresolved problems, not by the mere presence of a protocol.

Figure 1 shows how medication-state accuracy, home enactment, professional responsibility, and organizational infrastructure influence one another.

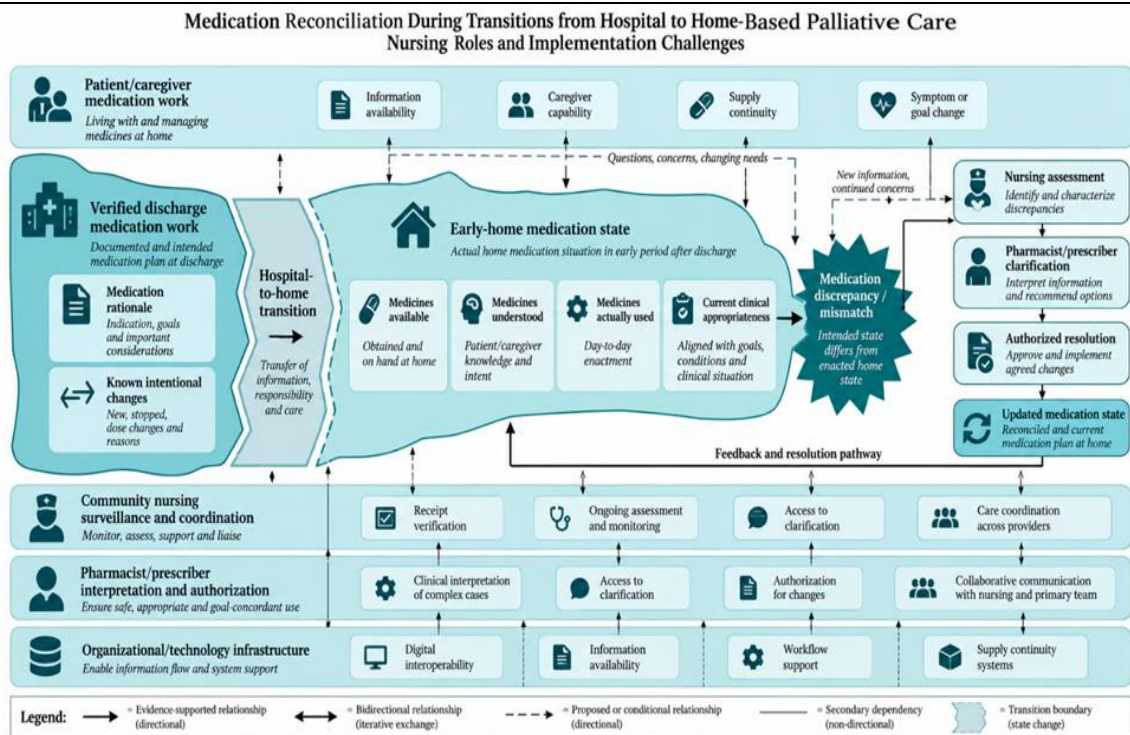


Figure 1. Medication-state continuity across the hospital-to-home palliative transition

Proposed hospital-to-home medication-reconciliation framework

Reconciliation preserves an interpretable medication state through changes in setting and responsibility. Transitional-care evidence supports coordinated continuity [4], medication-safety research shows that discrepancies persist after discharge [7], implementation studies support structured organizational processes [15], and co-design evidence differentiates tasks across patients and professionals [19].

The framework therefore contains five linked functions: creation of an intended medication state before discharge; reliable transfer and availability of its rationale; acceptance of downstream responsibility; comparison with actual medication use and clinical circumstances at home; and resolution with feedback when divergence occurs. Nursing occupies a particularly important interface because nurses can detect mismatch without necessarily holding authority to make every medication change [28].

The application logic is summarized in **Table 3**.

Table 3. Clinical application and boundary conditions for transitional medication reconciliation

Transition condition	Required medication-safety function	Primary implementation question	Appropriate response when stable	Response when uncertainty persists	Principal boundary condition
Intended discharge regimen established	Verify medication state and rationale	Are intentional starts, stops, dose changes and continuing medicines interpretable?	Transfer agreed regimen	Clarify before or immediately after discharge	Incomplete medication history or unresolved prescribing decision
Information crosses organizational boundary	Preserve availability and meaning	Can downstream actors access and understand the current regimen?	Incorporate into local workflow	Re-contact sending service or alternative authoritative source	Delayed documentation, interoperability or uncertain receipt
Patient reaches home	Compare documented and enacted medication state	Are supplied and actually used medicines concordant with the intended plan?	Continue monitoring	Perform focused reconciliation	Supply, cognition, caregiver capability or misunderstanding
Symptoms, goals or condition change	Reassess appropriateness	Is the accurate regimen still clinically appropriate?	Maintain treatment if consistent with goals	Seek pharmacist/prescriber review	Prognosis, treatment burden, time-to-benefit, new symptoms
Discrepancy identified	Interpret before correcting	Is the difference intentional, clinically acceptable, or erroneous?	Document explanation	Escalate to actor with decision authority	Missing rationale or inaccessible prescriber

Change authorized	Propagate corrected medication state	Have relevant patient, caregiver and services received the updated plan?	Continue with updated state	Confirm receipt and reconcile conflicting records	Multiple records or fragmented systems
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Critical transition points

The framework identifies risk at moments when either the medication state or the accountable actor changes. These include final pre-discharge reconciliation, production and transmission of discharge information, acquisition of medicines after discharge, first enactment of the regimen at home, initial community contact, recognition of a discrepancy, and subsequent treatment change. Evidence that discrepancies arise at several transition stages supports this temporal perspective [8]. Longitudinal palliative research further indicates that transition quality evolves after discharge [12]. A completed discharge therefore marks a change of state, not the end of reconciliation.

Responsibility matrix

Responsibility should be allocated by function rather than assumed from professional title. Co-design evidence demonstrates that discharge medication handover involves distinct activities distributed across clinicians, patients, and downstream services [19]. Nursing research similarly shows that nurses may check, educate, coordinate, and pursue unresolved questions without independently owning every prescribing decision [28].

The practical distinction is between participation and accountability. Patients and caregivers can identify what is actually being taken; nurses can detect discordance and triage its significance; pharmacists can reconstruct and clinically review complex medication histories; prescribers can authorize changes that require prescribing authority. Local systems may allocate these functions differently, but unresolved work should never depend on an unidentified future actor.

Feedback and escalation loops

Reconciliation becomes longitudinal when discrepancies can travel back through the care network. Communication research shows that fragmented systems and uncertain receipt can prevent important medication information from reaching the actor able to act [18]. Caregivers may consequently become informal carriers of unresolved questions [25], while community professionals reconstruct medication history from partial sources.

The framework therefore requires an escalation destination for clinically consequential uncertainty. The path may lead from patient or caregiver to nurse, from nurse to pharmacist or prescriber, or directly between professional services. Once a discrepancy is resolved, the corrected state must return to those who enact and monitor the regimen. Without this return path, resolution in one record can generate a new discrepancy elsewhere.

Implementation propositions

The framework generates five testable propositions. Reliability should improve when verification and responsibility transfer occur together; early-home comparison should reveal failures absent from discharge records; digital sharing should help most when information availability is the main failure mechanism [24]; nursing contribution should be strongest when escalation routes are explicit; and specialist-led reconciliation may perform better where expertise and prescribing access are consistently available [29]. Prospective testing is required.

Figure 2 shows the resolution states, escalation routes, and reassessment loop.

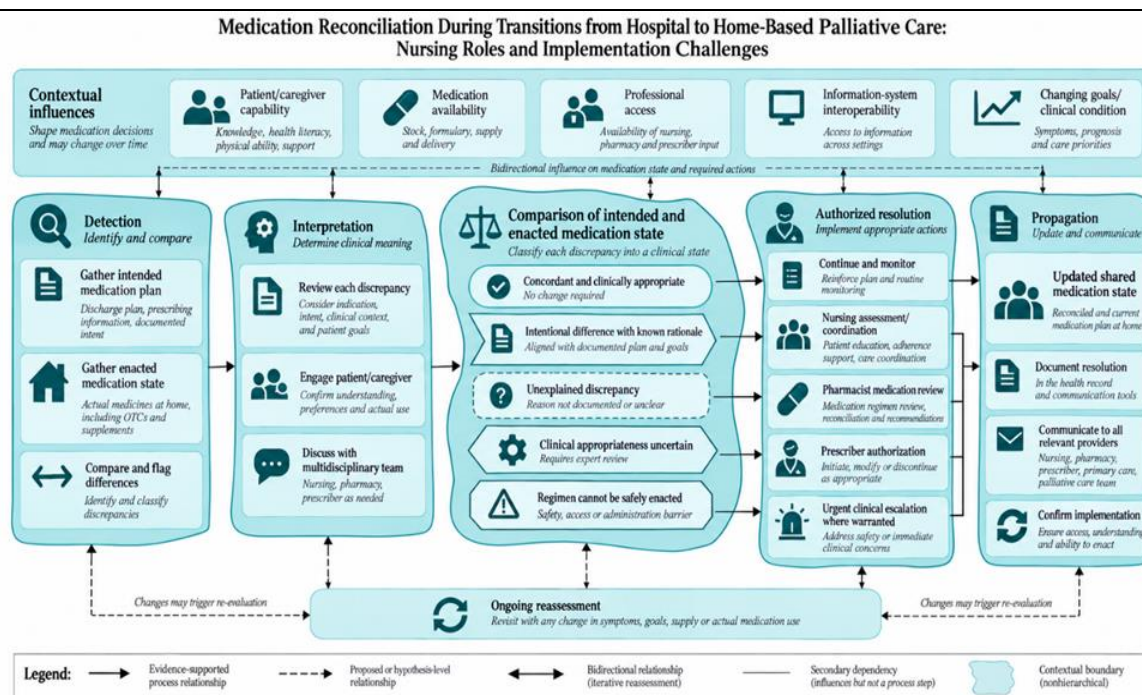


Figure 2. Discrepancy classification, resolution pathways, and contextual boundaries in home palliative medication reconciliation

Practice implications

Services should design reconciliation around functions that remain necessary after discharge. The patient and caregiver need an understandable regimen and a route for questions; community nurses need access to current information and a defined escalation pathway; pharmacists need sufficient history to review discrepancies; and prescribers need timely access to clinically relevant uncertainty. Shared digital records can support this arrangement but should be coupled with explicit responsibility for interpretation and follow-up. Practice design should therefore prioritize closed-loop clarification rather than assuming that successful transmission equals successful transition [33-42].

Research agenda

Research should move beyond whether reconciliation was “performed.” Priority outcomes include concordance between intended and actual medication use, time to resolution of clinically important discrepancies, confirmation that corrected information reached downstream actors, patient and caregiver ability to enact the regimen, and the proportion of unresolved problems attributable to information, supply, appropriateness, or responsibility failure. Because existing discharge studies use heterogeneous outcomes [2], future palliative-transition studies should define reconciliation functions explicitly and follow them longitudinally. Comparative studies are also needed to test distributed versus specialist-led responsibility configurations.

Results and Discussion

This framework changes the unit of analysis from the discharge medication list to the medication state as it moves through a care transition. Direct palliative research shows that hospital-to-home transitions involve changing readiness, caregiving work, and continuity needs [10]. Medication-safety studies show that discrepancy can persist after discharge [7]. Nursing, pharmacy, communication, and implementation evidence together suggest that reliability depends on linking accurate information with actors able to interpret and act on it.

The framework also avoids assuming that one professional arrangement is universally preferable. Pharmacist-intensive services may provide strong continuity where specialist resources and prescriber interfaces are readily available [31]. In other systems, community nurses may provide the most consistent surveillance while pharmacists and prescribers supply episodic interpretive and authorization capacity. The decisive issue is whether the configuration closes the loop from discrepancy detection to an updated medication state.

The distinctive implication for palliative care is that clinical appropriateness can change even when documentation is accurate. End-of-life prescribing and deprescribing evidence illustrates that treatment goals, prognosis, treatment burden, and expected benefit can alter the meaning of a reconciled regimen [30]. Medication reconciliation must therefore preserve both informational continuity and capacity for reassessment.

Limitations

The evidence base directly combining hospital-to-home transition, palliative care, medication reconciliation, and nursing is limited. Several mechanisms in this framework are therefore informed by broader studies of older adults, general hospital discharge, primary-care transition, pharmacy services, and medication safety. These sources establish plausible transition functions but cannot provide palliative-specific prevalence estimates or validate the integrated framework.

Many role and implementation studies are qualitative, feasibility based, or context dependent. Professional scope, digital infrastructure, home-care capacity, medication supply, and prescribing access vary across health systems. Proposed relationships in the framework should consequently be tested prospectively rather than interpreted as universal causal effects.

Conclusion

Medication reconciliation across hospital-to-home palliative care is a longitudinal medication-safety function, not a completed discharge task. An accurate list is only the starting state; safety depends on whether it remains available, understood, executable, appropriate, and correctable at home. Nurses provide surveillance and coordination, while pharmacists, prescribers, patients, and caregivers contribute distinct knowledge and authority. Reliability depends on connecting verification, explicit responsibility, early-home comparison, escalation, authorized resolution, and feedback.

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