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Patient Safety Tip of the Week

September 16, 2025

Faulty Communication at Discharge

Virtually all transitions of care are periods of vulnerability for patient care and patient safety, but hospital discharge is one of the most vulnerable. One of the most serious gaps in patient safety we see is poor communication at hospital discharge. We've all seen examples. A CT scan reviewed by the inpatient team showed improvement and the patient was discharged. But the official CT scan report was not yet back, and the inpatient team failed to let the outpatient clinician know to check that final report. That final report showed a suspicious incidental finding that no one followed up on. A year later the patient was diagnosed with an inoperable cancer. Or a specimen is sent to an outside lab, but no one lets the next responsible clinician that such test result is pending.

Often, the primary care physician (or other clinician who will be providing post-discharge care) is not even aware there was a hospitalization. We've seen cases where the EMR (electronic medical record) field intended for the name of the PCP is instead used for some other purpose and the PCP never gets sent a discharge summary. Sometimes a patient calls their PCP a few days after discharge with a question, perhaps about a new medication, and the PCP has no idea what they are talking about.

Or the inpatient team says the patient should follow up within a week with his/her PCP but no one actually checks with the PCP's office to ensure an appointment is available in that short period.

We still also see lack of interoperability of IT systems between many hospitals and community physician practices.

An investigation report by the Health Services Safety Investigations Body (HSSIB) in the UK recently highlighted significant patient safety issues that happen on discharge from inpatient services (HSSIB 2025). Among their key findings:

- Lack of awareness of constraints in the "local" system
- Lack of integration between primary and secondary teams
- Unclear accountability early after discharge

- Poor discharge summaries
- Lack of interoperability between IT systems
- Patients often don't receive a copy of their discharge summary
- Lack of regulatory or quality oversight of transitions between providers

Those findings should not surprise anyone this side of the Atlantic – we see all the same issues.

The discharge planner at the hospital should schedule an appointment for the patient within the timeframe expected by the discharging physician (and also ensure that the patient has transportation to that appointment). The discharge planner should also make sure the patient is given a copy of their discharge instructions and medication reconciliation sheet, plus a copy of the discharge summary to take to that visit in case that physician has not yet received a copy. The discharge instructions should have the names and phone numbers of the physician(s) to contact if they have questions or issues following discharge.

The disconnect between the inpatient and outpatient care teams can be significant. Seldom do primary care physicians care for their patients when hospitalized. Usually a hospitalist or an academic team provide the inpatient care. Ideally, an inpatient physician would have a verbal communication with the appropriate outpatient physician but that is probably the exception rather than the rule. The best arrangement we've seen is where a hospitalist is part of a medical group. That hospitalist not only has access to all the patient's outpatient medical records but also speaks directly to the patient's PCP both at or before admission and then at the time of discharge.

Writing discharge summaries is not easy. They should include all the relevant information, yet not be so verbose that the reader ignores most of it. It should include a specific section for "tests pending" (see our numerous columns on tests pending at discharge listed below). And it should make clear what next steps or actions are needed once the next physician assumes care of the patient.

Lack of IT interoperability remains a problem in many areas. Ideally, the information contained in a discharge summary would be transmitted in an electronic format that could easily be integrated into the EMR of the outpatient practice. But that may not be possible. A hard copy of the discharge summary should probably be sent to the outpatient physician as well. And avoid sending it via fax (see our columns listed below on problems encountered with faxed medical records).

Medication reconciliation should be performed at all transitions of care. Most hospital services currently perform medication reconciliation at discharge. But how often does the outpatient physician taking over the care of the patient do his/her own medication reconciliation after a hospital discharge? One particular problem we've often discussed is "failure to discontinue" a medication. If a medication was discontinued during the hospitalization and not intended to be restarted post-discharge, did anyone notify the pharmacy? Particularly now that many patients use mail order pharmacies, they often get

delivered every few months medications that had previously been prescribed and a patient (or especially a caregiver for a patient) may not recognize that the delivery includes a medication that was supposed to be discontinued.

Lastly, unless you are part of a truly integrated healthcare system, you probably are not measuring key components of the discharge process. A good quality management system would ask the following questions after a patient is discharged from an inpatient service:

- Did a copy of the discharge summary reach the appropriate outpatient provider(s)?
- Did it reach those providers in a timely fashion?
- Did it include a field indicating whether any lab or imaging reports were still pending?
- Did it include instructions regarding important next steps?
- Did the patient receive a copy of the discharge summary to the next provider (as insurance in case that provider had not yet received a copy of the discharge summary)?
- Was all the relevant information from the hospitalization (eg. lab results, etc.) integrated into the EMR of the outpatient practice?
- Was medication reconciliation accurate?
- Did the outpatient practice do its own medication reconciliation?
- Did the patient get prescriptions filled for any new medications?
- If some prior medications were discontinued, was the pharmacy aware of that discontinuation?
- Did the inpatient provider communicate verbally with the outpatient provider?
- Did the patient receive an outpatient appointment within the appropriate timeframe?
- Did the patient receive instructions on whom to call should issues arise before their outpatient appointment?
- Did the patient keep that outpatient appointment?
- Did the patient have an unscheduled ER visit or hospitalization prior to the first outpatient appointment?
- Did a radiologist (or other clinician interpreting images) contact the appropriate provider if a study found an unexpected finding?

A hospital with thousands of discharges would have to invest in enough staff to ask these questions for all discharges, or perhaps ask the questions on a subsample. But an outpatient practice having only a few patients who get hospitalized could conceivably ask these questions on all their discharged patients.

See also our other columns on communicating significant results:

- May 1, 2007 “The Missed Cancer”
- February 12, 2008 “More on Tracking Test Results”
- October 13, 2009 “Slipping Through the Cracks”

- July 2009 "Failure to Inform Patients of Clinically Significant Outpatient Test Results"
- March 9, 2010 "Communication of Urgent or Unexpected Radiology Findings"
- March 1, 2011 "Tests Pending at Discharge"
- August 21, 2012 "More on Missed Followup of Tests in Hospital"
- October 2, 2012 "Test Results: Everyone's Worst Nightmare"
- March 12, 2013 "More on Communicating Test Results"
- October 2013 "New AHRQ Toolkit: Improving Your Office Testing Process"
- January 2014 "Email Alerts for Pending Test Results"
- July 2015 "Technology to Avoid Delays in Follow-up of Significant Results"
- November 17, 2015 "Patient Perspectives on Communication of Test Results"
- December 20, 2016 "End-of-Rotation Transitions and Mortality"
- September 2018 "ECRI Institute Partnership: Closing the Loop"
- September 24, 2019 "EHR-related Malpractice Claims"
- November 26, 2019 "Pennsylvania Law on Notifying Patients of Test Results"
- January 2020 "The Joint Commission on Closing the Loop"
- September 8, 2020 "Follow Up on Tests Pending at Discharge"
- April 13, 2021 "Incidental Findings – What's Your Strategy?"
- May 25, 2021 "Yes, Radiologists Have Handoffs, Too"
- February 2022 "Managing Incidental Findings"
- April 5, 2022 "Follow-up on Incidental Findings"
- January 2023 "Never Assume"

See our prior columns on problems related to use of fax in healthcare:

June 19, 2012 "More Problems with Faxed Orders"
January 16, 2018 "Just the Fax, Ma'am"
September 2018 "ECRI Institute Partnership: Closing the Loop"
January 2019 "Still Faxing?"
May 2021 "Axe the Fax"
June 2023 "Faxes, Again!"

Some of our other columns on failed discontinuation of medications:

May 27, 2014 "A Gap in ePrescribing: Stopping Medications"
March 2017 "Yes! Another Voice for Medication e-Discontinuation!"
February 2018 "10 Years on the Wrong Medication"
August 28, 2018 "Thought You Discontinued That Medication? Think Again"
December 18, 2018 "Great Recommendations for e-Prescribing"
August 2019 "Including Indications for Medications: We Are Failing"
August 6, 2019 "Repeat Adverse Drug Events"
October 2021 "Tool to Prevent Discontinued Medications from Being Dispensed"

October 11, 2022 “Good Intentions, Unintended Consequences”

Some of our previous columns on medication reconciliation:

October 23, 2007 “Medication Reconciliation Tools”
December 30, 2008 “Unintended Consequences: Is Medication Reconciliation Next?”
May 13, 2008 “Medication Reconciliation: Topical and Compounded Medications”
September 8, 2009 “Barriers to Medication Reconciliation”
August 2011 “The Amazon.com Approach to Medication Reconciliation”
January 2012 “AHRQ’s New Medication Reconciliation Tool Kit”
September 2012 “Good News on Medication Reconciliation”
October 1, 2019 “Electronic Medication Reconciliation: Glass Half Full or Half Empty?”
July 2020 “Not Following Medication Changes after Hospitalization?”
April 2021 “Anticonvulsants High Risk: How Did We Miss That?”
November 2, 2021 “Adverse Drug Events After Hospitalization”
February 22, 2022 “Medication Reconciliation at ICU Exit”

References:

Health Services Safety Investigations Body (HSSIB). Investigation Report. Workforce and patient safety: electronic communications on patient discharge from acute hospitals. HSSIB 2025; Published July 10, 2025
https://www.hssib.org.uk/patient-safety-investigations/workforce-and-patient-safety/fifth-investigation-report/

http://www.patientsafetysolutions.com/

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