

Medication Safety after Hospital Discharge among Older Adults with Chronic Diseases in China: Risk Factors and Management Strategies

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Abstract

With accelerating population aging, the safety of oral medication among older patients with chronic diseases after hospital discharge has become a major public health challenge. Age-related physiological decline, polypharmacy, and limited health literacy—coupled with inadequate professional guidance and insufficient social support—collectively expose this population to a heightened risk of medication errors, drug-drug interactions, and poor adherence. This review synthesizes recent evidence on risk factors and emerging management strategies. At the patient level, standardized nursing protocols and stratified management models (e.g., red-yellow-green risk classification) have been introduced to improve adherence. At the institutional level, multidisciplinary collaboration has been leveraged to optimize prescribing and medication counseling. At the societal level, community-based and family-supported care models are being promoted to strengthen continuity of medication management. However, heterogeneous effects of standardized interventions, gaps in primary-care services, and limited technological capacity continue to constrain real-world implementation. Strengthening pharmacist-led services at the primary-care level, establishing an integrated “home-community-hospital” coordination network, and enhancing policy support may help bridge current practice gaps and provide an evidence-based foundation for longitudinal management of older adults with chronic diseases.

Keywords

Older Adults with Chronic Diseases, Oral Medications, Post-Discharge Patients, Medication Safety, Medication Management

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1. Introduction

Global population aging is progressing rapidly. According to World Health Organization projections, the number of individuals aged 60 years and older is expected to increase from approximately 1.1 billion in 2023 to about 1.4 billion by 2030, and further to around 2.1 billion by 2050, reflecting an unprecedented demographic shift affecting health systems globally [1]-[3]. China represents a rapidly aging, high-burden context in which post-discharge medication safety is increasingly recognized as a national priority. Recent epidemiological evidence indicates that approximately 180 million older adults in China are living with chronic diseases, and nearly 75% present with at least one comorbidity [4]. Pharmacotherapy remains the cornerstone of long-term chronic disease management; however, once discharged from inpatient care, older patients lose structured clinical supervision, resulting in suboptimal adherence and a high frequency of medication errors. Owing to the multifactorial nature of chronic illness in later life, unplanned readmission is common in this population, with reported rates approaching 32% [5], representing a major public health burden. Post-discharge pharmacotherapy constitutes the most vulnerable phase of chronic-disease management because clinical oversight becomes intermittent and regimen complexity remains high, making medication safety a key determinant of preventable readmissions and disease recurrence.

Oral medication is fundamental to disease control in geriatric populations, yet age-related physiological decline, polypharmacy, and cognitive impairment in combination elevate medication-related risk well above that of younger adults. For example, concomitant administration of anticoagulants and non-steroidal anti-inflammatory drugs can precipitate gastrointestinal bleeding, while many older patients lack the capacity to recognize or respond appropriately to such risks [6]. Furthermore, limited caregiver competency, inadequate professional guidance, and fragmentation of community-based follow-up exacerbate vulnerabilities in medication use after discharge.

Accordingly, systematic assessment of post-discharge oral medication risks in older adults, together with the development of effective safety-management interventions, is essential for protecting patients from avoidable harm and improving the quality of clinical nursing services. This review delineates the major determinants of preventable medication harm among older adults after discharge in China, synthesizes emerging patient-, institution-, and community-level management strategies, and highlights future directions for optimizing medication-management models in aging health-care systems.

2. Post-Discharge Oral-Medication Safety Risks in Older Adults with Chronic Diseases

2.1. Patient-Related Factors

2.1.1. Physiological Decline

Age-related deterioration in sensory and physiological function substantially in-

creases the risk of medication errors in older adults. Declining visual acuity may lead to misreading of medication labels, while hearing impairment can compromise accurate comprehension of physician instructions. Hepatic metabolism and renal clearance also decline with age; studies indicate age-associated reductions in hepatic blood flow and hepatocellular function, resulting in impaired biotransformation and detoxification capacity [7]. Consequently, medications may accumulate in the body, prolong systemic exposure, and potentiate organ-specific toxicity [8]. In addition, oversized tablets or capsule formulations pose a choking or aspiration hazard. Some patients, owing to dysphagia, may crush enteric-coated tablets, thereby disrupting controlled-release mechanisms and causing gastrointestinal mucosal injury.

2.1.2. Polypharmacy

Polypharmacy is common among older adults and is strongly associated with medication-related harm. A cross-sectional survey of hospitalized patients aged > 65 years found an average of 7.51 comorbidities per individual and a medication burden ranging from 4 to 18 agents [9]. The likelihood of adverse drug reactions increases with the number of concurrent medications, rising from approximately 4.2% in individuals taking five agents to 7.4% in those taking six to ten agents [10]. Prescribing fragmentation across specialties, together with concurrent use of traditional Chinese and Western medicines, may also lead to therapeutic duplication or unintended drug-drug interactions.

2.1.3. Limited Health Literacy and Medication Knowledge

Insufficient medication literacy is widely documented among older adults worldwide [11]. More than 60% of older individuals report limited understanding of medication characteristics, therapeutic mechanisms, or appropriate storage conditions [12] [13]. Some may ingest medications with tea or milk, or fail to comply with temperature-controlled storage requirements. Medication literacy is positively associated with educational attainment ($P < 0.01$) [14], individuals with lower education levels have greater difficulty interpreting medication leaflets and are less able to administer medications correctly.

2.1.4. Poor Medication Adherence

Cognitive impairment and memory decline contribute directly to missed doses, incorrect timing, and accidental overdose. Approximately 72.7% of older adults consider forgetting medication to be “normal”, and intermittent nonadherence has been reported in 44.1% of this population [15] [16]. Some discontinue therapy once symptoms improve, while others express reluctance toward long-term medication use. Only a minority maintain adherence according to medical advice.

2.1.5. Economic and Lifestyle-Related Factors

Chronic-disease treatment is long-term and costly. Financial constraints may lead families to reduce dosages, substitute cheaper medications, or interrupt therapy altogether [17]. In addition, smoking, alcohol consumption, and other unhealthy life-

style behaviors may diminish therapeutic effectiveness or exert synergistic toxicity when combined with medications, further compromising treatment outcomes.

2.2. Health-System Factors

2.2.1. Deficiencies in Discharge Counseling and Clinical Processes

Medication-related safety risks after discharge are frequently attributable to health-system failures. In the study by Setter *et al.*, approximately 54.3% of post-discharge medication errors were associated with provider-level causes [18]. In many hospitals, discharge prescriptions do not specify dosing schedules, timing, or special precautions, leading patients to misunderstand instructions or adjust regimens independently. The absence of standardized medication lists, pictorial explanations, or simplified dosing summaries further impairs the ability of older adults to execute complex regimens accurately.

2.2.2. Fragmented Multidisciplinary Collaboration

Weak coordination among physicians, nurses, and pharmacists contributes to inconsistent medication management. Modifications in treatment plans are not consistently communicated to medication-counseling personnel, and multidisciplinary team (MDT) models remain uncommon in primary hospitals. The lack of interoperability across electronic health-record (EHR) systems prevents timely exchange of medication data between hospitals and community clinics, increasing the likelihood of therapeutic duplication or dosing inconsistencies.

2.2.3. Limited Digital Support and Delayed Informatization

Technological tools that could support post-discharge medication safety remain underutilized. Smart pillboxes, medication-reminder applications, and real-time counseling platforms are not routinely integrated into clinical workflows, leaving older adults with insufficient access to guided medication support. Digital surveillance and predictive-analytics systems are also lacking. Although collaborative research from the Massachusetts Institute of Technology has demonstrated machine-learning models capable of predicting drug-drug interactions [19], such systems have not been widely deployed in routine hospital practice.

2.3. Social-Support Factors

2.3.1. Insufficient Caregiver Capacity

Family support is a critical determinant of medication appropriateness among older adults. Studies comparing older individuals living alone versus with family indicate that family involvement substantially improves medication management and facilitates self-care [20]. However, caregivers frequently lack proficiency in medication storage, dose preparation, or recognition of adverse reactions. Time constraints and limited supervision may lead to inconsistent monitoring of dosing schedules or quantities, thereby increasing medication deviations.

2.3.2. Gaps in Community Resources and Pharmacy Services

Several community-level deficiencies further undermine medication safety: 1)

Limited community pharmacy support: The availability of trained pharmacy personnel remains low in many regions, and professional competency in clinical medication assessment and dispensing practices is insufficient [21], resulting in inadequate ability to provide regimen review or dosing assistance. 2) Lack of age-friendly support structures: Community pharmacies rarely offer large-print materials, audio instructions, or accessibility-enhancing devices. Educational sessions on geriatric medication safety are infrequent, restricting health-knowledge dissemination. Evidence suggests that reinforcing medication counseling in community settings substantially improves disease understanding and adherence among older adults [22].

2.3.3. Sociocultural and Environmental Factors

Medication behavior in older adults is also influenced by macro-level social determinants: 1) Traditional beliefs and misinformation: Some individuals rely on folk remedies or “food-based substitutes”, or combine Chinese herbal preparations with Western drugs, introducing drug-herb interactions. Others rely on commercial advertising or unsolicited drug marketing and self-purchase medications without oversight [7]. Concerns about stigma may lead patients to conceal medication use from family members, undermining supervision. 2) Regional disparities in access: pronounced urban-rural gaps exist in pharmacy density and service availability. In remote regions, long-distance travel for medication refills increases the likelihood of treatment interruption. Although metropolitan initiatives—such as Shanghai’s “contracted family pharmacist” model—have demonstrated efficacy, replication in central and western regions is limited by resource constraints.

Taken together, these intertwined risk factors amplify preventable adverse drug events and increase the likelihood of unplanned rehospitalization among older adults following discharge. **Table 1** provides an overview of the key risk domains and their corresponding multilevel management strategies and responsible stakeholders, serving as a framework for the intervention approaches discussed in the following section.

3. Management Strategies for Post-Discharge Oral Medication in Older Adults with Chronic Diseases

3.1. Patient-Level Interventions

3.1.1. Standardized Nursing Protocols

Standardized nursing procedures can enhance medication safety by improving patients’ comprehension and adherence.

A structured “3-2-1” educational model, developed and applied in institutional nursing practice, has been reported to improve medication understanding and adherence among hospitalized older adults. This model has been proposed, consisting of: three staged reinforcement sessions during hospitalization (within 24 hours of admission, 72 hours before discharge, and on the day of discharge) [23] [24]; two core teaching domains—mechanisms of drug action (e.g., instructing

Table 1. Key post-discharge medication risks and multilevel management strategies in older adults.

| Risk category | Typical manifestations | Core management strategies | Primary stakeholders |
|---|---|---|--|
| Physiological and cognitive decline | Sensory impairment; reduced drug clearance; swallowing difficulties | Age-friendly education; simplified regimens; individualized counseling | Physicians; nurses; pharmacists; caregivers |
| Polypharmacy and regimen complexity | Multiple drugs; therapeutic duplication; drug-drug/drug-herb interactions | Pharmacist-led medication review; regimen optimization; interaction screening | Pharmacists (lead); physicians |
| Limited medication literacy | Poor understanding of indications, administration, and storage | Standardized discharge education; repeated reinforcement; caregiver involvement | Nurses; pharmacists; caregivers |
| Poor medication adherence | Missed or incorrect dosing; premature discontinuation | Risk-stratified counseling; reminder and follow-up support | Nurses; primary-care teams; caregivers |
| System-level discharge gaps | Inadequate counseling; unclear prescriptions; fragmented information transfer | Medication reconciliation; MDT coordination; structured follow-up | Hospitals; MDTs |
| Insufficient primary-care and community support | Weak continuity of care; limited pharmacy services; urban-rural disparities | Strengthened primary-care capacity; community pharmacist services; interoperability | Primary care; community pharmacies; policymakers |
| Caregiver and sociocultural factors | Limited caregiver skills; traditional beliefs; self-medication | Caregiver empowerment; public education; culturally sensitive guidance | Community health services; families |

that α -glucosidase inhibitors should be taken with the first bite of a meal), and emergency responses for hypoglycemia; and one home-care toolkit that includes a medication list, glucose-monitoring records, and emergency contact information. Evidence suggests that standardized nursing protocols increase patient satisfaction and adherence while reducing adverse drug reactions among older adults [25].

3.1.2. Risk-Stratified (“Red-Yellow-Green”) Management

The Red-Yellow-Green stratification model described here represents a locally implemented risk-management framework, commonly adopted in hospital-based geriatric nursing practice [26]. A stratified management model can be implemented during hospitalization to tailor medication counseling according to risk characteristics:

Red (high-risk): memory impairment combined with polypharmacy; patients receive ≥ 30 minutes of one-to-one coaching, including scenario-based simulation. Yellow (moderate-risk): partial dependence on caregivers; education focuses on medication timing, diet-drug interactions (e.g., acarbose with the first bite of food), adverse effects, and contraindications, delivered partly through short-video education platforms (e.g., TikTok/Douyin). Green (low-risk): capable of self-management; patients receive illustrated medication checklists supplemented with short-video education.

Nursing staff should receive targeted training to develop individualized coun-

seling plans, reduce anxiety associated with complex regimens, and overcome resistance to long-term pharmacotherapy. Caregivers are encouraged to participate actively in medication supervision and establish family-based monitoring routines.

3.1.3. Age-Friendly Health Education

Age-adapted educational strategies can reduce cognitive and operational barriers to medication use. Pill-sorting baskets minimize missed or duplicate doses. Short-video interventions—including dialect versions—and physical aids such as medication-box simulators lower learning thresholds. For patients with visual impairment or limited literacy, compartmentalized pillboxes (morning-noon-evening) and graphic time cues (e.g., sun for morning, moon for nighttime) simplify dosing routines and improve recognition of administration schedules. Visual cues and intuitive graphics enhance comprehension and facilitate correct medication-use behaviors.

3.1.4. Digital and Assistive Technologies

Digital tools incorporating artificial intelligence and mobile-health technologies may support medication adherence. Applications with timed and abnormal-event alerts enable patients—or their caregivers—to schedule reminders and reinforce sustained self-management behaviors [27]. Smart medication boxes linked to mobile applications may offer: 1) Voice-prompted dosing: automatic alerts at scheduled intervals to prevent missed or incorrect dosing; 2) Remote monitoring: caregivers can review dosing records (e.g., whether a pillbox was opened) and receive automated notifications via text or WeChat if doses are missed; 3) Emergency response: a long-press activation triggers contact with a designated emergency caregiver; 4) Photographic record-keeping: medication bottles, prescriptions, or instructions can be stored by taking photographs, avoiding manual data entry.

Optimizing age-friendly design—simplified interfaces, enlarged fonts, and voice output—reduces the digital divide. In disease-specific modules, online multidisciplinary continuing-care teams consisting of specialist physicians, rehabilitation therapists, psychologists, and nurses may provide individualized real-time guidance. Evidence shows that mobile-application platforms can significantly improve psychological well-being, medication adherence, and nursing satisfaction among older adults with chronic diseases [28].

3.2. Institutional-Level Coordination Strategies

3.2.1. Multidisciplinary Team (MDT) Collaboration

Effective coordination among professionals is critical to reducing medication discrepancies after discharge. National recommendations in China have emphasized establishing comorbidity-management teams that integrate physicians, clinical pharmacists, and nursing staff to optimize care pathways and deliver individualized interventions. In an MDT-based model, nurses function as the central coordinator linking multiple disciplines through a structured “assessment-intervention-follow-up” network. Pharmacists lead medication-review processes to iden-

tify drug-drug interactions and optimize therapeutic appropriateness; physicians simplify complex regimens and adjust clinical indications; and nurses provide medication education, develop visual patient-education tools, and conduct scheduled follow-ups. Evidence demonstrates that strengthened MDT participation in medication management significantly reduces post-discharge medication discrepancies and adverse drug events [29] [30].

Given the frequent concomitant use of Traditional Chinese Medicine and Western medications among older adults, pharmacist-led medication review within a MDT framework should explicitly address potential drug-herb interactions. This process includes systematic reconciliation of prescribed medications, over-the-counter products, and herbal preparations, as well as patient counseling to discourage unverified drug combinations, which may interfere with drug metabolism, anticoagulant efficacy, or glycemic control.

3.2.2. Strengthening Primary-Care Capacity

Primary-care systems should adopt a family-doctor-based model to stratify chronic-disease management and enhance continuity of care. National policy and expert in China recommendations have highlighted the role of contracted family-physician services combined with hybrid online-offline training platforms to improve competency among primary-care clinicians, supplemented by tertiary-hospital support. Expanding community-pharmacist functions is essential, including home-based medication assessments, individualized dose organization, and counseling on storage requirements, with reimbursement mechanisms covering specific pharmacist-led services, such as post-discharge medication reconciliation, home-visit medication assessments, individualized dose organization, caregiver education, and follow-up monitoring of medication adherence. Development of regional health-information platforms enabling interoperability between hospital and community prescribing data would further reduce therapeutic duplication and dosing errors.

3.3. Societal-Level Support Measures

3.3.1. Caregiver Empowerment Programs

Periodic community-based courses may be used to train patients and family caregivers in practical competencies, including medication storage (e.g., refrigeration of insulin), dose organization (e.g., avoiding crushing extended-release tablets), and early recognition of adverse reactions such as skin rashes or symptoms of hypoglycemia [31]. Such caregiver-empowerment models help compensate for cognitive or functional limitations in older adults and enhance domestic supervision.

3.3.2. Public Education and Cultural Advocacy

Population-level education campaigns—including short-video dissemination and community radio programs—can strengthen awareness of safe medication practices. Freely distributed geriatric medication handbooks may facilitate self-management, while public initiatives aimed at reducing stigma toward psychotropic

medications encourage open communication regarding medication needs and adherence support.

These multilevel interventions directly target previously identified barriers—including cognitive burden, regimen complexity, limited supervision, and insufficient access to professional support—and may jointly mitigate preventable medication harm among older adults after hospital discharge.

4. Summary

Post-discharge oral-medication safety in older adults with chronic diseases is a multifactorial challenge shaped by physiological vulnerability, health-system constraints, and limited social support. Patient-related barriers, institutional deficiencies, and gaps in community- and family-level resources in aggregate constitute the primary drivers of medication risk. Current management strategies emphasize individualized education, multidisciplinary collaboration, and the use of digital or assistive technologies; however, heterogeneous effects of standardized interventions and insufficient technological diffusion continue to limit large-scale implementation.

Future work should prioritize an integrated “home-community-hospital” coordination network, supported by strengthened primary-care capacity and health-insurance mechanisms, to establish a full-cycle medication-safety ecosystem. Clinically, enhancing the participation of nurses, primary-care physicians, and clinical pharmacists in medication reconciliation, regimen simplification, risk-stratified counseling, and sustained follow-up may reduce preventable harm and unplanned readmissions. From a policy perspective, aligning reimbursement with pharmacist-led services, expanding community-based medication management, and improving cross-institutional health-information interoperability will be essential for scalable, population-level adoption.

In summary, multilevel and multisector interventions provide a pathway to systematically mitigate medication-related risk and support the broader goal of healthy aging in older adults with chronic diseases.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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