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Preventing Medication Discontinuity Across Care Transitions an Integrative Review of General Practice, Nursing, Pharmacy, and Health Administration Roles

Nawaf Methri Alanazi[1], Musaad Saket Alanazi[2], Adnan Atiah Hamadi Albelady[3], Ahmed Hammadi Hammad[4], Naif Moslih Hamadan Alolowi[5], Bandar Nafea Munawir Alharbi[6], Abdulhadi Aqeel Alrashdi[7], Mohammad Ayed Hilal Al-Amri[8], Mohammad Hudiban Baket Alsaedi[9], Mubarak Bukra Alsayed[10], Ahmad Majed Aljoudi[11], Abdulaziz Salah Saleh Aljohani[12], Fahad Hamdi Alzibali[13], Osama Ayesh Almurashi[14]

[1]Prison Health Center – Hafar Al-Batin Haboob99@hotmail.com Pharmacy Technician
[2]Prison Health Center – Hafar Al-Batin Pa-7-to@hotmail.com nurse
[3]Madinah Health Cluster Adnan.1401@hotmail.com Specialist-Health Administration
[4]Madinah Health Cluster ahh.alharbi@hotmail.com Specialist-Health Administration
[5]Madinah Health Cluster nalolowi@moh.gov.sa Specialist-Health Administration
[6]Madinah Health Cluster Bmunawir@moh.gov.sa Specialist-Health Administration
[7]Madinah Health Cluster a-body-7@hotmail.com Specialist-Health Administration
[8]Ministry of Health Branch in Madinah – Hajj Moalomari@moh.gov.sa Health Services Management Specialist
[9]Home Health Care Center (northe) – Madina mohalsaadi@moh.gov.sa Nurse
[10]Jeddah General Prison Health Center – Jeddah mubarak54443@gmail.com Nursing specialist
[11]Medical Services – Ministry of Interior (MOI), Jeddah (GP) General Practitioner
[12]General Directorate of Prison Health – Jeddah aaazozjh@gmail.com nursing specialist
[13]General Directorate of Prison Health – Jeddah K.ss.ss@hotmail.com Nursing specialist
[14]General Directorate of Prison Health – Jeddah osama_4849@hotmail.com Nursing specialist

ABSTRACT: Patients moving between healthcare settings may leave with a documented medication plan but without the information, supply, understanding, or follow-up needed to implement it. Medication discontinuity can therefore arise despite completion of a discharge document or reconciliation task. This review examines how general practice, nursing, pharmacy, and health administration can coordinate continuity while distinguishing unintended interruption from clinically authorized treatment changes. A targeted integrative review purposively selected twenty verified publications

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within a 2010–2026 eligibility window. Indexed records and accessible full texts were examined through structured charting and qualitative comparison. The corpus included randomized trials, observational and qualitative studies, improvement evaluations, and evidence reviews concerning hospital discharge, primary care, and prison-community transitions. Findings distinguish medication discrepancies, actual access to medicines, service contact, and patient harm as separate outcomes. Trials reported both beneficial and nonsignificant results, and reviews differed in their conclusions and certainty. Reconciliation can support accurate information but does not independently demonstrate that treatment was obtained, understood, or reviewed after transfer. The synthesis proposes a continuity framework linking an authorized medication plan with practical access, a named receiving service, and reassessment. Pharmacy technicians contribute information and supply support within local supervision; clinical decisions remain with appropriately authorized professionals. Three original figures illustrate continuity requirements, the composition of the selected evidence, and distinct levels of outcome verification. No participants or patient records were analysed, and the framework has not been prospectively validated. Future evaluation should examine feasibility, workload, confidentiality, equity, and clinical outcomes before claims of effectiveness or generalizability are made.

1 INTRODUCTION

A patient can move between services with an apparently complete medication list and still experience an interruption in treatment. The receiving clinician may not know why a medicine was changed, a prescription may not translate into an available supply, or the patient may not understand which instructions remain current. These are related but different failures. This review examines medication continuity as the coordinated implementation and reassessment of an authorized plan across a transition. Continuity does not mean continuing every medicine unchanged. An intentional, documented discontinuation may be appropriate; the problem is an unintended interruption, unexplained change, or unresolved requirement that becomes lost between services.

Observational evidence establishes the importance of examining what happens after discharge rather than relying on the departure record. Bell et al. (2011) studied prescription renewal after hospitalization and identified associations with potentially unintended discontinuation. The operational measure cannot establish the reason for every missing renewal, but it demonstrates a gap that routine discharge documentation may not resolve. Kwan et al. (2013) reviewed reconciliation as a patient-safety strategy and distinguished correction of discrepancies from wider transitional interventions. These publications support a precise question: which parts of continuity have actually been checked when a service states that the medication transition is complete?

Intervention studies show why that question cannot be answered by assuming that more components always improve clinical outcomes. Kripalani et al. (2012) tested a pharmacist-delivered intervention after cardiovascular admissions without a significant reduction in the primary medication-error outcome. Farris et al. (2014) likewise found no significant differences in several medication and utilization outcomes across its trial groups. In contrast, Ravn-Nielsen et al. (2018) reported benefits for selected utilization outcomes with an extended multifaceted intervention. These findings concern different populations, arrangements, and endpoints. Their contrast supports examination of mechanisms and implementation context rather than a universal claim about one professional contribution.

Quality-improvement evidence contributes another perspective. Schnipper et al. (2018) evaluated implementation of a medication reconciliation toolkit across hospitals and reported improvement in total discrepancies without a corresponding overall reduction in potentially harmful discrepancies beyond baseline trends. Schnipper et al. (2022) subsequently evaluated a refined toolkit across a larger group of hospitals and found declining discrepancy rates. These are important process findings, but a discrepancy count is not identical to medication access, adherence, or patient harm. The review therefore retains the outcome measured instead of converting all improvements into a single assertion of safer care.

The review literature also requires careful comparison. Mekonnen et al. (2016) reported favorable pooled findings for some clinical utilization outcomes, whereas Redmond et al. (2018) emphasized uncertainty and limitations in the randomized evidence. Tomlinson et al. (2020) examined interventions supporting older people's medication continuity and highlighted approaches that bridged the transition. These publications overlap in subject matter but differ in eligibility, populations, intervention coding, and evidence appraisal. They should not be treated as independent votes for a single intervention. Their common contribution is to make the relationship between an intervention, the population, and the chosen outcome explicit.

Communication and postdischarge problems extend beyond reconciliation. Hesselink et al. (2012) reviewed hospital-to-primary-care handovers and found difficulty isolating effective components within complex interventions. Alqenae et al. (2020) described the varied prevalence and nature of medication errors and harm after hospital discharge. Together, these sources suggest that sending information is only one part of an ongoing care process. A documented plan needs an identifiable recipient, practical arrangements for implementation, and a route for addressing discrepancies. Patient understanding and access cannot be inferred solely from the existence of an electronic message.

Prison-community transitions introduce additional organizational constraints without creating a wholly separate clinical objective. Planner et al. (2026) explored staff perspectives on medication safety during release and identified interacting issues involving planning, information, staffing, and patient circumstances. Wang et al. (2012) and Kinner et al. (2016) tested approaches to linking people leaving prison with primary care. Their endpoints concern service use and engagement rather than proof that every medicine was obtained and taken appropriately. These studies nevertheless demonstrate why continuity requires a receiving service that the person can realistically reach, particularly when the timing of transition is uncertain.

Evidence from incidents and records further identifies vulnerable interfaces. McFadzean et al. (2023) analysed reported prison healthcare incidents, while Cooper et al. (2024) mapped data-linkage studies of primary care after release. Abbott et al. (2017) examined documented continuity arrangements for women moving between prison and community care. Their designs provide different kinds of evidence and cannot establish one national failure rate. Their shared relevance is the visibility of access arrangements, information transfer, and follow-up responsibility. The settings represented in these publications are not presumed to reproduce conditions in the contributors' workplaces.

The professional contribution must also be defined accurately. Champion et al. (2019) reviewed pharmacy students and technicians in reconciliation, and Mueller et al. (2012) synthesized hospital-based reconciliation practices. These sources support distinguishing information gathering and administrative support from clinical interpretation and prescribing. In this manuscript, general practice contributes authorized review of the treatment plan; nursing contributes assessment, education, and follow-up observations; pharmacy contributes medication expertise and supply-related coordination; and administration supports access, records, staffing, and accountability. Pharmacy technician participation does not confer authority to prescribe, independently alter treatment, or replace an appropriately qualified clinician.

The primary review question is how these four domains can connect an authorized medication plan with practical access and continuing review across settings. Subsidiary questions ask what counts as evidence that a transition was completed, how intentional changes differ from unresolved interruption, and where conclusions remain theoretical. Twenty core publications are critically compared before development of the conceptual framework. No institutional performance data or new clinical outcomes are generated. The resulting figures describe requirements and evidence boundaries, with evaluation proposed before any claim of effectiveness or widespread implementation.

2 LITERATURE REVIEW

Prescription renewal after hospitalization

Bell et al. (2011) examined administrative records for older adults prescribed selected long-term medicines in Ontario. The cohort compared prescription renewal after hospital or intensive care admission with renewal among nonhospitalized controls. Hospital exposure was associated with more potentially unintended discontinuation. The large population supports investigation of a transition-related problem, but the absence of renewal does not establish intent, ingestion, or clinical appropriateness in every case. Confounding also limits causal conclusions. The framework uses this distinction to separate an authorized

stop from an unexplained gap requiring review. A discharge list cannot establish what happened after transfer. The study does not justify restarting a medicine automatically when a renewal record is absent, and its population limits application to other age groups.

Reconciliation and wider transitional care

Kwan et al. (2013) systematically reviewed hospital medication reconciliation interventions and their effects on discrepancies and postdischarge utilization. The review distinguished reconciliation itself from broader bundles of transitional support. Its findings suggested that reconciliation alone was unlikely to explain improvements in hospital use, while multicomponent approaches could contribute. However, intervention differences and outcome definitions constrained attribution of benefit to any single activity. The source helps define the scope of a completed reconciliation task without equating it with completed care. In the framework, an accurate list is one requirement alongside access and a receiving service. The review does not establish that every additional component is effective, or that the complete coordination model proposed here has already been tested.

Comparative interpretation

The cohort and review examine different levels of continuity. Prescription renewal is an observed administrative outcome, whereas reconciliation is a process intended to address discrepancies. Neither fully describes what the patient was meant to take and could actually obtain. Their combination supports preserving the rationale for changes and a route to clarify unexplained gaps. It does not justify interpreting every missing renewal as an error or every reconciled list as completed care.

A trial of pharmacist delivered support

Kripalani et al. (2012) randomized adults admitted with acute coronary syndromes or heart failure to a tailored pharmacist intervention or usual care. The intervention combined reconciliation, counseling, adherence aids, and follow-up. Among 851 participants, clinically important medication errors remained common, and the primary outcome was not significantly reduced. Random allocation strengthens interpretation for that intervention and population, while the participating hospitals and clinical conditions limit generalization. The finding is not evidence that communication has no value; it cautions against assuming clinical benefit from a plausible bundle. The framework therefore distinguishes intervention delivery from the outcome achieved. It retains patient understanding and reassessment while requiring separate evaluation of whether coordination changes reduce harm in a new setting.

The Iowa continuity intervention trial

Farris et al. (2014) tested pharmacist case management in a randomized trial involving 945 participants assigned to enhanced, minimal, or usual care. The enhanced approach added communication with community clinicians and pharmacies and an early follow-up call. Several medication, adverse-event, and utilization outcomes did not differ significantly between groups. The study provides a useful counterpoint to favorable intervention reports and suggests that baseline care and context may influence detectable benefit. However, nonsignificance does not demonstrate equivalence for every possible outcome or subgroup. The framework uses the trial to avoid treating transmission of a care plan as proof of improved continuity. Information delivery, practical implementation, and clinical consequences require distinct assessment rather than a single completion label.

Comparative interpretation

The two trials provide important nonsignificant findings. They challenge an assumption that a plausible intervention bundle must reduce every clinical outcome. Their results do not remove the professional duty to communicate accurately, but they limit claims

about effectiveness. The synthesis therefore separates implementation of an activity from proof that it improved medication continuity or reduced harm in the population being considered.

An extended pharmacist intervention

Ravn-Nielsen et al. (2018) compared usual care, medication review, and an extended pharmacist intervention in a multicentre randomized trial. The extended programme included interviews and follow-up across the hospital and community interface. It reduced selected readmission and composite utilization outcomes, while some drug-related outcomes were not significantly different. The controlled design supports a causal interpretation for the tested package, but not attribution to each individual component. Its population and health-system arrangements also constrain transfer. The framework draws on the connection between review, patient involvement, and receiving services, without copying a fixed intervention schedule. The study does not show that all transitions need identical staffing or that a reduction in hospital contacts proves uninterrupted medication supply for every participant.

The first MARQUIS improvement study

Schnipper et al. (2018) evaluated a multifaceted reconciliation toolkit through a pragmatic improvement study at five hospitals. The analysis used time-series methods, with concurrent controls available at some sites. Total discrepancies decreased, but the primary measure of potentially harmful discrepancies did not improve overall beyond baseline trends. Variation in implementation and electronic-record changes helped explain why results differed across sites. The study therefore supports attention to how an intervention is introduced, not simply whether a toolkit exists. In the framework, information quality remains a process measure that requires explicit interpretation. The findings do not establish that reduced discrepancy counts always translate into fewer adverse events or validate a universal digital solution for medication transitions.

Comparative interpretation

The randomized programme and improvement toolkit differ in design and endpoints. A reduction in hospital contacts and a reduction in discrepancies cannot be treated as the same result. Likewise, a nonsignificant harmful-discrepancy outcome should not disappear when total discrepancies improve. The framework retains both favorable and qualified findings, linking a proposed activity to the outcome that was actually evaluated.

A refined toolkit across more hospitals

Schnipper et al. (2022) evaluated a refined toolkit with mentored implementation at eighteen hospitals or hospital systems. The study sampled admission and discharge records over time and reported a reduction in unintentional discrepancies associated with implementation. Its multisite approach extends evidence about operational adoption, but the improvement design does not remove every influence of secular change or differences between sites. The principal outcome remained a discrepancy rate rather than confirmed medication access or clinical harm. The framework uses the publication to connect training, responsibilities, information sources, and follow-up of identified problems. It does not assume that every toolkit component caused the observed change, or that a hospital intervention can be transferred unchanged into community or custodial services.

Pooled evidence on clinical outcomes

Mekonnen et al. (2016) reviewed pharmacist-led reconciliation programmes and pooled clinical outcomes across seventeen studies. Several utilization outcomes favored intervention, whereas mortality and some composite comparisons did not show clear differences. Many programmes included counseling or follow-up as well as reconciliation. The synthesis

supports examining services that bridge settings, but heterogeneity and inclusion of different designs complicate interpretation. Its pooled estimates cannot identify a single universally effective component. The framework therefore separates the role of medication information from the broader arrangements surrounding it. This review is considered alongside later evidence rather than treated as definitive proof of benefit. It does not establish a transferable effect size for the theoretical four-domain coordination model proposed in this manuscript.

Comparative interpretation

The improvement study supports attention to implementation capacity, while the meta-analysis synthesizes clinical outcomes across varied programmes. Their findings are complementary but do not create independent confirmation of one identical intervention. Reviews may contain related primary studies, and programme components overlap. The framework uses this evidence to identify candidate requirements rather than calculate a combined reduction in harm.

Cochrane evidence and uncertainty

Redmond et al. (2018) assessed randomized reconciliation interventions in a Cochrane review including twenty-five trials. The review examined discrepancies, adverse drug events, and healthcare utilization, with certainty assessed separately for different outcomes. Much of the evidence was rated low or very low certainty, and effects on several clinical outcomes remained uncertain. Its contribution is methodological caution: a favorable pooled estimate may still have substantial limitations. The framework does not select conclusions solely because they appear positive. Instead, it retains the distinction between a plausible process and demonstrated patient benefit. The review also prevents the assumption that all interventions described as reconciliation are equivalent. Its findings require interpretation alongside intervention content, setting, and the outcome being claimed.

Medication continuity for older people

Tomlinson et al. (2020) reviewed randomized interventions supporting older people's medication continuity during and after hospital discharge. Twenty-four studies were included, with components such as self-management support, reconciliation, and telephone follow-up. Interventions bridging the transition appeared promising, but coding of components was subjective and the underlying studies were heterogeneous. The contribution is to extend attention beyond a single discharge encounter. However, associations between components and outcomes cannot identify the independent effect of each activity. The framework consequently connects the plan with implementation and reassessment rather than endorsing one fixed bundle. Its application to younger populations or prison release requires additional evaluation. The review does not establish that a successful follow-up contact proves correct use of every prescribed medicine.

Comparative interpretation

These reviews differ in populations, inclusion criteria, component coding, and certainty judgments. Favorable findings for selected components should be considered alongside uncertainty in the underlying trials. The synthesis consequently treats continuity as a proposed relationship among requirements, not a package with an established universal effect. It also retains patient and caregiver participation without assuming that the same support suits every person.

Hospital to primary care handovers

Hesselink et al. (2012) systematically reviewed interventions intended to improve discharge handovers from hospital to primary care. The included randomized studies commonly used multiple components involving information, planning, and shared follow-up. Many reported favorable outcomes, but intervention complexity and inconsistent descriptions prevented firm attribution to particular elements. This distinction is important when a service proposes improving continuity by changing only a discharge template. The

framework uses the review to connect sender and recipient responsibilities and the need for usable information. A document must reach an appropriate service and be acted upon when required. The source does not establish that one communication technology is sufficient or that every positive outcome was medication-specific.

Medication problems after discharge

Alqenae et al. (2020) reviewed the prevalence and nature of medication errors, discrepancies, and medication-related harm after hospital discharge. Fifty-four studies were included, using different populations, definitions, and follow-up periods. The findings demonstrate that postdischarge problems need investigation, but their reported rates should not be collapsed into one universal probability. Errors, discrepancies, adverse reactions, and adverse events are distinct constructs. The framework retains those distinctions when specifying evaluation measures. General practice and nursing can identify difficulties after transfer, while pharmacy input may clarify the medication problem and administration can support access. The review describes the burden reported in existing studies rather than proving that the proposed framework reduces it or identifying one intervention suitable for every care setting.

Comparative interpretation

Handover research and postdischarge epidemiology establish the importance of examining what happens beyond departure. They do not show that document completeness prevents all medication problems. A receiving service, practical access, and a route for reassessment remain distinct. The framework therefore proposes measurements at each interface, with separate evaluation of process completion and clinical consequences.

Staff perspectives on prison release

Planner et al. (2026) interviewed twelve staff members involved in transitions from prison to community healthcare. The qualitative analysis examined interacting human, organizational, and technological influences on medication safety, including release timing, communication, staffing, and patient circumstances. The study contributes recent detail about how an apparently planned transition can become difficult to implement. Its professional-network recruitment and staff perspective limit representation of all patients and services. Proposed improvements are not tested intervention effects. The framework draws on the need for early preparation, a receiving service, and practical arrangements when release is unexpected. It does not infer that the same barriers occur at the contributors' institutions or that one technical change would resolve all continuity problems.

Primary care after release from prison

Wang et al. (2012) randomized two hundred people recently released from prison to a transitions-clinic programme or expedited primary care. Participants had a chronic condition or met an age criterion. The tailored programme reduced emergency-department use, but the primary-care utilization comparison did not show a significant difference. The active comparator is important because both groups received access support. The study supports considering the conditions of engagement rather than assuming that referral alone completes a transition. However, utilization is not a direct measure of uninterrupted medication use. The framework uses the trial as evidence about linkage and coordination, while retaining the need to assess medication information and supply separately. Its results do not establish one model for every release setting.

Comparative interpretation

The staff study describes mechanisms and constraints; the randomized trial evaluates a particular service model. The designs should not be combined into a claim that every staff suggestion is proven effective. Together they support asking whether a

person can reach an appropriate receiving service and whether relevant information is usable there. Medication access and clinically appropriate use still need separate assessment.

Low intensity case management

Kinner et al. (2016) evaluated a personalized information booklet and brief telephone contacts in a multisite randomized trial involving people approaching prison release. The intervention increased reported contact with general practice at several follow-up points. Its design provides stronger evidence about service engagement than an uncontrolled description, although self-report, follow-up, and local service conditions affect interpretation. Increased contact cannot establish that the intended treatment was supplied or used correctly. The framework therefore treats receiving-service engagement as an important intermediate outcome. Administrative arrangements and nursing follow-up may support that engagement, while clinical review remains separately authorized. The study does not justify assuming that a booklet and calls alone can resolve every barrier or prevent medication-related harm in all populations.

Reported safety incidents in prisons

McFadzean et al. (2023) combined analysis of reported prison healthcare incidents with expert workshops in England. Medication and access concerns were prominent, and the interpretation linked incidents to continuity and competing organizational priorities. The study identifies types of failure that may be missed by a narrow focus on discharge documentation. However, voluntarily reported incidents do not represent all events, and report counts cannot provide population incidence without an appropriate denominator. The framework uses the findings as prompts for examining local interfaces, not as a national rate transferable elsewhere. Administration contributes through resources and coordination rather than clinical override. The publication does not prove that every proposed improvement would prevent the incidents described or validate the model developed here.

Comparative interpretation

The case-management trial measures contact, whereas incident analysis describes reported failures and their context. Their combination emphasizes both access and the organization of work. Increased appointments may help continuity, but appointment counts cannot establish correct treatment. The framework proposes tracing the medication plan alongside service engagement, while respecting clinical authority and resource limitations.

Primary care utilization in linked data

Cooper et al. (2024) mapped data-linkage studies of primary-care use after prison release and included seventeen publications. The review found variable engagement and identified gaps in continuity and preventive care. Linked records can show patterns across systems, but contact frequency does not independently establish the quality or content of medication management. Differences in datasets and healthcare arrangements also limit direct comparison. The framework uses the review to distinguish access to a service from completion of the clinical work needed after transfer. A receiving practice should be identifiable, but subsequent assessment still matters. The source does not provide a single expected utilization rate or demonstrate that the proposed four-domain framework improves outcomes across jurisdictions.

Documented continuity for women leaving prison

Abbott et al. (2017) reviewed 212 medical records of women released from prisons in New South Wales. The analysis examined information transfer and continuity arrangements, with qualitative record content providing explanatory context. Documented arrangements were often linked to formal prerelease programmes. Its contribution is

evidence about what was recorded at a vulnerable interface, not proof of every action that occurred or did not occur. Missing documentation and actual absence of care must remain distinguishable. The framework draws on the need to identify the receiving service and record relevant arrangements. Its application beyond the population and period studied requires care. The publication does not establish that a formal programme alone guarantees medication access or correct follow-up after release.

Comparative interpretation

Linked data and medical-record review provide complementary but incomplete views of a transition. A recorded encounter may omit its clinical content, while an absent entry may not establish that no communication occurred. The synthesis retains those limitations rather than treating records as direct observation of every action. Their practical implication is to define what evidence is needed before continuity is described as achieved.

Pharmacy technician support and boundaries

Champion et al. (2019) reviewed pharmacy students and technicians participating in medication reconciliation. The literature examined medication-history accuracy, discrepancies, time, and resource implications across different models. Trained support staff could contribute useful information, but the evidence was heterogeneous and roles depended on local arrangements. The framework uses the review to separate gathering and checking source information from clinical judgment. Pharmacy technicians may support histories, records, supply coordination, and escalation under appropriate supervision. Their participation does not confer prescribing authority or permit independent resolution of every therapeutic discrepancy. Because studies included students as well as technicians, their results should not be assigned indiscriminately to every workforce group. The review does not validate the complete continuity framework proposed here.

Hospital reconciliation practices

Mueller et al. (2012) reviewed twenty-six controlled studies of hospital reconciliation practices. Pharmacy involvement and targeting higher-risk patients were common features of promising interventions. Reductions in discrepancies were more consistent than reductions in postdischarge utilization, and rigorous direct comparisons between intervention types were limited. The source therefore supports attention to the outcome used when a reconciliation programme is described as successful. The framework treats accurate information as necessary but insufficient evidence of implemented care. Access, patient understanding, and clinical review remain separate questions. The publication also cautions against selecting a staffing model solely from one favorable process outcome. Its hospital evidence informs component practices while leaving community and custodial transferability to further assessment.

Comparative interpretation

The two reviews support skilled pharmacy involvement while preserving differences between information support and therapeutic decisions. Neither authorizes transfer of professional responsibility through a job label alone. The overall literature gap concerns how the authorized plan, practical access, receiving responsibility, and reassessment remain connected. The results chapter presents this relationship as a conceptual contribution requiring future evaluation.

3 METHODOLOGY

This manuscript is a targeted integrative review with conceptual framework development. The review compares evidence about medication information, practical access, receiving-service engagement, and follow-up across settings. The purpose is to connect distinct requirements rather than estimate a pooled effect of a single intervention. Torraco (2016) provides the integrative rationale for developing conceptual understanding from existing literature. Twenty core publications were purposively selected, and five supplementary publications support methodological reporting and professional context. No original survey, interview, clinical dataset, or institutional audit was conducted.

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Discovery and verification were completed on 16 November 2026. Searches used combinations of medication continuity, reconciliation, unintentional discontinuation, discharge, transitions of care, prison release, primary care linkage, nursing, and pharmacy technicians. Public scholarly searches identified relevant publications; Europe PMC supplied indexed metadata and abstracts through title, PMID, and DOI queries. Examples include EXT_ID:21862745 AND SRC:MED, TITLE:"Effects of a refined evidence-based toolkit and mentored implementation", and EXT_ID:42076834 AND SRC:MED. Available full texts were examined. These were purposeful discovery and verification searches, not an exhaustive search of all databases.

Eligibility required publication between January 2010 and 16 November 2026, sufficient accessible source information, and relevance to at least one continuity requirement. The core corpus actually spans 2011–2026. Randomized trials, observational and qualitative studies, improvement evaluations, and evidence reviews were eligible. Unrelated drug efficacy trials, reports without adequate supporting information, and duplicate versions of the same publication were not included. Reviews and related improvement programmes may share underlying evidence, so the corpus is not twenty independent confirmations of one effect. Table 1 defines the boundaries used in interpretation.

Table 1 Eligibility and interpretation boundaries

Dimension	Procedure or inclusion	Boundary
Period	2010 to 16 November 2026	Selected core publications span 2011–2026
Focus	Medication continuity across healthcare transitions	No complete coverage of all populations or medicines
Design	Trials, other empirical studies, and reviews	Design and certainty remain explicit
Verification	Indexed metadata and available source text	Abstract-based limitations retained
Unit	A finding, process, barrier, or outcome definition	No participant-level reanalysis
Output	Qualitative synthesis and proposed framework	No pooled treatment effect or validated score

Verification checked author names, year, title, journal, volume, pagination or article number, and DOI. Final issue years were used when different from early online dates. Thus the women's continuity record review is cited in its 2017 journal issue and the technician review in its 2019 issue. Table 2 describes the core corpus and the material examined. Access status is not a quality score. Findings drawn from an abstract were restricted to its stated design and results, while accessible full texts supplied additional context. No inference was based solely on a title.

Structured charting recorded population, setting, design, intervention or exposure, comparator where present, outcome, main finding, limitation, and relevance to the four continuity requirements. Outcome categories were kept separate: list discrepancies, intended treatment changes, supply or access, service contact, and patient-level harm. A prescription record was not assumed to prove ingestion, and an appointment did not prove successful medication review. An intentional stop required a documented clinical rationale within the proposed framework; uncertain intent remained an issue for clarification rather than automatic correction.

Selection and extraction were not independently duplicated. A protocol was not preregistered, formal inter-rater reliability was not measured, and no fabricated screening or exclusion totals are reported. Reporting principles from Page et al. (2021), Peters et al. (2020), and Tricco et al. (2018) informed transparency, without a claim of complete systematic-review or scoping-review compliance. The evidence-profile chart groups each publication once by its principal design. It describes the purposively chosen corpus and does not measure the share of all research supporting an intervention or the strength of a professional group.

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Table 2 Verified core publications and material examined

Publication	Design family	Main contribution	Access
Bell et al. (2011)	Other primary	Information and continuity	Abstract
Kwan et al. (2013)	Review	Information and continuity	Abstract
Kripalani et al. (2012)	RCT	Information and continuity	Abstract
Farris et al. (2014)	RCT	Information and continuity	Abstract
Ravn-Nielsen et al. (2018)	RCT	Information and continuity	Abstract
Schnipper et al. (2018)	Other primary	Information and continuity	Abstract
Schnipper et al. (2022)	Other primary	Information and continuity	Abstract
Mekonnen et al. (2016)	Review	Information and continuity	Abstract
Redmond et al. (2018)	Review	Information and continuity	Abstract
Tomlinson et al. (2020)	Review	Information and continuity	Full text
Hesselink et al. (2012)	Review	Information and continuity	Abstract
Alqenae et al. (2020)	Review	Information and continuity	Abstract
Planner et al. (2026)	Other primary	Prison-community interface	Full text
Wang et al. (2012)	RCT	Prison-community interface	Abstract
Kinner et al. (2016)	RCT	Prison-community interface	Full text
McFadzean et al. (2023)	Other primary	Prison-community interface	Full text
Cooper et al. (2024)	Review	Prison-community interface	Abstract
Abbott et al. (2017)	Other primary	Prison-community interface	Abstract
Champion et al. (2019)	Review	Reconciliation roles	Abstract
Mueller et al. (2012)	Review	Reconciliation roles	Abstract

Synthesis began with within-source interpretation, preserving the population, comparison, and outcome. Cross-source comparison examined whether findings concerned information accuracy, ability to implement the plan, receiving-service engagement, or reassessment. Favorable, nonsignificant, and uncertain findings were retained. Contrasting review conclusions prompted examination of design restrictions, populations, intervention content, and certainty rather than selection of the most favorable estimate. The resulting framework connects four requirements while distinguishing established component findings from the new conceptual relationships proposed here.

Appraisal was narrative rather than scored. Randomized studies were considered in terms of allocation, comparator, endpoints, and setting; observational studies in terms of confounding and operational definitions; qualitative and incident studies in terms of

perspective and selection; and reviews in terms of heterogeneity and evidence overlap. No new GRADE assessment was performed. The World Health Organization (2019) report supplied supplementary context for medication safety during transitions. Table 3 states proposed contributions and boundaries. Local regulation, credentialing, staffing, and available expertise determine the final operational arrangement.

Ethical considerations

Only published literature was used. The review did not recruit participants, access identifiable patient information, or analyse the contributors' institutions. No research ethics approval, institutional permission, or consent waiver is claimed. Ethical considerations concern the proposed framework and its future evaluation. Continuity must respect clinically appropriate treatment changes and informed patient choices. An unexplained gap should prompt clarification through an authorized professional, not automatic restarting or continuation of medication. Information sharing should have a valid purpose and remain proportionate to that purpose.

Future evaluation should protect sensitive medication and custodial information, restrict access appropriately, and minimize unnecessary disclosure. Patient and caregiver involvement should be accessible and voluntary within the relevant care context. Barriers involving housing, language, literacy, disability, or access to a receiving service should be considered without assigning automatic blame. Administrative coordination does not override clinical responsibility. Affiliations do not imply institutional endorsement, and contributors must confirm authorship, funding, and conflicts before submission. A prospective study or workflow intervention would require a separate ethics and governance assessment, particularly where treatment access could be affected.

Table 3 Proposed responsibilities and limits of authority

Domain	Contribution to continuity	Boundary
General practice	Review intended treatment; clarify changes; plan reassessment	Clinical changes require authorized judgment
Nursing	Assess difficulties, explain the plan, observe use, and escalate concerns	Education and follow-up do not replace prescribing authority
Pharmacy professionals	Support reconciliation, medicines advice, access, and review	Clinical responsibilities depend on qualification and authorization
Pharmacy technicians	Gather source information and support records and supply under supervision	Do not independently prescribe or resolve therapeutic questions
Health administration	Support appointments, records, staffing, access, and clear ownership	Administrative completion does not prove clinical continuity
Patient and caregiver	Describe actual use, preferences, access difficulties, and understanding	Participation should be supported rather than presumed

4 RESULTS

The twenty-publication corpus contains five randomized trials, six other primary empirical reports, and nine reviews. The other primary reports comprise a cohort, two improvement evaluations, a qualitative interview study, a multi-method incident analysis, and a medical-record review. These categories describe designs, not rankings of quality. The synthesis identifies four continuity requirements: a clinically authorized plan, practical access to medicines, an identifiable receiving service, and reassessment. Patient understanding and usable information connect these requirements. No source tests the complete framework proposed here.

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The first result is a continuity bridge in which information and the means to act on it travel together. Figure 1 depicts the transition between services supported by a verified plan, practical access, and receiving responsibility with follow-up. The structure is a conceptual illustration rather than a patient pathway observed in this review. It indicates why a discharge document alone cannot establish continuity: the person must be able to implement the current plan and obtain clarification or review when needed.

The plan includes reasons for starting, stopping, or changing treatment when relevant. This follows from the distinction between potentially unintended discontinuation measured through renewal records and an intentional clinical decision (Bell et al., 2011). Reconciliation literature supports careful comparison of medication information while qualifying its wider effects (Kwan et al., 2013; Mueller et al., 2012). The framework therefore treats an unexplained discrepancy as a question requiring a responsible recipient. It does not equate all differences with errors or authorize a support worker to change treatment.

The bridge also exposes the limits of information transfer. A message can be sent without being received, a prescription can exist without a practical supply, and an appointment can be arranged without a completed review. Nursing observations and the patient's account may reveal these gaps after transfer. Pharmacy teams can help clarify information and access within their scope, while administration supports communication and service arrangements. These contributions are proposed organizational relationships; they are not measured reductions in interruption, readmission, or adverse events.

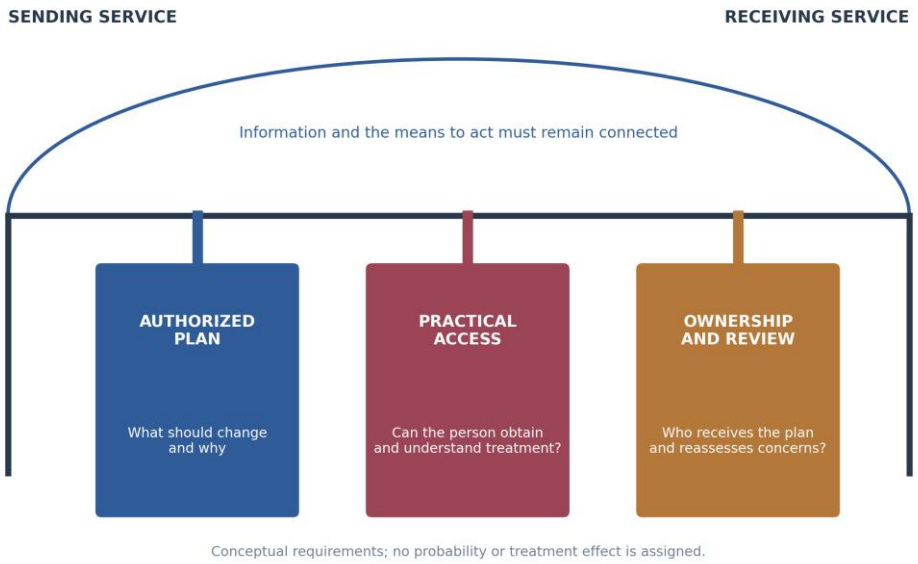


Figure 1 Conceptual continuity bridge linking services through an authorized plan, practical access, and receiving responsibility. The supports represent proposed requirements, not validated predictors or measured patient outcomes.

The second result concerns the nature of the evidence available for this synthesis. Figure 2 displays the principal design families of the twenty selected publications. The counts are verified descriptive properties of the corpus: five randomized trials, six other primary reports, and nine reviews. They are not patient counts, effect estimates, or a measure of independent confirmation. Reviews can include related trials, and improvement studies may evaluate successive versions of an intervention. No statistical pooling across these publications was attempted.

Clinical effects were not uniformly favorable. The trials by Kripalani et al. (2012) and Farris et al. (2014) did not demonstrate significant improvement in several principal outcomes, whereas the extended programme evaluated by Ravn-Nielsen et al. (2018) improved selected utilization measures. MARQUIS evidence concerns medication discrepancies and implementation, with important differences between the first and second programmes (Schnipper et al., 2018; Schnipper et al., 2022). The synthesis consequently rejects a simple conclusion that more complete information necessarily produces a specified reduction in harm.

The same discipline applies to prison-community transitions. The trials by Wang et al. (2012) and Kinner et al. (2016) concern service engagement or utilization, not direct confirmation of every medication supply. Recent qualitative work identifies

mechanisms that can disrupt continuity, including short-notice release and difficulties with communication (Planner et al., 2026). Record and linkage studies add different views of arrangements and contact (Abbott et al., 2017; Cooper et al., 2024). These sources support the need for a reachable receiving service while retaining uncertainty about the detailed medication work performed there.

The design profile therefore shapes the proposed evaluation strategy. A feasibility study can investigate whether responsibilities and information are understandable and usable. Clinical effectiveness requires a suitable comparison and explicitly defined patient outcomes. A larger number of reviews does not remove uncertainty in their underlying studies. Similarly, a trial of one service package does not validate the four-domain framework in another country or institution. The framework is intended to make these differences visible during protocol development and interpretation.

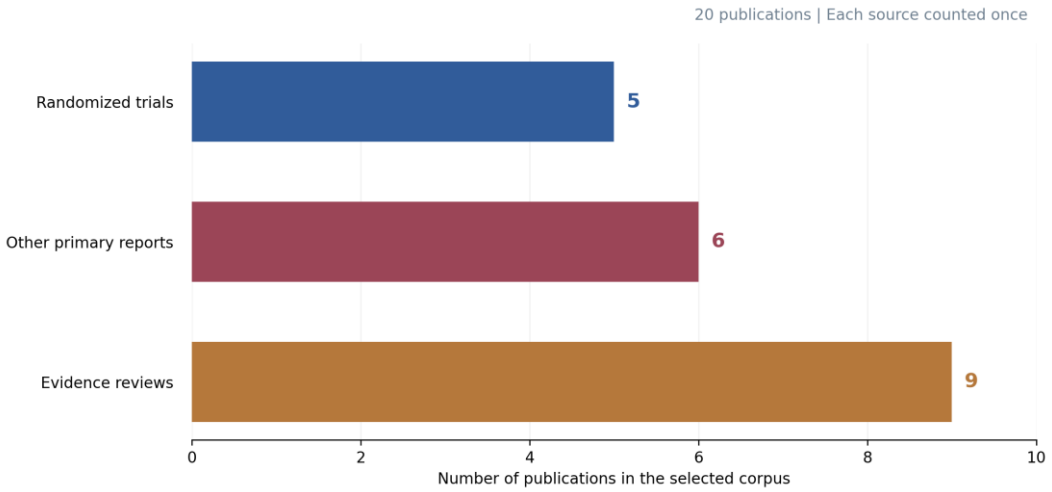


Figure 2 Principal design families in the purposively selected twenty-publication corpus. Counts describe publications only; they are not pooled clinical results or counts of independent supporting studies.

The third result is a distinction among levels of verification. Figure 3 presents progressively different questions about documentation, implementation, and clinical consequences. A reconciled list answers an information question; confirmation that the person can obtain the intended medicines answers an access question; a completed receiving-service review answers a follow-up question; and patient outcomes answer a clinical-effectiveness question. Movement between these levels requires additional evidence, not a relabeling of the original process measure.

This distinction explains several apparently conflicting results. A programme may reduce discrepancies without a demonstrable change in hospital use, and an access intervention may increase service contact without establishing medication adherence. The reviews by Redmond et al. (2018), Tomlinson et al. (2020), and Alqenae et al. (2020) reinforce the need to retain outcome definitions and uncertainty. The framework therefore proposes a record of what was actually confirmed, by whom, and which uncertainty remains. It does not assume that a completed electronic field or follow-up call provides all required confirmation.

A future evaluation could define eligible transition episodes and examine whether the intended plan, reasons for changes, access arrangements, receiving responsibility, and reassessment are recorded and usable. Denominators should be explicit, and missing information should remain distinguishable from confirmed absence of care. Potentially intentional changes require clinical review before classification as error. Measures of patient understanding, supply access, workload, and service contact should accompany, rather than replace, appropriately defined adverse-event and utilization outcomes.

Implementation also requires attention to equity and burden. A person may lack a telephone, stable accommodation, transport, or access to the receiving practice. Adding reminders without addressing those constraints may create the appearance of follow-up while leaving the practical problem unchanged. Incident analysis and qualitative prison-transition evidence support examining such work-system conditions (McFadzean et al., 2023; Planner et al., 2026). Patient and caregiver participation should help identify difficulties without shifting institutional responsibilities onto people who cannot resolve them alone.

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The synthesis remains limited by purposeful selection, incomplete full-text access for some sources, and absence of independent duplicate extraction. No stakeholder validation, field testing, patient-level reanalysis, or causal estimate for the combined framework was produced. Findings are most defensible as a structured conceptual account and a basis for further investigation. Generalization requires assessment across different transition types and workforce arrangements. The framework does not establish that every service needs the same bundle, staffing pattern, software, or schedule of follow-up.



Figure 3 Distinct levels of verification from information to clinical consequences. The steps represent different questions and evidence needs, not a validated score, mandatory treatment sequence, or guaranteed progression to benefit.

5 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Medication continuity depends on a clinical plan and the practical conditions needed to implement and review it. This integrative review examined twenty publications linking general practice, nursing, pharmacy, and health administration across care transitions. The synthesis distinguishes accurate information, access to medicines, receiving-service engagement, and patient outcomes. Completion of one requirement does not independently establish the others, and continuity must preserve clinically authorized changes rather than encourage indiscriminate continuation.

The evidence supports component practices while retaining uncertainty. Trials reported beneficial and nonsignificant findings for different packages and endpoints. Improvement studies demonstrated changes in medication discrepancies without establishing every downstream clinical consequence. Reviews differed in eligibility and certainty judgments. Prison-community research identified barriers to information transfer and engagement, but contact with a service cannot be treated as proof of implemented medication care.

The proposed framework connects an authorized plan with practical access, identifiable receiving responsibility, and reassessment. Its three figures depict continuity requirements, the design composition of the selected corpus, and different levels of outcome verification. They are theoretical or descriptive representations rather than measured benefits of the combined model. The framework has not undergone prospective validation, and the review generated no new patient or institutional outcomes.

The contribution is an account of what a completed transition should mean and which uncertainty remains unresolved. Professional roles are complementary but do not confer interchangeable authority. Future evaluation should examine feasibility, information quality, workload, equity, confidentiality, and clinical consequences before the framework is described as effective or transferred across services and healthcare systems.

5.2 Recommendations

Services considering this framework should identify the medication information, access arrangements, and receiving responsibilities required for each transition type. Records should distinguish the intended treatment plan from previous lists and explain clinically relevant changes. Uncertain intent should prompt clarification by an authorized professional. An unexplained gap must not trigger automatic continuation or restarting of treatment without appropriate review.

General practice and nursing teams should establish arrangements for reassessment and for reporting problems after transfer. Pharmacy professionals should support reconciliation, medicine-related advice, and access within their roles. Pharmacy technicians can assist with histories, documentation, and supply coordination under supervision. Administration should support appointments, staffing, information sharing, and escalation, while avoiding status labels that imply clinical completion without supporting evidence.

Patients and caregivers should receive understandable information and opportunities to describe actual use, preferences, and access difficulties. Follow-up methods should account for language, literacy, disability, housing, telephone access, and other constraints. Sensitive medication and custodial information should be shared only for a valid purpose and with appropriate safeguards. Clinical and organizational responsibilities should remain visible when barriers arise.

A prospective feasibility study should precede wider implementation. Evaluation should separately measure discrepancies, confirmed access, receiving-service engagement, patient understanding, workload, and clinical outcomes using definitions and denominators. A suitable comparison is needed before attributing reductions in harm to the framework. Contributors should confirm authorship, affiliations, funding, and conflicts before submission. Results of local evaluation and professional review should guide revision before the framework is adopted as an institutional procedure or extended to healthcare settings.

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