Daily practice performance (work-as-done) compared to guidelines (work-as-imagined) of medication reconciliation at discharge
Outcomes of a FRAM study

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Medication reconciliation at discharge

To decrease errors on discharge and during transition of care by carrying out the following steps:

1. **Verify**: collect a current medication list.
2. **Clarify**: make sure the medications and doses are appropriate.
3. **Reconcile**: compare new medications with the list and document changes in the prescriptions for medication.
4. **Transfer**: communicate the updated and verified list to the appropriate caregivers and to the patient.

➢ However, research showed that medication reconciliation was only performed for 44% of all discharged patients\(^5\).
Research objective

To reveal possible discrepancies between guidelines/hospital protocols (work-as-imagined) and clinical practice (work-as-done) for the process of medication reconciliation at discharge.

This could explain when and why healthcare professionals deliberately or accidentally deviate from these protocols.
Methods

• **Document analysis** work-as-imagined ➞ National guidelines & hospital protocols

• **Interviews** work-as-done ➞ 8 HCPs (physicians, nurses and pharmacy technicians)

• **Feedback meeting** results ➞ Online or on location

➢ Participants: 9 cardiology and orthopedics wards from 8 Dutch hospitals.
Functional Resonance Analysis Method (FRAM)

• There may be misalignment between guidelines and daily practice.
• Guidelines do not regard varying conditions in everyday practice.
• HCPs have to adjust their performance (i.e. be resilient) to provide care safely → practice variability.

The **Functional Resonance Analysis Method (FRAM)** helps to visualize the ‘process as-Imagined’ and the ‘process as-Done’. This could enable the dialogue between HCPs to learn from each other.
Work-As-Imagined national guidelines

Prescribing phase

- Decided that patient may be discharged
- To create a current medication overview
- To write and authorize the discharge prescriptions
- Data from hospital pharmacy and patients’ medical file

Informing phase

- As soon as possible before discharge
- Healthcare professional has been trained
- As soon as necessary for continuity of care
- Overview of relevant care facilities present
- Digital system/fax

To undertake patient counseling
- To transfer medication overview and discharge prescriptions

Patient leaves the hospital
General Work-As-Imagined model

Prescribing phase
- To convert admission medications into discharge medications
- To place a discharge order
- To write and authorize the discharge prescriptions

Verification phase
- To verify the discharge medications and recipe
- To accept and process the discharge order
- To create a medication overview and dosing schedule

Informing phase
- To transfer medication overview to primary care
- To undertake patient counseling

Decided that patient may be discharged

Physician Yellow Nurse Blue Pharmacy technician

Patient leaves the hospital
General Work-As-Done model

Prescribing phase:
- Decided that patient may be discharged
- To review the discharge medications
- To convert admission medications into discharge medications
- To transfer the recipes to the pharmacy
- To prepare and execute the transfer to the GP

Verification phase:
- To compare recipes, admission and discharge medications
- To create a MO and dosing schedule
- To prepare the discharge medications
- To transfer MO to primary care
- To collect discharge documents
- To undertake patient counseling

Informing phase:
- MO, recipes, pharmacy label, dosing schedule
- Patient leaves the hospital
Variability

Comparing WAD to WAI
• More involved healthcare professionals.
• More proceedings were carried out and in a different order.
• Non-linear process.

Considerations by HCPs
• When to perform a certain activity.
• How thoroughly to carry out a activity.
Conclusion

• Several adjustments were made to
  1. translate the national guidelines into hospital protocols.
  2. make the protocols workable in practice.

• Medication reconciliation at discharge is a complex process.

• HCPs sometimes deliberately deviated from protocols to succeed under varying conditions.

• Follow-up studies could focus on the effects of practice variability on patient experiences and patient safety.
References


