

ASHP statement on the role of the pharmacist in patient-focused care

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Patient-focused care is a term applied to a range of site-specific multidisciplinary work designs ideally intended to improve patient care outcomes and patient satisfaction while also improving efficiency and reducing costs. Patient-focused care has primarily been implemented in hospitals, although it could be applied in integrated health care systems and other settings as well. The term arose because of the perception that hospital functions have traditionally been "department-focused" in order to optimize the scheduling and efficiency of compartmentalized service units. This department focus often results in complex logistical processes, communication problems, delays in patient care, idle time for some employees, and numerous hospital employees interacting with the patient. Patient-focused care typically reorients functions, task assignments, and schedules to the needs of the patient through the use of various techniques, including (1) work redesign to eliminate unnecessary steps and documentation; (2) organizational restructuring, including significant decentralization of high-volume patient care services; (3) interdisciplinary patient care work teams; (4) cross-utilization of staff to carry out work previously done by specialists and to minimize the number of different staff members having unnecessary contact with a single patient; and (5) case management using multidisciplinary clinical care plans.¹ These management tools (interdisciplinary patient care work

teams and case management in particular) may also be implemented in specific work sites independent of any reference to patient-focused care. Some of these tools might also be used to facilitate positive change within a pharmacy independent of any organizationwide initiative.

Patient-focused care evolved primarily from a consulting firm study, which concluded that a significant percentage of dollars was spent by hospitals to cover the logistics associated with scheduling direct patient care, documenting that the care was given, and paying for "structural idle time," such as time spent by specialized department-based staff waiting for orders or requests for service.²

ASHP supports the concept of patient-focused care when it (1) is planned and implemented with pharmacists' involvement; (2) fosters the provision of pharmaceutical care³; and (3) is motivated by a goal of improved patient care. Some patient-focused care arrangements, however, do not meet these criteria and have been perceived as detriments to the provision of pharmaceutical care.

The effect of patient-focused care on pharmacy practice can vary substantially by site. From a broad perspective, the idealistic goals and approaches to patient-focused care can be quite compatible with pharmaceutical care and, in fact, may facilitate its implementation. The elimination of some time-consuming documenta-

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tion, scheduling, and idle time and the decentralization of services to the patient care unit may help to overcome major obstacles to pharmaceutical care, including access to patients, access to patient-specific clinical information, and access to other health care professionals.

Conversely, patient-focused care can be implemented with a less favorable effect on the pharmacy. Cost control and staff reduction are sometimes the primary intended outcomes of patient-focused care initiatives. In the negative extreme, organizations may be forced to undergo radical staff reduction, reorganization, and cross-training of staff to the point of misapplication of valuable professional talent and curtailment of important professional services.

A central message of this ASHP Statement is that pharmacists should become involved early and assertively in all aspects of patient-focused care when it is initiated or contemplated for their work sites. In general, pharmacists who have established some success in the provision of pharmaceutical care before patient-focused care is begun seem more likely to be positioned well for full involvement and invitation into the planning of such projects. ASHP recommends that pharmacists review published literature on patient-focused care and that they consult with other pharmacists who have successfully adapted to patient-focused care and used it in furthering pharmaceutical care.

Some general ideas regarding pharmacists' participation in patient-focused care follow.

1. Patient-focused care should be designed and implemented in ways that enhance or expand the capacity of pharmacy staff members to provide pharmaceutical care.¹
2. Patient-focused care should be designed and implemented in ways that foster the pharmacist's adherence to established standards of professional practice, prevention of drug misadventures, and fulfillment of legal responsibilities.¹
3. Pharmacy staff members assigned to patient care teams must be philosophically committed to the concept of interdisciplinary patient care and prepared to contribute to the work of the teams.¹
4. Pharmacists should be involved in the development of clinical care plans that involve medication use.¹
5. The prevention, detection, and resolution of drug-related problems should be a high-priority function of patient-care-team pharmacists.¹
6. Pharmacy staff members assigned to a specific patient care team should be consistently available for that team so that the number of different staff members working on a specific team is minimized.¹
7. Pharmacy managers should anticipate efforts to simplify the drug distribution process for most medication orders.¹ Pharmacists should be open to experimentation with medication-use system changes. However, they have a professional obligation to consider the patient-safety implications of prospective changes.
8. In planning for patient-focused care, the role of pharmacy technicians in patient-focused care teams should be addressed. Different roles may be appro-

priate with respect to cross-training and cross-utilization of technicians with advanced credentials (e.g., certification or graduation from an accredited training program).

9. In patient-focused-care decision-making, special diligence should be exerted to consider the systemwide implications (especially patient safety implications) of decisions about products and procedures.
10. Pharmacy staff members, including pharmacy technicians, working on patient care teams may be asked to assume cross-functional roles.¹ Requisite preparation and documented credentials should be obtained by staff members who are not trained, educated, or experienced in performing a particular task. Clear documentation of the roles and duties should exist in position descriptions and organizational policies and procedures.
11. If nonpharmacy personnel are used to perform tasks traditionally carried out by pharmacy personnel, this must be accomplished without compromising patient safety or violating laws or regulations. Appropriate oversight by pharmacists must be provided.
12. In some patient-focused care arrangements, the use of automated dispensing devices may be viewed as a justification for staff reduction and cost control. These devices have the potential for misuse if the system does not provide for an adequate review of the medication order by a pharmacist before the medication is administered to the patient.
13. In patient-focused care, charting by exception is sometimes proposed as a work simplification measure. This is an approach to patients' medical records in which it is assumed that all ordered medications have been administered and that they have been administered according to medication orders *unless* a record to the contrary is made. The safety of such an arrangement is questionable. Substantial safeguards would have to be in place for it to be acceptable. Unless such safeguards can be devised, overt charting of all doses of medications administered is seen as a safer procedure.
14. Organizational re-engineering associated with patient-focused care can be applied to different levels in an organization. It may be applied, for example, primarily at the patient care level and result in the formation of multidisciplinary care teams of professionals and others in direct contact with patients. In some cases, it has been applied organizationwide. In some extraordinary cases, entire departments, departmental structures, and departmental directorships have been abolished. When pharmacists have input into such decisions, they are encouraged to consider carefully which pharmacy functions may be better (including more safely) accomplished centrally or on a decentralized basis.
15. Consultants experienced in implementing patient-focused care may present data and experiences from one contract site as an indication of what can be achieved in a subsequent contract site. This may be useful information, but pharmacists are encouraged to carefully analyze the accuracy and applicability of the information in their own sites.

Pharmacists should make every effort to educate consultants on the pharmaceutical care role of the pharmacist in health systems.

Recommendations for additional reading

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ASHP guidelines on pharmaceutical services in correctional facilities

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Introduction

Pharmaceutical services in correctional facilities encompass many aspects of community, hospital, and consultant pharmacy practice. These guidelines are intended to address some of the unique aspects of pharmacy practice and services in correctional facilities. Some correctional facilities may not require, or be able to obtain, the services of a pharmacist. However, the concepts, principles, and recommendations contained in this standard are applicable to all correctional facilities, regardless of size or type. Thus, the part-time pharmacy director or consultant pharmacist has the same basic obligations and responsibilities as his or her full-time counterpart in larger settings. This document should serve as a guide for the provision of pharmaceutical services in correctional institutions.

Administration

Pharmaceutical services are an integral part of health care provided in correctional institutions. The pharmacist is usually responsible for multiple tasks ranging from the management of the pharmacy to the direct provision of services to inmate-patients. Two primary management responsibilities pertain to human and fiscal resources.

Personnel.¹

- Sufficient support personnel should be available to maximize the use of pharmacists in tasks requiring professional judgment. Appropriate supervisory controls for support personnel should be maintained. The use of pharmacy technicians graduated from ASHP-accredited pharmacy technician training programs is recommended. Pharmacy technicians should be certified by the Pharmacy Technician Certification Board.
- All personnel should possess the education and training needed to carry out their responsibilities. The competence of all staff may be enhanced through relevant continuing education. Credentialing of eligible staff as Certified Correctional Health Professionals through the National Commission on Correctional Health Care is recommended.
- A pharmacist should be available, at a minimum, on a consulting basis; the pharmacist should visit each facility no less than monthly. If the only pharmaceutical services provided are those of a consultant pharmacist, the consultant pharmacist should assume the role of pharmacy director.
- If the pharmacist is an employee of a contract vendor, he or she should be designated as the pharmacy director and assume the associated obligations and responsibilities.
- Health care services should be available to inmate-patients 24 hours a day. Pharmacist services should

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