Farmacia Hospitalaria
ISSN: 1130-6343
ISSN: 2171-8695
Grupo Aula Médica

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Farmacia Hospitalaria, vol. 42, no. 4, 2018
Grupo Aula Médica
Available in: http://www.redalyc.org/articulo.oa?id=365962269001
DOI: 10.7399/fh.11078

EDITORIAL

Tackle the complexity. Pharmaceutical care to the chronic complex patient

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Farmacia Hospitalaria, vol. 42, no. 4, 2018

Grupo Aula Médica

Received: 18 May 2018
Accepted: 31 May 2018

DOI: 10.7399/fh.11078

Complexity will appear when we are close to the patients, in terms of making decisions that will have impact on their care. To decide the adequate treatment intensity, to prioritize health problems, to treat or not to treat, to listen to their will and that of their relatives: all this within a setting where there are not many certainties, because these are derived from clinical trials and limited to simpler patients. In this reality, healthcare professionals require tools to facilitate decision making in terms of providing care for complex chronic patients[1]; and the frailty index is placed within this setting.

At the Pharmacy we can take sides by the rest of professionals or not, we can prioritize technical aspects over patient follow-up or involvement in preparing a plan of care. There are some experiences in the nursing homes and hospital setting along this line. Person-centered care, as the new paradigm of care, is something we are increasingly accepting and working on[2,3]. These are not only words, or a drawing in a slide, to continue doing the same; it demands a cultural and structural change, as well as a different organization within the Pharmacy Unit. This is not only about integrating patients in the traditional process of prescription-validation-dispensing-follow-up, because this is really the medication process; this is about integrating the Pharmacy in a much wider and complex process for comprehensive assessment-individualized plan of care-follow-up. That is to say, to move from a medication-centered process to being involved in a process centered in the person as the real axis around which our work will revolve. And for another reason which is more straightforward and might be easier to understand: if we center the model in the classical process (validation), we are only involved in the decision to treat, but not in the decision not to treat; and at least in the case of chronic or fragile patients, one decision is equally important than the other.

In this sense, the previous issue of this journal published an article addressing the improvement of drug treatment adherence on the basis of person-centered assessment[2], and an article appears in this issue on the use of the Frailty Index as a tool to facilitate a diagnosis of the situation in the nursing home setting. These are two easy examples that show that the Hospital Pharmacy can be fully involved, together with the rest of

professionals, in the comprehensive care for the person managed, as well as contribute to the design of a treatment plan more adequate to their needs.

Experiences in this sense are very limited; and the pressure to focus management on medication is very obvious, even though sometimes it can appear disguised. The hospital setting must make a major effort to adapt to the frailty of these persons, and the Pharmacy Unit is no exception. This line of care is very clear for the social and health care setting, and Pharmacy Units are forced to follow it if they want to be part of multidisciplinary teams.

This is a key moment for the development of Specialized Pharmacy Care in the nursing homes. The models to be implemented must be initially designed at micro-care level (patient setting), which can really improve patient care and be able to provide health outcomes. Based on this, it is possible to continue drawing lines until the medication and its dispensing are reached, avoiding those barriers that complicate the care experience and the ability of the specialized pharmacist to provide a balance, or act as a bridge, between pharmacotherapeutical quality and system efficiency, always remembering the triple objective set by Berwick[4], and in this order: to improve the patient care experience, to improve health, to reduce costs.

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