



XVI JORNADAS DE FARMÁCIA HOSPITALAR

[INTELIGÊNCIA E ADAPTAÇÃO: PASSAPORTE PARA A EVOLUÇÃO]

23 E 24 FEVEREIRO
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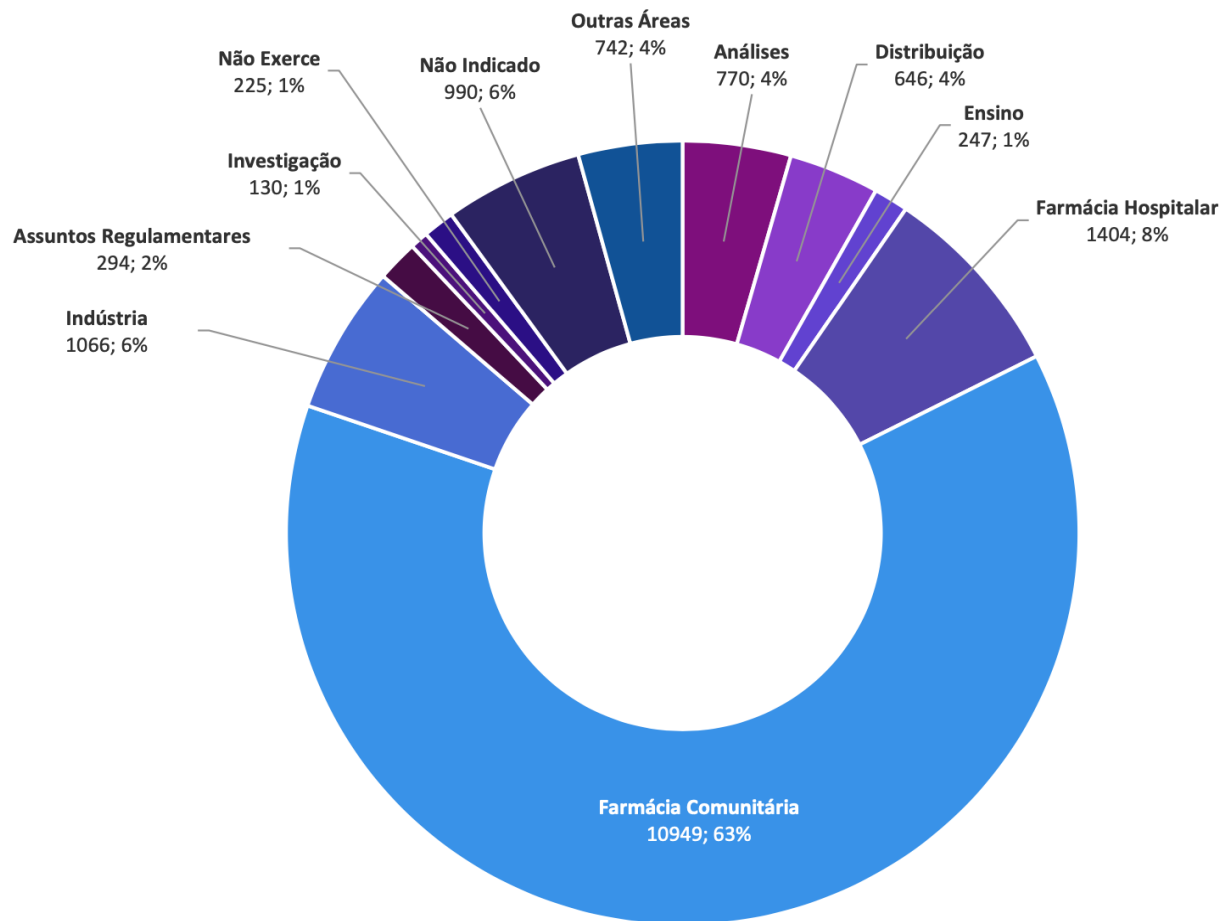
CONSENSOS PARA RÁCIOS DE FARMACÊUTICOS POR ÁREA

Ana Mirco
ULSLO - HSFY

Consensos para rácios de Farmacêuticos/área

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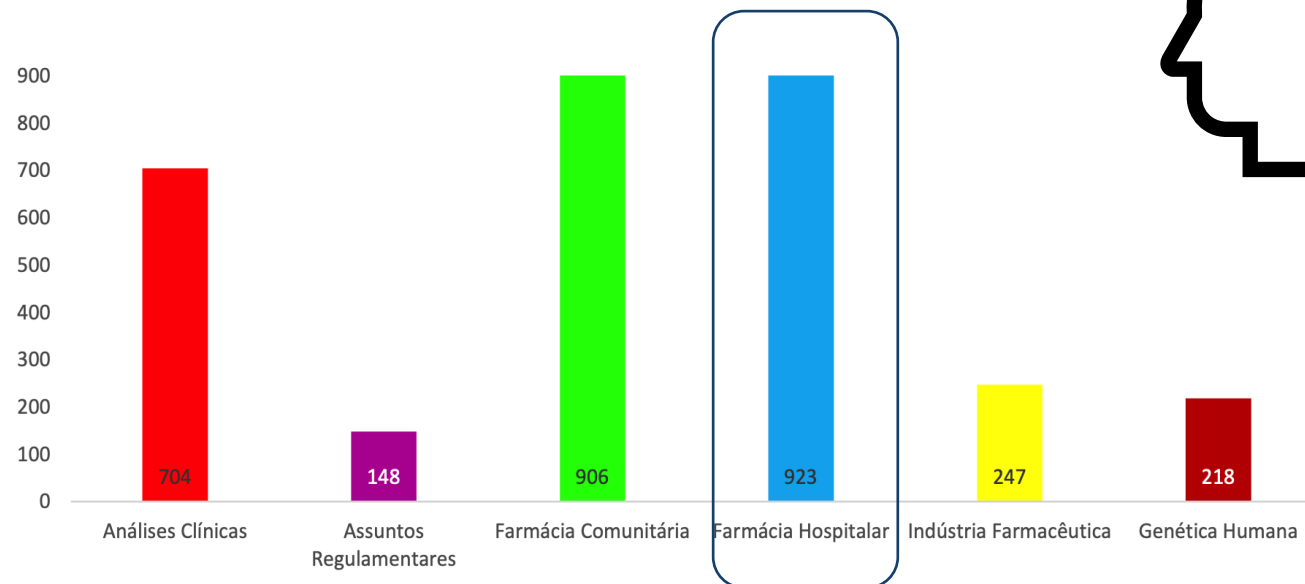


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» Número de Especialistas ativos em exercício



FONTE: OBSERVATÓRIO DA ORDEM DOS FARMACÊUTICOS 2022

E quantos
seremos em
2026?



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Farmácia Clínica

A farmácia clínica é um conceito que transforma a farmácia hospitalar de fabricante e dispensador de medicamentos, para uma intervenção farmacêutica baseada no doente e na melhor maneira de lhe dispensar os cuidados farmacêuticos com os menores riscos possíveis.

Para isso, o farmacêutico hospitalar tem de fazer parte da equipa clínica, acompanhando directamente o doente nos serviços, prestando apoio contínuo aos médicos e enfermeiros desse serviço.

Os estudos feitos em diversos países demonstram os números impressionantes de morbilidade e mortalidade atribuída directamente a medicamentos, números esses que se reduzem drasticamente com a existência de farmacêuticos clínicos nos serviços.

É necessário haver farmacêuticos especializados e disponíveis para este serviço, assim como suporte técnico adequado.

O ratio aconselhado para a farmácia clínica é de um farmacêutico por serviço de internamento ou por 60 camas.

É necessário também assegurar um local de trabalho para esse profissional nesses serviços, que pode ser partilhado com outros profissionais, para facilitar uma presença efectiva do farmacêutico clínico nesses locais.

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ASHP guidelines: minimum standard for pharmacies in hospitals

American Society of Hospital Pharmacists

PMID: 23988605 DOI: [10.2146/sp130001](https://doi.org/10.2146/sp130001)

The mission of pharmacists is to help people make the best use of medications.¹ Therefore, pharmacists shall be concerned with not only the provision but the outcomes of pharmacy services. The elements of pharmacy services that are critical to safe, effective, and cost-conscious medication use in a hospital include (1) practice management, (2) medication-use policy development, (3) optimizing medication therapy, (4) drug product procurement and inventory management, (5) preparing, packaging, and labeling medications, (6) medication delivery, (7) monitoring medication use, (8) evaluating the effectiveness of the medication-use system, and (9) research. Although the scope of pharmacy services will vary from site to site, depending upon the needs of patients and the hospital as well as the resources available, these core elements are inextricably linked to successful outcomes. Failure to provide any of these services may compromise the quality of patient care.

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The European Statements of Hospital Pharmacy

SECTION 4: CLINICAL PHARMACY SERVICES

- 4.1 Hospital pharmacists should be involved in all patient care settings to prospectively influence collaborative, multidisciplinary therapeutic decision-making; they should play a full part in decision making including advising, implementing and monitoring medication changes in full partnership with patients, carers and other health care professionals.
- 4.2 All prescriptions should be reviewed and validated as soon as possible by a hospital pharmacist. Whenever the clinical situation allows, this review should take place prior to the supply and administration of medicines.
- 4.3 Hospital pharmacists should have access to the patients' health record. Their clinical interventions should be documented in the patients' health record and analysed to inform quality improvement interventions.
- 4.4 All the medicines used by patients should be entered on the patient's medical record and reconciled by the hospital pharmacist on admission. Hospital pharmacists should assess the appropriateness of all patients' medicines, including herbal and dietary supplements.
- 4.5 Hospital pharmacists should promote seamless care by contributing to transfer of information about medicines whenever patients move between and within healthcare settings.
- 4.6 Hospital pharmacists, as an integral part of all patient care teams, should ensure that patients and carers are offered information about their clinical management options, and especially about the use of their medicines, in terms they can understand.
- 4.7 Hospital pharmacists should inform, educate and advise patients, carers and other health care professionals when medicines are used outside of their marketing authorisation.
- 4.8 Clinical pharmacy services should continuously evolve to optimise patients' outcomes.



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Hospital Pharmacist Role Expands in Patient Care

May 23, 2019

Ken Krizner

Publication

Article

MHE Publication

Managed Healthcare Executive June 2019 Issue

Volume **29** Issue **6**

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The suggested pharmacist-to-patient ratio for optimal care is about 1-to-30 (1-to-20 in the intensive care unit), notes Kimberly A. Boothe, PharmD, MHA, system director, pharmacy services for [St. Elizabeth Healthcare](#) in Fort Thomas, Kentucky. (The traditional pharmacist-to-patient ratio is in the 1-to-50 to 1-to-100 range).



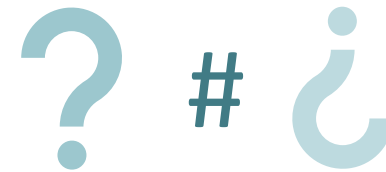
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SEFH National Survey-2019: general characteristics, staffing, material resources and information systems in Spain's hospital pharmacy departments

Encuesta Nacional de la SEFH-2019: caracter sticas generales, recursos humanos, materiales y sistemas de informaci n en los Servicios de Farmacia Hospitalaria en Espa a

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A survey of critical care pharmacists to patient ratios and practice characteristics in intensive care units

J Am Coll Clin Pharm. 2020;3:68–74.

In this cross-sectional survey of critical care pharmacists throughout the United States, a majority of pharmacists had a higher pharmacist to patient ratio than has been traditionally recommended in the literature. This high patient care demand was coupled with high rates of pharmacist involvement with nonpatient care activities. These obser-

Conclusions: Heterogeneity exists among critical care pharmacy activities that may influence pharmacists' perceptions of workload and patient safety. Critical care pharmacists report that their institutions should have more critical care pharmacists. Pharmacists' perceptions of workload vary based on differences in their activities outside of patient care.

Chapter 9: Staffing Levels and Structure for the Provision of Clinical Pharmacy Services

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Table 9.1. Pharmacist staffing levels for provision of clinical pharmacy services based on 'overnight beds'

Category	Service related group/ bed type	Beds to 1 FTE pharmacist for clinical pharmacy services 5 days/ week*
1 Specialist units, high dependence on medicines	Haematology, Immunology and Infections, Medical Oncology, Renal Medicine, Transplantation, Qualified Neonates	15
2 Medical bed type	General medical units, Cardiology, Interventional cardiology, Dermatology, Endocrinology, Gastroenterology, Chemotherapy, Neurology, Psychiatric, Respiratory medicine, Rheumatology, Pain management, Definitive Paediatric medicine	20

3 Surgical bed type	General surgical units, Breast surgery, Cardiothoracic surgery, Colorectal surgery, Upper GIT surgery, Head and Neck surgery, Neurosurgery, Orthopaedics, Plastic and Reconstructive surgery, Urology, Vascular surgery	25
4 Palliative care	Palliative care	25
5 Minimal change to medicines anticipated	Ear Nose and Throat, Gynaecology, Obstetrics, Unqualified Neonates, Perinatology	30
6 Longer stay admissions	Drug and Alcohol, Non Acute Geriatric, Geriatric Evaluation and Management, Palliative care, Rehabilitation	30
FTE = full-time equivalent. *Service on a weekend (assuming few admissions and discharges and medication chart review only) would require an additional 2 to 2.5 hours per day.		

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Chapter 9: Staffing Levels and Structure for the Provision of Clinical Pharmacy Services

Table 9.2. Pharmacist staffing levels for provision of clinical pharmacy services based on the number of patients per day

Category	Patient/service type	No. of patients to 1 FTE pharmacist for clinical pharmacy services per day*
7 Critical care units, high dependence on medicines	All critical care units, extensive burns, tracheostomy, extra corporeal membrane oxygenation	10
8 Review and advice on medicine usage – with urgency	Emergency,† Medical Assessment and Planning Units, Short stay acute medical assessment units <48 h	10
9 Review and advice on medicine usage – ambulatory	Pharmacists providing review and advice on medicine usage services in Allied Health and/or Clinical Nurse Specialist Interventions clinics - Tier 2 Non-admitted Service 40.04 ¹¹	5

10 Review and advice on medicine usage – outreach services	Pharmacists providing review and advice on medicine usage services in Allied Health and/or Clinical Nurse Specialist Interventions clinics - Tier 2 Non-admitted Service 40.04 as outreach service or in the patient's home ¹¹	3
11 Same day admission	Day surgery beds, Diagnostic GI, Endoscopy, Ophthalmology, Dentistry, Oncology, Renal Dialysis, Hospital in the Home	22
12 Outpatient clinics	Pharmacists participating in Medical Consultation clinics (including all Tier 2 Non-admitted Service 20.1–20.51) ¹¹ Pharmacists providing services in Allied Health and/or Clinical Nurse Specialist Interventions clinics (including Tier 2 Non-admitted Service: 40.01, 40.02, 40.07, 40.13, 40.19, 40.20, 40.21, 40.26) ¹¹	22

FTE = full-time equivalent.

*Includes services on weekdays and weekends.

†Figure presented on the basis of admitted patients only but allowance for workload for some patients discharged from ED (based on admission rate of 27%).⁷

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Chapter 9: Staffing Levels and Structure for the Provision of Clinical Pharmacy Services

Three major factors drive changes to the staffing levels for clinical pharmacy services. These include:

1. range of clinical pharmacy services required and expected by patients, funders and boards of management
2. complexity of care required (linked to patient age, range and number of diagnoses, and number, range and type of medicines used)
3. hospital throughput, which is a combination of the number of beds, length of stay and occupancy and the usage of same-day and ambulatory services.

Chapter 9: Staffing Levels and Structure for the Provision of Clinical Pharmacy Services

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Additional resources should be dedicated for other related activities such as clinical pharmacy management, drug protocol management, antimicrobial stewardship, relevant to the scope and size of the clinical pharmacy service. See *Chapter 14: Improving the quality of clinical pharmacy services*.

Additional resources are also required to allow dedicated time for training and education, research and involvement in other clinical pharmacy services to support the *National Medicines Policy*.¹⁰ See *Chapter 10: Training and education* and *Chapter 11: Participating in research*.

Consensos para rácios de Farmacêuticos/área




Characteristics Contributing to a Pharmacy Services Excellence Model in a Large Health System

[L. Hayley Burgess](#), PharmD, MBA, BCPP, CPPS,^{✉1} [Sara Fletcher](#), PharmD, MHIIM,¹ [Mandelin K. Cooper](#), PharmD, BCPS, [Elizabeth Wiggins](#), PharmD, BCPP,¹ [Susan S. Horton](#), PharmD,² and [Joan S. Kramer](#), PharmD, BCPS, CPPS, DPLA¹

While the subgroup analysis of manageable pharmacist-to-patient ratios appeared to be associated with optimized clinical pharmacy services, future research is needed to further understand the ideal pharmacist ratios required to improve patient outcomes. Areas of future study include validation of optimal best practice models, specifically the impact of advanced pharmacist training, board certification and accredited residency programs on achieving clinical pharmacy metric goals and improved patient outcomes. As at-

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Defining clinical pharmacy and support activities indicators for hospital practice using a combined nominal and focus group technique

Hugo Lopes^{1,2,3}  · Andrea Rodrigues Lopes¹ · Helena Farinha^{4,5,6}  · Ana Paula Martins^{4,6} 

Received: 5 January 2021 / Accepted: 10 June 2021 / Published online: 24 June 2021
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International Journal of Clinical Pharmacy (2021) 43:1660–1682
<https://doi.org/10.1007/s11096-021-01298-z>

Table 2 (continued)

EAHP Standards	Assessment area	Key performance indicators	Type of KPI	Relevance (average)	Measurability (average)	Final list
III. Production and preparation	Drug preparations	Ability to prepare internally sterile and injectable preparation blends	saKPI	4.8	2.6	N
	Drug preparations	Number of biological controls performed	saKPI	4.8	2.0	N
	Drug preparations	Number of sterile and injectable preparation blends performed	saKPI	4.8	2.0	N
IV. Clinical Pharmacy services	Prescription review and reconciliation	Number of inpatient prescriptions validations (medication review), adjusted by pharmacist FTE	cpKPI	5.0	4.3	Y
	Prescription review and reconciliation	Number of outpatient prescription validations (medication review), adjusted by pharmacist FTE	cpKPI	4.5	4.5	Y
	Prescription review and reconciliation	Number of pharmacist interventions in patient therapy, adjusted by pharmacist FTE	cpKPI	4.5	4.5	Y
	Prescription review and reconciliation	Number of blood products dispensed, per 1000 patients discharged	saKPI	4.4	4.3	Y
	Prescription review and reconciliation	Number of narcotic and psychotropic requests analysed, per 1000 patients discharged	cpKPI	4.3	4.2	Y

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ROYAL
PHARMACEUTICAL
SOCIETY

**Professional Standards
for Hospital
Pharmacy Services**

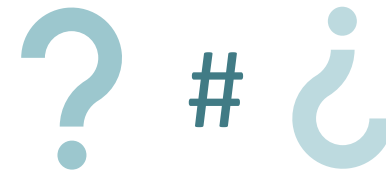
2022

Standard 8 Workforce

The pharmacy team has the right skill mix, capability, and capacity to provide safe, quality services to people whilst being supported to maintain their personal development and health and wellbeing.

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**HOSPITAL
PHARMACY
EUROPE**

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Published on 24 March 2022

Pharmacy workforce: matching staffing resource to service demand

The WISN approach calculates staffing requirements from the equation shown in Figure 1.

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Figure 1 WISN equation

$$\text{Staff resource required} = \frac{\text{Time to perform role for patient population}}{\text{Available staff time}}$$

Where:

Time to perform role for patient population = 'activity standard' x number of patients

'Activity standard' = the full list of task required to deliver care for one patient, how long they take and how often they should be completed by what staff group
and

Available time = That portion of employed time available for patient care, i.e. what remains after annual leave, sickness, training or travelling is excluded

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Prioritizing Quality over Quantity: Defining Optimal Pharmacist-to-Patient Ratios to Ensure Comprehensive Direct Patient Care in a Medical or Surgical Unit

Shazia Damji ¹, Michael Legal ², Karen Dahri ³, Nilufar Partovi ⁴, Stephen Shalansky ²

Affiliations + expand

PMID: 38204503 PMID: PMC10754399 (available on 2024-07-10) DOI: [10.4212/cjhp.3437](#)

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Results: Ten pharmacists participated in the modified Delphi study, and 31 participated in the work sampling study. A total of 15 comprehensive care tasks were identified, 7 of which were categorized as tasks to prioritize in settings where staffing is limited. The optimal staffing ratios were 1 pharmacist to 13 patients in internal medicine teaching units, 1 pharmacist to 26 patients in hospitalist or internal medicine nonteaching units, and 1 pharmacist to 14 patients in surgical units.

Conclusions: The optimal staffing ratios determined in this study should enable pharmacists to provide comprehensive care to each patient. Implementing these staffing ratios could increase the consistency of clinical pharmacy services, improve patient outcomes, and improve pharmacists' work satisfaction. Further research is required to validate these ratios in a variety of settings.

Keywords: clinical pharmacy; key performance indicators; patient ratio; pharmacy staffing; work sampling; workload.

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Formação/Especialização

Competências (novas!)

Diversidade de atividades

Complexidade

Exclusividade

Suporte informático

Satisfação