were empirical prescriptions, 518 (33.9%) inappropriate prescribing, 489 (31.9%) documented and 258 (16.8%) were according to the protocol approved by the institution. The physician's acceptance of pharmacy interventions was 52.5%. The mean treatment duration varied according to type of prescription: 9 days for documented prescription; 8.1 days for empirical prescriptions; 6.3 days for prescriptions according to protocol; and 5.5 days for inappropriate prescriptions ($p=0.0001$). The interventions reduced the mean duration of therapy: 5.5 days for prescriptions with intervention and 7.6 days for the ones without ($p<0.0001$). It was found that in 652 prescriptions with microbial isolates, 369 were multidrug-resistant microorganisms (24.1%). Patients who were discharged early with antibiotics for ambulatory care (21.7%) had lower mean duration of treatment (5.8 days) and a lower proportion of multidrug-resistant strains (42.5%) than patients who were discharged without antibiotics (56.6%; 7.7 days and 62.9%) or patients who died (14.6%; 7.1 days; 52.2%) ($p=0.0001$).

Conclusion Pharmacy-driven interventions could be a strategy for decreasing costs with human resources associated with antimicrobial stewardship due to the effective screening of antibiotics prescriptions. Investment in the surveillance results in early hospital discharge with a shorter length of antibiotic treatment with a consequent decreasing of multidrug-resistant strains.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-196 ABSTRACT WITHDRAWN

4CPS-197 DETERMINING THE NECESSARY COMPONENTS OF A PHARMACEUTICAL CARE COMPLEXITY SCREENING TOOL: AN E-DELPHI STUDY

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Background With increased pressure on clinical pharmacy services there is a demand for reliable screening tools to appropriately allocate pharmaceutical care to those patients with most urgent and/or complex needs. Several such tools have been developed, however, they are often locally developed with a lack of agreement on their components. To date, no broad consensual agreement of experts exists on valid components of a pharmaceutical care complexity screening tool in the adult hospital setting.

Purpose To obtain consensus on the necessary components of a pharmaceutical care complexity screening tool for use on admission to hospital.

Material and methods Complexity tool components were identified and refined in three phases: first, a systematic literature review was conducted to identify existing tools and their components. Second, a national survey and semi-structured telephone interviews identified non-published tools and their components. The obtained components from phase I and II were reviewed by the research team and an expert reference group to remove non-clinical factors and duplicates. Third, an expert Delphi panel, including international leading pharmacists, researchers and clinicians, was recruited by email to take part in a two-round Delphi study. Items were scored. The panel were asked to rank each component according to importance via a web-based anonymised electronic questionnaire using a nine-point Likert-scale. Consensus was set at 67%: items that 67% of people deemed to be important were listed. Ethical approval was not required.

Results Forty-one invited experts joined the panel and completed round one, and 33 of them completed the second round. One-hundred and nine of the complexity tool components were initially identified and validated by the panel. After two Delphi rounds, 92 components (84.4%) achieved the limit of agreement for importance. These were grouped into three component types (demographic, clinical-related and medication-related) and reduced to 31 items for inclusion into a screening tool.