Conclusion This study systematically and rigorously identified a set of 31 items which are important for assessing pharmaceutical complexity. This information can then be used for the development and refinement of future and current pharmaceutical complexity screening tools that can aid more efficient targeting of hospital clinical pharmacy services.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-198 CLINICAL EXPERIENCE WITH DALBAVANCIN IN A TERTIARY HOSPITAL

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Background Very limited labelled indications have been approved for the newer antimicrobials and extensively drug-resistant gram-positive bacterial infections that are a clinical challenge.

Purpose Data on the clinical uses, efficacy and safety of dalbavancin, a novel lipoglycopeptide, in real life is scarce, thus we sought to describe our clinical experience.

Material and methods Descriptive study of patients treated with dalbavancin from June 2016 to September 2017 in a tertiary hospital in southern Spain.

Results Twenty-two patients were involved. Demographics, microbiology, therapy characteristics, adverse events and clinical outcomes are described in Table 1. Eighty-six per cent were used under off-label indications in patients who had tried and/or failed other therapies.

Abstract 4CPS-198 Table 1

DEMOGRAPHICS	n (%)	TREATMENT	(%)
Age	69.6 (46–85)	DAL administered following hospitalisation	77.3%
Male	59.1%	Previous antimicrobials for actual episode	100%
DIAGNOSES		**Switching to DAL**	
Osteoarticular infections	45.5%	Discharge	64.7%
		Resistant pathogens	22.7%
		Drug-induced toxicity	13.6%
Bloodstream infections	22.7%	Difficult vascular access	9.1%
Acute bacterial skin and skin structure infections	13.6%	Drug-drug interactions	4.5%
Endocarditis	13.6%	**DAL initial – weekly doses**	
		1,000–500 mg	63.3%
MICROBIOLOGY		750–350 mg	4.5%
Samples available	90.9%	1,500–1,500 mg	4.5%
S. aureus	54.5%	1,500 – single dose	27,3%
MRSA	58.3%	**DAL number of doses:**	
CNS	27.3%	2	36.4%
Methicillin-resistant CNS	66.7%	single	31.8%
E. faecalis	4.5%	≥5	27.3%
E.faecium	4.5%	**ADVERSE EVENTS**	
OUTCOMES		Infusion site reaction	4.5%
Success treatment	95.2%	Others	0

Conclusion Further evidence beyond labelled indications is urgently needed. Despite the limitations, in our clinical practice, the use of dalbavancin under multidisciplinary antimicrobial stewardship team supervision appears to be a promising, safe and effective option for adult patients who have tried and/or failed other therapies due to multidrug-resistant gram-positive organisms and/or may offer added safety and potential cost reductions.

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4CPS-199 ASSESSMENT OF MEDICATION RECONCILIATION IN CHRONIC COMPLEX PATIENTS

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Background Transitions in care put the patients at risk for medication error as a result of poor communication and information loss. Medication reconciliation (MR) was conducted to record the best possible list of all the medications patients were taking upon admission. Reconciliation errors are an important cause of morbidity and have a predominant role in hospitalised patients, specifically in chronic complex patients (CCP).

Purpose To assess a programme of MR at admission and at discharge implemented in a CCP and their degree of acceptance by the physician.

Material and methods A prospective study was made from January to June 2018. All patients that at admission to hospital were classified as CCP were included (palliative patients were excluded). At admission to the hospital, the pharmacist carried out an interview with the patient/guardian, review of clinical history and the patient's current medication list (PCM).

This complete and accurate list was registered in the clinical history and compared with the PCM registered by the physician. Medication discrepancies were analysed and communicated.

A registry was made of all the unjustified discrepancies detected, reconciliation errors, pharmaceutical interventions carried out, type and acceptance. At the time of discharge, the reconciliation report was made consisting of the following information: current treatment of the patient at discharge, interactions and recommendations for the patient.

Results A total of 66 patients' CCP were admitted (51.5% female and 48.5% male), mean age 84.9 years (±5.9 SD). Fifty-five (84%) patients were reconciliated at admission. The mean number of medication lines were 10.7. The following were detected: 54 unjustified discrepancies,and 0.98 medication error/patient (46 omissions, four contraindicated medications, two different doses, one wrong medication and one start medication not prescribed), of which 45 were accepted (83%). At discharge, 41 reports were made (62.1%) and 32 interactions were detected. The rest of the reports at discharge were not carried out due to: 12 (18.2%) were exitus during admission and 13 (19.7%) for other reasons.

Conclusion A pharmacist MR is an effective procedure in identifying and resolving medication errors. The degree of acceptance of pharmacists' interventions by the prescriber was