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

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

Abstract 4CPS-198 Table 1

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

Abstract 4CPS-199

**CLINICAL EXPERIENCE WITH DALBAVANCIN IN A TERTIARY HOSPITAL**


10.1136/ejhpharm-2019-eahpconf.347

**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.

**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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

**ASSSESSMENT OF MEDICATION RECONCILIATION IN CHRONIC COMPLEX PATIENTS**

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10.1136/ejhpharm-2019-eahpconf.348

**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 documented.

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 reconciled 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
REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.

4CPS-200
USE OF PROHEMOSTATIC DRUGS IN MASSIVE HAEMORRHAGE EPISODES

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Background Prohemostatic drugs are those used in the treatment or prevention of the haemorrhagic phenomenon, by stimulating the mechanisms that increase haemostasis or by stopping those that inhibit it endogenously.

In our centre, a massive transfusion protocol (MTP) was approved in November 2014, which included the approach to massive haemorrhage episodes (MHE) according to a decision diagram focused on thromboelastometry.

Purpose To evaluate the use of prohemostatic drugs in patients who suffered an MHE.

Material and methods Retrospective descriptive observational study, including all the patients that suffered an MHE during the year 2016.

The data collected were demographic (sex and age), type of MHE, activation or not of the MTP drugs used according to the MTP and doses used.

Results MHE were collected in 43 patients during 2016. The median age was 55 (21–84) years; 36.59% were female.

The types of MHE were obstetric 11.63%, surgical 34.88%, digestive bleeding 25.58%, polytraumatic 13.95% and others (haemorrhagic, septic, hypovolemic and haemodynamic shock) 13.96%.

MTP was activated in 36 patients (83.72%). The prescribed prohemostatic drugs were: fibrinogen in 58.14% of patients, tranexamic acid (TXA) in 48.84% and prothrombin complex concentrate (PCC) in 20.94%. Overall, 105 g of fibrinogen, 32.9 g of TXA and 9603 IU of PCC were used.

According to the type of MHE the following prohemostatic drugs were consumed:

- Obstetric: fibrinogen 14 g, PCC 600 IU and TXA 5 g (four, one and three patients respectively).
- Surgical: fibrinogen 64 g, PCC 7800 IU and TXA 13.5 g (11, four and five patients respectively).
- Digestive bleeding: fibrinogen 14 g, PCC 3 IU and TXA 4 g (four, one and two patients respectively).
- Polytraumatic: fibrinogen 7 g, PCC 1200 IU and TXA 5 g (three, one and four patients respectively).
- Others: fibrinogen 2 g (one patient), and TXA 2.4 g (one patient).

Conclusion Surgical haemorrhages were the most frequent type of MHE during the study period. Fibrinogen was the most used prohemostatic drug in MHE.

The patients who presented a surgical type MHE were the ones who consumed more prohemostatic drugs.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-202
ANTICHOLINERGICAL RISK IN CHRONIC COMPLEX PATIENTS

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Background Numerous studies demonstrate the association between the use of anticholinergic medication and cognitive