single initial empirical antibiotic whereas 92% received combination antibiotics. A total of 122 patients received appropriate initial empirical therapy on the first day of hospitalisation: 9.4% of patients received broad spectrum antibiotics that were not warranted. Eighty-one (58.7%) of the patients had a change in antimicrobial regimen during hospital admission. Overall appropriateness of CAP management based on the composite of initial empirical treatment, duration of treatment and switching antibiotics according to culture and sensitivity during the admission period was 58.0%. Severe respiratory illness was the most significant independent risk factor.

Conclusion and relevance The study showed that adherence to CAP guidelines for an initial empirical therapy on the first day of hospitalisation was optimal whereas overall adherence to CAP management throughout the hospital stay was low.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-160 MANAGEMENT OF DRUGS IN PATIENTS WITH SWALLOWING DIFFICULTIES IN A PUBLIC RESIDENTIAL CARE HOME: ROLE OF THE HOSPITAL PHARMACIST

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Background and importance Institutionalised people in a nursing home have a profile characterised by advanced age, multiple pathologies and many also suffer from swallowing problems. This not only affects nutrition but can also affect taking medications. Many drugs must be crushed or dissolved to facilitate administration and in many cases the stability of the drugs under these conditions is not known.

Aim and objectives The aim of the study was to evaluate medication administered to patients with swallowing problems in a public residential care home and to establish possible commercialised alternatives or develop compounding pharmaceutical preparations.

Material and methods A prospective longitudinal study was performed (1 month) in a public nursing home. Data collected were: patients with swallowing difficulties and oral treatments which had to be subdivided or crushed for administration, nasogastric tube use, age, sex, number of drugs and pharmaceutical forms. We also did a literature search for drugs and use in this manner (small therapeutic windows, slow release, enteric coats, etc) to look for alternatives that might facilitate administration and guarantee stability and safety.

Results Eighty-five institutionalised elderly patients lived in the nursing home and 20% had dysphagia or difficulty taking their oral treatment. Mean age of the patients with swallowing difficulties was 90.35 (SD=4.27) years. None had a nasogastric tube. Fifty-three different medications were identified and only 11 had an adapted pharmaceutical formulation: 50% (26/53) had an alternative of the same composition but of a different pharmaceutical form commercialised as syrup, oral solution, drops or powder. In 47 cases the drugs could be crushed and diluted and administered immediately. In five cases the drugs were being crushed and should not have been. The pharmacist proposed other alternatives, such as drinking

parenteral ampoules (5/53), sublingual administration (1/53) or elaborate compounding preparations (8/53). The possibility of preparing eight compounding pharmaceutical preparations was facilitated.

Conclusion and relevance Most of the treatments that were analysed did not facilitate swallowing and were manipulated, which can provoke errors in medicine administration. Hospital pharmacists should assess the suitability of compounding medication formulations and propose solutions to guarantee stability and safety of medicines.

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4CPS-161 PHARMACIST INTERVENTIONS IN A HOSPITAL AT HOME UNIT

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Background and importance Hospital at home (HaH) units provide hospital level care at home to patients who would otherwise remain hospitalised. A HaH unit is hospital based with a multidisciplinary team in which the pharmacist role is essential to provide pharmaceutical care in potential medication related problems.¹ Our HaH unit was started in 2015 and 1340 patients were admitted up to August 2019.

Aim and objectives To analyse pharmacist interventions (PIs) in HaH admitted patients.

Material and methods This was a retrospective study conducted between December 2018 and August 2019. All patients admitted to the HaH unit were included, except those <65 years of age or with <5 drugs prescribed. PIs made by email and by electronic notification were recorded. Telephone PIs were excluded. PIs were classified by intervention type (medication review, pharmacokinetics monitoring, prescription validation, information and therapeutic reconciliation), reason for intervention and therapeutic recommendation.

Results During the study period there were a total of 80 PIs in 53 patients from a total of 425 patients admitted to the HaH unit. Most patients (63.5%) had more than 10 drug prescriptions, and mean age was 74.7 years.

The major PI were related to pharmacokinetic monitoring (45.0%), medication review (28.8%) and prescription validation (23.8%). The principal pharmaceutical recommendations were related to dose adjustment, low therapeutic index (34.6%), blood analysis for monitoring (23.5%) and alterations in prescribed drugs (16.0%). Thirteen cases of severe interactions were detected, of which 69.2% led to drug alteration and 30.8% to de-prescription. The acceptance rate of the pharmacist recommendations was 96.3%.

Conclusion and relevance PIs were mainly in polymedicated patients, reinforcing the need for pharmaceutical care in these high risk patients. Although the study population was small, compared with the total number of patients admitted to the HaH, the PIs showed a high impact, reducing potential harm to patients (antibiotics with low therapeutic index, detection of severe or moderate interactions). The high acceptance rate of the interventions by physicians revealed their importance and significance. Participation of a pharmacist in the HaH team contributes to improve patient safety and avoids drug related problems.