The most prescribed antibiotics were piperacillin/tazobactam (22), ceftriaxone (16), cotrimoxazole (15), amoxicillin/clavulanate (8) and metronidazole (5).

The sources of infection were respiratory (26.2%), urinary (21.3%), intra-abdominal (21.3%), skin and soft tissue (9.8%), catheter-associated (6.6%) and unclear (14.8%).

Recommendations were made to continue treatment (67.8%), discontinue for excessive duration (10.3%), de-escalate (9.2%), discontinue for unnecessary antimicrobial (8.0%) and escalate (4.6%).

The acceptance rate was 98.8%.

Conclusion and relevance: The recommendations made by the ASP team were almost entirely accepted by the responsible clinician. Advice from a multidisciplinary team of experts in the field benefits these patients in optimising their antimicrobial therapy.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest: No conflict of interest

4CPS-152 CHARACTERISATION OF A COMPOUNDED VORICONAZOLE SOLUTION FOR NEBULISATION AND DESCRIPTION OF ITS USE IN THE CLINICAL SETTING
M Larrosa García*, S Terradas Campanario, A Fernandez Polo, C Cañete Ramirez, A Pau Parra, L Domench Moral, D Campany Herrero, MR Gomez Domingo, MQ Gorgas Torner. Vall d’Hebron University Hospital, Clinical Pharmacy, Barcelona, Spain

Background and importance: Voriconazole is the primary treatment for invasive pulmonary aspergillosis. Antifungal nebulisation has advantages, but there are no commercial antifungal pharmaceutical presentations for nebulisation.

Aim and objectives: To physicochemically characterise a compounded voriconazole solution for nebulisation and to describe its use in a cohort of patients.

Material and methods: Voriconazole solution for nebulisation was prepared in the Pharmacy Department. Accord, Kern and Normon vials were used.

Clinical data from patients treated with nebulised voriconazole in our hospital were retrospectively collected.

Voriconazole concentration in plasma was determined using high-performance liquid chromatography.

Results: Voriconazole vials containing 200 mg of powder for solution for infusion were diluted with sterile water for injection (19 mL). The solutions were adequate for nebulisation (pH 4.97, 7 and 5; osmolality 359, 503 and 313 mOsm/kg, respectively). Syringes containing 40 mg/4 mL were dispensed.

Ten patients received nebulised voriconazole, 9 adults and 1 child; median age was 35 years (minimum 5 and maximum 69 years), all men. Five patients had cystic fibrosis and 8 had undergone lung transplantation (LT) 7 (0–84) months ago. 6 patients had respiratory distress and 2 were colonised. Treatment was started on the hospital floor (5), intensive care unit (3) or outpatient department (2).

Fungi detected were Aspergillus spp (5) (A. flavus (4)), Scedosporium spp (4) and Pseudallescheria boydii (1).

Treatment was started due to lack of response to systemic treatment (4), toxicity (4), avoiding drug-drug interactions (2), post-LT prophylaxis (1) and booster oral voriconazole effect (1).

Doses (40 mg for adults, 10 mg for children) were administered every 12–24 hours (2–3 days in the case of colonisation) during a median of 130 (26–911) days.

Three patients died, 3 fungal infections resolved, 2 had colo

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest: No conflict of interest

4CPS-164 DURABILITY OF ORAL DUAL ANTIRETROVIRAL THERAPY IN HIV PATIENTS
L Perez Cordon*, 1, A Sanchez Ullayar, 2, S Marin Rubio, 1, V Aguillera Jimenez, 1, L Campins Berndas, 1, J Delgado Rodriguez, 1, M Biltoch Obiols, 1, R Merino Mendez, 1, T Gurria Roig, 1, D Lopez Falco, 1, Hospital de Mataro, Pharmacy, Mataro, Spain; 2Hospital Germans Trias I Pujol, Pharmacy, Badalona, Spain

Background and importance: Dual antiretroviral therapy (DAT) is currently used as initial treatment in naïve patients or as a maintenance therapy in those who are virologically suppressed. The simplification of antiretroviral regimens is associated with a reduction in treatment toxicities and costs and an adherence improvement. However, there are a lack of studies reporting data on DAT effectiveness beyond clinical trials.

Aim and objectives: To assess the durability and reasons for discontinuation of DAT in HIV-infected patients.

Material and methods: This was a retrospective, cohort study. Adult HIV-infected patients who started a treatment with DAT between 2015 and 2019 in a general hospital were included. Sociodemographic data, HIV-1 RNA copies at baseline and treatment data (DAT combination, previous treatment, time to discontinuation and reason for discontinuation) were collected from clinical records. Treatment durability was assessed using the Kaplan-Meier analysis up to 48 weeks.

Results: Fifty-one patients were included: 31 patients were male, mean age was 49±11 years. Mean time from HIV diagnosis was 16.2±9.1 years, 20 patients had a previous classification Centers for Disease Control and Prevention (CDC) stage C and 15 had a history of intravenous drug use. Thirty-six patients were previously treated with a three-drug regimen, 8 with a DAT, 5 with an antiretroviral monotherapy and 2 were treatment-naïve. Thirty-seven patients were virologically suppressed at baseline. DAT combinations were: integrase inhibitor (INI) plus nucleoside reverse transcriptase inhibitor (NRTI) or non-nucleoside reverse transcriptase inhibitors (NNRTI) (n=29), boosted protease inhibitor (PI/b) plus NRTI or NNRTI (n=15) and INI plus PI/b (n=7).

Thirty-nine patients maintained DAT at 48 weeks and mean treatment...
duration was 40.5±14.8 weeks. The reasons for discontinuation were: lack of effectiveness (n=1), treatment simplification (less-pills regimen) (n=3), abandonment (n=2), drug-drug interactions (n=2), kidney failure (n=1), death (n=1) and follow-up losses (n=2).

Conclusion and relevance A broad spectrum of DAT combinations were used according to patients’ characteristics. Although 14 patients were not at virological suppression at baseline, DAT showed a high durability at 48 weeks and only 2 patients discontinued due to lack of effectiveness or toxicity.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest

Abstract 4CPS-177 Table 1 Themes and interviewee illustrative quotes for facilitators and barriers to advancing prescribing practice

<table>
<thead>
<tr>
<th>Themes</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitators – management support</td>
<td>“I think because I’ve built a rapport with the team and get lots of support from them.” [Pharmacist 13]</td>
</tr>
<tr>
<td>Barriers – no renal specific training</td>
<td>“We could have better course around use of medications in patients with CKD.” [Pharmacist 3]</td>
</tr>
</tbody>
</table>

Background and importance Chronic kidney disease (CKD) has a high risk of morbidity and mortality. The available evidence worldwide demonstrates that non-medical prescribing by pharmacists in various clinical specialties is a safe and effective approach. There is lack of evidence of information on the implementation and development of pharmacist prescribing for patients with CKD.

Aim and objectives Aim was to explore the development, implementation and evaluation of pharmacist prescribing for patients with CKD in the UK.

Material and methods This study used a qualitative semi-structured interview. The development of the theory-based semi-structured interview tool followed a rigorous iterative process using findings from the literature, underpinned by the Consolidated Framework for Implementation Research (CFIR) and reviewed independently by an expert panel. A date/time for a telephone interview was arranged following receipt of signed consent. All interviews were transcribed verbatim. Interview data were analysed thematically. The Francis method of checking for data saturation was used. Ethical approval was granted by RGU School of Pharmacy.

Results Data saturation was reached after 14 interviews. Demographic details included: 11 female, 7 had >16 years experience in the profession, all had secondary care as their main practice setting and 8 had >11 years as a prescriber. The interviewees were generally very positive about their prescribing practice and they articulated that they were prescribing in a variety of settings. CFIR helped identify themes related to facilitators and barriers to advancing prescribing practice. There was enthusiasm for the future development of prescribing practice including further establishment of clinics and taking responsibility for groups of patients.

Conclusion and relevance This work provides information relating to the current status of the development of pharmacist prescribing practice in the UK. Further ‘deep dive’ case study work will help explore the practice of leading edge advanced and consultant level practitioners to learn even more about practice development.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest

Background and importance This project focused on direct interaction between hospital pharmacists and patients, through clinical pharmaceutical counselling. Drug safety and patient well-being are promoted and possible user errors and uncertainties concerning the medication and interactions are communicated direct. During the consultation patients were given the opportunity to ask questions, express uncertainties and receive information regarding their medication. Two different settings for the project (outpatient and inpatient) were explored and investigation of which questions were of primary concern in these different situations.

Aim and objectives Most chronic obstructive pulmonary disease (COPD) patients have up to at least three comorbidities in addition to their primary pulmonary disease. These can affect the heart, bones, metabolism and/or psyche, among others. Therefore polypharmacy is almost inevitable. Clinical-pharmaceutical counselling of patients is intended to promote adherence and medication safety. Especially for these patients, adherence to therapy is crucial and close monitoring of the medication is essential. This patient-oriented service is intended to be a tool for optimal drug therapy, since it has already been shown that clinical-pharmaceutical interventions, such as targeted education of patients, can reduce adverse drug events and readmissions.

Material and methods A guideline with predefined questions about health status, medication scheduling, intake modalities, uncertainties, and a final satisfaction survey was created in order to be able to offer a comparable consultation to all patients. Prior to the consultation, patient records were reviewed and the medication was checked for possible interactions using drug interaction software programs.

Results It could be shown that the consultation for the inpatient area was related to medication changes during the stay and the expected benefits from those changes, thus promoting the patients’ medication knowledge for the time after hospital discharge, whereas most outpatients’ questions were about self-medication and over the counter (OTC) drugs. In this cohort some examples of severe drug interactions could be found.

Conclusion and relevance In summary, this medication consultation benefits the patients by increasing their knowledge regarding their medicine which leads to better adherence and