therapeutic changes throughout the pandemic. It should be noted that 2 patients completed antiviral therapy with remdesivir at home. Strategic implementation of home visits clearly impacts on the hospital beds' capacity.

Conclusion and relevance HaH COVID Unit is a safe and effective option in carefully selected patients with COVID-19.

Collaborative and multidisciplinary management could have a great impact on the improvement of healthcare provided to COVID-19 patients.

Pharmacists should actively participate in therapeutic decisions, in the formulation and adjustment of therapeutic regimens for COVID-19 patients, ensuring the monitoring, evaluation of the safety of the medication, efficacy and management of drug interactions.

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Conflict of interest No conflict of interest

4CPS-150 ABILITY TO ASSESS ACUTE KIDNEY INJURY IN PATIENTS ADMITTED TO HOSPITAL

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10.1136/ejhpharm-2022-eahp.165

Background and importance Different criteria were created to identify acute kidney injury (AKI) based on serum creatinine (SCr) levels, namely AKIN, KDIGO, RIFLE.

Aim and objectives To assess the ability to monitor AKI occurrence based on the availability of timely measured SCr levels in a retrospective cohort of patients admitted to hospital.

Material and methods Data from patients admitted to hospital between 1 June 2018 and 31 December 2020 were collected. AKI stage was calculated for each patient based on the AKI staging cut-offs using the three major guidelines (RIFLE, AKIN and KDIGO) and five criteria. In a first analysis, time to reach the SCr cut-off was ignored. In a second analysis, patients reaching any AKI stage were re-evaluated considering the time recommended between SCr tests: 48 hours AKIN and 7 days RIFLE and KDIGO. Descriptive analyses of the AKI stage allocation were performed.

Results During 31 months, 25 777 admissions occurred corresponding to 18 935 patients (4112 patients with more than 1 admission; range 1–18). Mean age of admissions was 60 years (SD 27), 14 146 (54.9%) were female and the mean length of stay was 10 days (SD 16); 63 admissions had a duration <24 hours. During 263 969 bed-days, 81 892 SCr tests were recorded, representing 1 test per 3.22 bed-days. In 4407 admissions (17.1%) no SCr test was recorded. The first SCr test was done on average 2.2 days (SD 2) after admission. A total of 6958 tests increased 0.3 mg/dL from baseline and 1500 tests increased 1.5–2 times their value (stage 1); of these, 1689 and 323 exceeded the 48 hours, and 103 and 29 the 7 day-interval, respectively. In 1618 tests, baseline increased 2–3 times (stage 2) with 363 over 48 hours and 33 over the 7-day interval. In 477 tests, baseline increased more than three times and in 166 increased 4.0 mg/dL (stage 3), where 105 and 39 were over 48 hours and 10 and 4 were over the 7-day interval, respectively.

Conclusion and relevance To accurately monitor AKI, hospital pharmacists need access to SCr levels of inpatients measured at least every 48 hours.

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Conflict of interest No conflict of interest

4CPS-151 EVALUATION OF CASPOFUNGIN USE IN THE PAEDIATRIC HAEMATOLOGY WARD OF THE NATIONAL BONE MARROW TRANSPLANT CENTRE

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10.1136/ejhpharm-2022-eahp.166

Background and importance Invasive fungal infections are becoming frequent in hospitals and present a major mortality cause for transplanted patients. With the systemic emergence of these fungemia, caspofungin consumption is increasing greatly and consequently so are the pharmaceutical expenses in our establishment.

Aim and objectives To evaluate caspofungin prescriptions in the National Bone Marrow Transplant Centre (NBMTC), the indications, treatment duration and estimates of the treatment cost.

Material and methods A 5-month retrospective study from March to July 2021 in the paediatrics ward of 545 prescriptions for 19 patients where a data collection sheet was elaborated and validated for each new prescription. Data were processed afterwards and the results explored with Microsoft Excel Professional Plus 2016.

Results 95% of prescriptions adhere to the drug marketing authorisation (MA) approved indications (neutropenic fever, *Candida* and *Aspergillus* documented infections) and 5% use outside the MA, a mucormycosis. Average treatment duration was 25 days, with a 15-day average neutropenic fever and invasive candidiasis and a 63-day average for documented invasive aspergillosis. 32% of the treatment cost was attributed to post-transplant complications while 63% were costs for non-transplanted chemotherapy patients' 'complications'. In total the use of caspofungin cost € 290 580, 51% of which were expenses to be paid by the National Health Insurance Fund and 49% to be paid in full by the NBMTC.

Conclusion and relevance With the high cost of caspofungin treatment and the type of patients treated at the NBMTC (immunosuppressed, transplanted, undergoing chemotherapy) a better optimisation of caspofungin use seemed inevitable and indispensable, starting by implying guidelines for a stricter control of the empirical treatment prescriptions and the regular follow-up of treatment durations and necessity of use of caspofungin.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest