Background. There is a need to develop successful antibiotic stewardship interventions that do not require ID physicians. Our hospital implemented a pharmacist-driven intervention to prompt critical assessment of antibiotic regimens during interdisciplinary team rounds. We evaluated the acceptance of this intervention and the effects on concordance with institutional prescribing guidance.

Methods. This quality improvement initiative took place between November 2016 and June 2017 on a medical ward in an urban, level 1 trauma, public teaching hospital. During interdisciplinary team rounds, if the medicine team’s antimicrobial choice was not concordant with institutional prescribing guidance, the clinical pharmacist made a recommendation. We assessed prescribing for urinary tract infection, skin and soft-tissue infection, and pneumonia pre- and post-intervention. Prescribing was classified as overall guideline-concordant if the antibiotic choices and duration of therapy were consistent with institutional guidance.

Results. Thirty cases from each period were evaluated. Recommendations to the medical team were made on 63% (92/146) of days and on 31% (205/664) of patients on antibiotics. The most common recommendation was regarding days of therapy (Figure 1). The recommendations were accepted in 76% (116/205) of cases. There were improvements in both the inpatient (70% to 83%, P = 0.22) and discharge (64% to 86%, P = 0.35) antibiotic choices and overall guideline concordance (53% to 63%, P = 0.43); however, these were not statistically significant. Concordance with duration of therapy was similar between the periods (76% vs. 77%, P = 0.94) (Figure 3).

Conclusion. During interdisciplinary rounds, prompting by pharmacists to critically assess antibiotic regimens is a feasible antibiotic stewardship intervention that does not require ID expertise, is generally accepted by physicians, and may increase guideline-concordant antibiotic selection.

Figure 1:

![Number of recommendations](image1)

Figure 2:

![Acceptance of pharmacist recommendations on rounds](image2)

| Baseline (N = 30) | Intervention (N = 30) | P-value |
|------------------|----------------------|---------|
| Concordance with guidelines | | |
| Inpatient antibiotic choice | 21/30 (70%) | 25/30 (83%) | 0.22 |
| Discharge antibiotic choice | 7/11 (64%) | 12/14 (86%) | 0.35 |
| Duration of therapy | 22/29 (76%) | 23/30 (77%) | 0.33 |
| Overall concordance | 16/30 (53%) | 19/30 (63%) | 0.43 |

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