

- There was a well supported process of induction for the nurses and introduction of the service to the Health Board prior to becoming clinically available in September 2016.

Outcomes

- 569 patients have been seen since clinically active (Sept 2015)
- Median reduction in length of hospital stay (LOS) from 11 to 5 days for patients with carcinoma of unknown primary (CUP)
- Median LOS since introduction of service is 5 days for all cancer diagnoses. This equates to a 1 day reduction in LOS. Median LOS in preceding years 2011–2015 = 6 days
- The largest number of referrals to the service has been for patients with lung cancer (21%) – see Table

Conclusions/personnel reflections An effective AOS service improves quantitative outcomes (reduced LOS, efficient processing of CUP patients,) and enhances qualitative outcomes for patients (advocates for CUP patients, better communication*)

The majority of cancers dealt with by the AOS service are lung cancer

The outcomes above are almost exclusively down to the AOS nurses but of all medical and surgical specialties, chest physicians (who deal with lung cancer) are ideally placed as clinical leads for this service due to their cancer experience and established links with radiology, pathology and palliative care (Author's own opinion.)

For present and future AOS services, this team would recommend that an amenable/enthusiastic chest physician would be a valuable asset to the service

* Patient feedback can be provided on request

P204

QUALITY IMPROVEMENT PROJECT FOR EMERGENCY OXYGEN DELIVERY ON A RESPIRATORY WARD

KE Hutchinson, S Craik, K Srinivasan, H Moudgil, N Ahmad. *Princess Royal Hospital, Telford, UK*

10.1136/thoraxjnl-2016-209333.347

Background British Thoracic Society (BTS) guidelines state that oxygen should be used to treat hypoxaemia and prescribed to a target saturation range.¹ Patients at risk of type 2 respiratory failure should target 88–92%, with the rest 94–98%. In the BTS national audit in 2013, out of 6214 patients, 55% had oxygen prescribed and 52% were prescribed and delivered to within a target saturation range.²

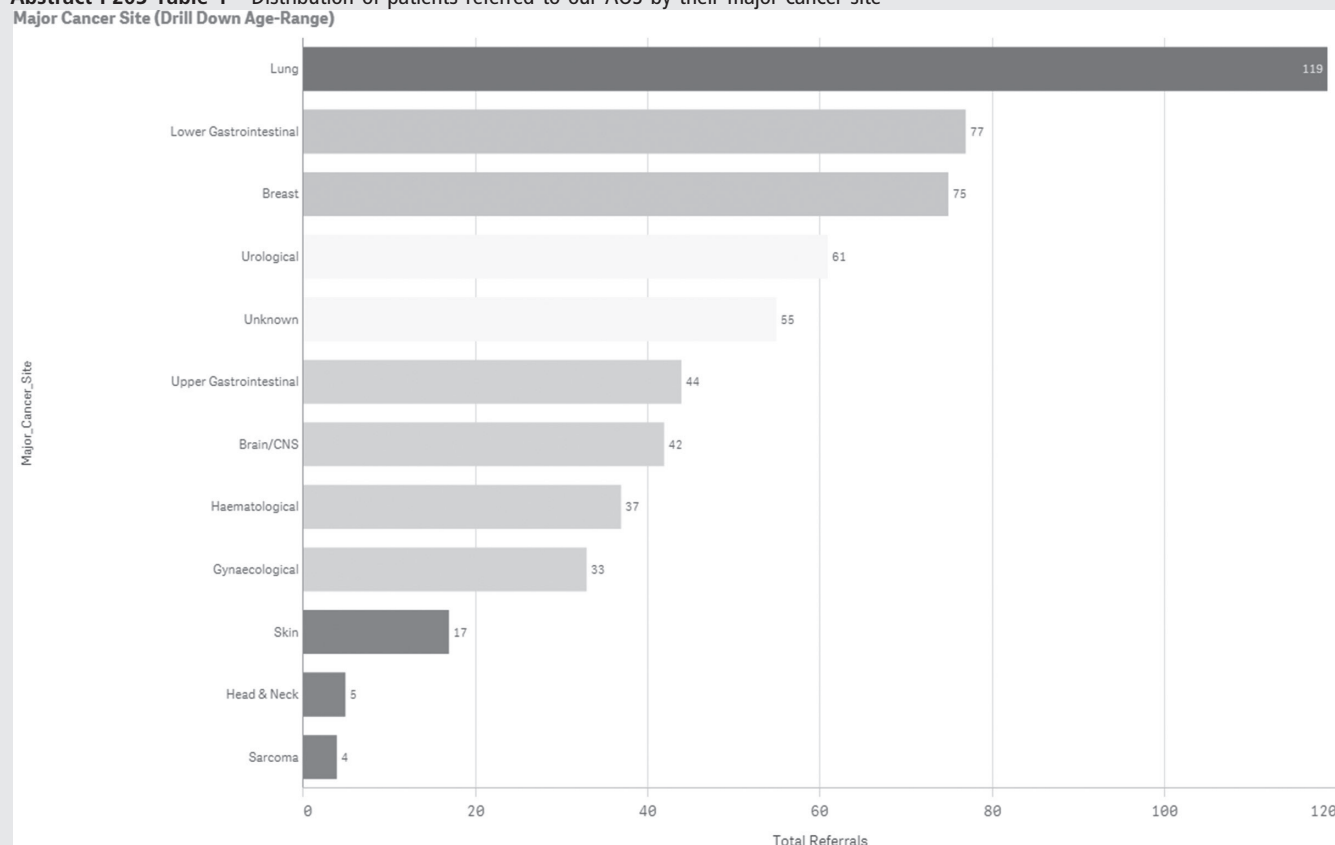
Methods We ran a Quality Improvement Project (QIP) involving three PDSA cycles to improve the delivery of oxygen to patients on the Respiratory Ward at the Princess Royal Hospital, Telford.

We set our standards as:

1. 90% of patients receiving oxygen have it prescribed on a drug chart
2. 100% of patients prescribed oxygen have a documented target saturation range
3. 100% of patients have oxygen delivered appropriately to target

The QIP process commenced in Autumn 2015. After the first cycle we used bedside prompt cards and delivered teaching sessions with doctors, nurses and healthcare assistants (HCAs). After the second cycle we appointed a nurse, HCA and two FY1

Abstract P203 Table 1 Distribution of patients referred to our AOS by their major cancer site
Major Cancer Site (Drill Down Age-Range)



doctors as 'O2 Ninjas'. Data were collected at three points after each cycle from drug charts and VitalPaC.

Results See Table

Abstract P204 Table 1

	National Audit 2013	National Audit 2015	Telford Audit Autumn 2015	Telford Re-audit Spring 2016	Telford Re-audit Summer 2016	Target Standards
Number of patients on oxygen	6214	7741	70	75	31	–
Prescribed	55%	58%	61%	79%	84%	90%
Prescribed & Targeted	–	53%	95%	98%	100%	100%
Prescribed, Targeted & Delivered	52%	69%	63%	62%	62%	100%

Conclusions Our QIP shows that education and empowerment of 'grass root' healthcare workers can improve oxygen prescription on a Respiratory ward. We suggest this QIP is replicated in other trusts and specialties to improve safe oxygen delivery.

REFERENCES

- 1 O'Driscoll BR, Howard LS, Davison AG. BTS guideline for emergency oxygen use in adult patients. *Thorax* 2008;**63**(Suppl VI):vi1–vi68.
- 2 BTS Oxygen Audit 2013. <https://www.brit-thoracic.org.uk/document-library/audit-and-quality-improvement/audit-reports/bts-emergency-oxygen-audit-report-2013/> (accessed 21 January 2016).

P205

IMPROVING LONG TERM OXYGEN PRESCRIBING AT HOSPITAL DISCHARGE: A BEFORE AND AFTER STUDY

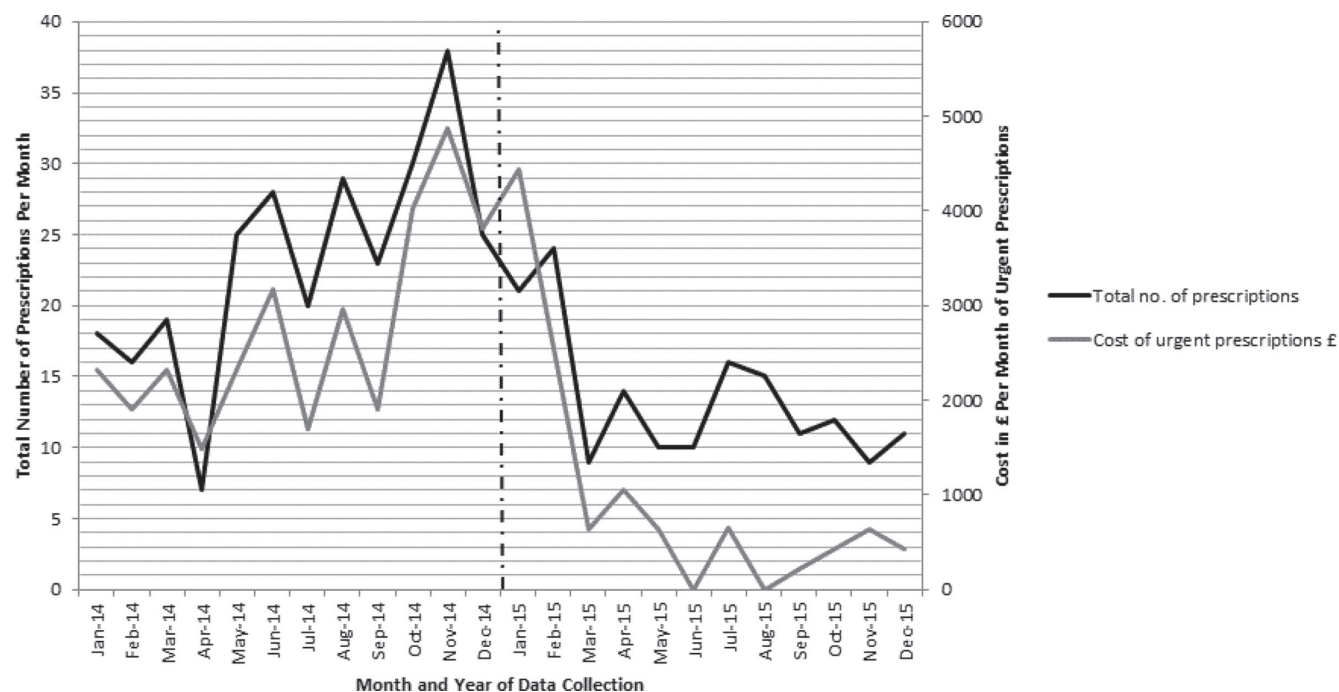
¹S Forster, ²G Lowrey, ²S Smith. ¹University of Nottingham, Nottingham, UK; ²Royal Derby Hospital, Derby, UK

10.1136/thoraxjnl-2016-209333.348

Introduction Home oxygen costs the NHS approximately £120 million a year, with £13 million spent on oxygen that is never used.¹ Home oxygen teams require integration into the wider respiratory care pathway to ensure appropriate assessment of clinical need and risk, education and follow-up.² In Derbyshire, prescriptions initiated in the community had appropriate assessments in 90% of cases. In contrast, home oxygen initiated in secondary care at discharge was often prescribed on day of discharge, by junior doctors with no specialist training, without appropriate assessment and education, frequently necessitating early community input. Following two serious incidents post discharge, a study was implemented to evaluate the impact of a different approach to home oxygen prescription following acute hospital stay. The new service included an in-reach oxygen nurse and bespoke risk assessment for hospital discharges.

Methods A before and after study was performed recording key outcomes, including number of prescriptions, cost, and input required post-discharge. This was carried out over a period of 12 months before and 12 months after implementation of the new service, assessing impact on compliance with guidelines and patient safety.

Results In the pre-intervention period there were 278 home oxygen prescriptions resulting from the acute care setting, all performed by junior doctors, with 155 urgent (same day) prescriptions totalling £32,815. In the 12 months post-intervention there were 145 home oxygen prescriptions, 88 by in-reach nurses, including 56 urgent orders totalling £11,655. The pre-



Abstract P205 Figure 1 Trend in total oxygen prescriptions and cost of urgent prescriptions throughout the trial period