Multiple other factors (eg age, ethnicity, having English as first language, weekend admission, distance of home from hospital) were not significantly related to pre-admission behaviour.

Conclusions The majority of admitted adult CAP cases presented directly to hospital, but a significant minority had pre-admission NHS contact. Efforts to reduce CAP mortality should primarily be directed at in-hospital care.

Abstract P242 Table 1.

Symptoms		Total n (%)	No pre-admission NHS contact n (%)	Pre-admission NHS contact n (%)	P value
Sputum	Yes	30 (68)	15 (50)	15 (50)	**0.044**
	No	14 (38)	12 (86)	2 (14)	
CURB65 score	0	8 (18)	4 (50)	4 (50)	**0.038**
	1-2	20 (46)	16 (80)	4 (20)	
	3	13 (30)	7 (54)	6 (46)	
	4/5	3 (6)	0 (0)	3 (100)	
Duration of illness	1-2 days	6 (13)	5 (83)	1 (17)	**0.028**
	3-7 days	25 (57)	18 (72)	7 (28)	
	8-14 days	3 (7)	0 (0)	3 (100)	
	>14 days	10 (23)	4 (40)	6 (60)	

P243 INFLUENZA A OUTBREAK IN A UK RESPIRATORY CENTRE

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10.1136/thoraxjnl-2013-204457.395

Introduction In March 2013, 12 patients on a single ward in a tertiary respiratory transplant centre contracted influenza within 72 hours. There was no corresponding community outbreak. Staff with symptoms went off sick. Trust policies outlining respiratory infection and isolation existed but there were no guidelines for this specific novel situation. We found no published reports of such an event in England.

Methods Patients quickly developed pyrexias and respiratory symptoms. All had throat swabs and blood cultures. Influenza A, H3N2 variant, was identified. A team of infection control and respiratory physicians, nurses and managers met regularly to implement these measures:

- Closure of ward and cohorting of bays
- Ward avoidance for non-essential personnel and anyone with symptoms
- Cancellation of non-essential procedures
- Strict hand hygiene and use of PPE and FFP3 masks
- Stockage of oseltamivir for treatment for all affected high risk staff and patients and prophylaxis offered to all ward patients and exposed high risk staff.
- No crossover of ward staff to transplant patients.
- Contact tracing of all immunocompromised patients on ward up to one week and all high risk patients 48 hours prior to the index case; advice on prophylaxis and their GPs contacted.
- Writing an information sheet for staff and GPs
- Increased and terminal ward cleaning

Results On the respiratory ward, 151 bed days were lost and 53 on two other wards. Fourteen patients (including two on another ward) had positive swabs for H3N2. There were 27 symptomatic staff members; 15 had swabs, two were positive. All patients and two staff members were given treatment oseltamivir. Fourteen patients and two staff members had prophylaxis.

No influenza complications or deaths occurred.

The department staff had 45% influenza vaccination uptake in 2012/2013. All affected patients had been vaccinated.

Conclusions Containment, pathogen identification, prompt treatment and contact tracing were priorities, to limit number of individuals affected. This is widely applicable.

Our departmental staff vaccination rate is below Department of Health targets. Importance of vaccination needs emphasising, whilst recognising that vaccine effectiveness against all laboratory-confirmed influenza in primary care is 51% for 2012/2013.

P244 ACCURACY OF ADMISSION DIAGNOSIS OF PNEUMONIA

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10.1136/thoraxjnl-2013-204457.396

Background The inclusion of 'new infiltrates' on the admission chest radiograph (CXR) is part of the BTS audit tool (1), but it has been reported that up to 37% of inpatients coded (using the ICD-10 coding system) as pneumonia did not have CXR consolidation (2). We assessed our local audit population for potential reasons for this pneumonia miscoding.

Methods Patients selected by coding for the 2012/13 BTS Pneumonia Audit at hospitals within Imperial Healthcare Trust (Charing Cross (CX), Hammersmith (HH) and St Mary's (SMH) Hospitals) underwent a notes review.

Results Of all patients clinically coded as community-acquired pneumonia (CAP), 88/176 (50%) had a diagnosis of CAP compatible with the audit criteria, with infiltrates on the admission CXR–in 15 (39%), 25 (61%) and 48 (50%) of cases at CX, HH and SMH respectively.

Of the patients found not to have CAP by the current BTS audit criteria (n = 88), 47/88 (53%) had an abnormal admission CXR *not* showing CAP. The main abnormalities in these admission CXRs were pulmonary oedema (in 30%), COPD/bronchiectasis (27%), malignancy (13%), interstitial lung disease (ILD) (7%) and pleural effusions (7%). In the 88 'non-audit criteria CAP' patients, in combination with symptoms, inflammatory markers (WCC 10.4 (1.7–33) $x10^9$ and CRP 84.8 (3.6–381) mg/L), and the CXR series, the likely diagnosis was felt to be LRTI (35%), CAP (17%), HAP (13%), COPD (10%), pulmonary oedema (9%), malignancy (4.5%), UTI (3%), and ILD, asthma and effusions (all 2%), in the 'non-audited CAP' patients.

Of those remaining 41 patients with a normal admission CXR excluded from the audit, 24 patients (59%) had a repeat CXR within 72h, of which 5 (21%) then showed CAP. An additional 12 patients with normal admission CXRs had CT scans performed within 72h, 6 of which (50%) detected consolidation. Thus, of all the patients with a normal admission CXR, 11 (27%) had CAP that was missed by solely looking at the admission CXR.

Conclusion We confirm earlier findings that coding diagnoses are insufficiently accurate to judge quality of care, but also show that current audit criteria exclude a significant proportion of cases.

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