Abstract P302 Table 1 Bed day cost of in-patient stay post section 5 for patients initiated on HMV

		<5 days: Group 1 n = 5	>5 days: Group 2 n = 7
Length of stay once declared medically fit for discharge			
Neuromuscular disease (%)		80	71
		205	6,172
Cost of stay once declared medically fit (£)	Mean	(0–820)	(2,460–10,455)
	Total	1,025	43,205
		0	4270
			(0–12,810)
Cost of HDU readmission (£)		Total	0
Total cost (£)		1,025	73,095
In-patient Mortality (%)		0	86

Results Twelve patients were identified and separated into 2 groups according to LoS: less than 5 days (group 1; n = 5) or greater than 5 days (group 2; n = 7).

Various primary diagnoses were represented in each group. The main variable separating groups was pre-admission social status. Patients with a live-in carer, willing spouse or established 24-hour care were discharged back to their original home within 4 days of being declared medically fit. Those without such care had an average LoS of 27.4 days (17–51), with a large increase in associated cost and mortality. (Table 1). All patients in Group 1 survived and were successfully discharged. The in-hospital mortality for patients in Group 2 was 86%.

Discussion HMV is a complex modality requiring specialist training to facilitate home use. Patients unable to manage HMV independently have significant care needs. This study showed that patients who do not have an established care network pre-discharge have an increased LoS and higher mortality. The current Continuing Healthcare process and Social Services structure is not robust enough to meet these patients' needs.

REFERENCES

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P303 DOES REGULAR SURVEILLANCE ENSURE THE OPPORTUNITY OF NON-INVASIVE VENTILATION TO PATIENTS WITH MOTOR NEURONE DISEASE?

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Introduction Most people with motor neurone disease (MND) die from respiratory failure and non-invasive ventilation (NIV) can improve survival. The median survival of patients with good bulbar function not treated with NIV was just 11 days in one RCT (1). We wished to establish whether our 3 monthly follow up regime, following NICE guidance (2), ensures all patients are offered NIV or whether many are dying without this treatment opportunity.

Aim Establish what proportion of patients died before NIV was offered while under our follow up.

Method A retrospective analysis of case notes of patients who died during the calendar year 2013. Survival was calculated as days (d) from starting of NIV until death.

Abstract P303 Figure 1 Kaplan-Meier curve showing survival in NIV compliant group

Results From our cohort, 24 patients died in 2013 of whom 20 had been offered NIV (17 compliant). Median survival was 390 (IQR 147–798) d. Median survival for NIV compliant patients was 462 (IQR 223–848) d. Median survival was 190 d for the 2 NIV compliant patients with severe bulbar dysfunction and 85 days for 3 patients who were non-compliant with NIV.

Of the 4 patients who died before NIV was offered, 2 had severe bulbar dysfunction and 1 patient was on CPAP for treatment of obstructive sleep apnoea. Pneumonia was reported as the cause of death in 2 of these patients. Details of the mode of dying of the other 2 patients could not be established (certified as MND).

Conclusion Most of the patients dying with MND had been offered NIV, 85% were compliant with treatment and survival was at least as good as published results. 4 died before NIV was offered but in 2, death was precipitant due to pneumonia, not ventilatory failure. As a default, 3 monthly review seems a reasonably safe interval for ventilatory surveillance in people with MND balancing intrusive hospital visits with the risk of missing the opportunity to try NIV at the end of life.

REFERENCES

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P304 COMPLICATIONS RELATED TO TRACHEOSTOMY TUBE CHANGE: EVALUATION OF PRACTICE

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Introduction and objectives Tracheostomy tubes are used outside intensive care unit in a variety of settings. Tracheostomy tube change is a potentially high risk procedure with life threatening complications attached to it. The Respiratory Sleep and Support Centre (RSSC) at Papworth Hospital specialises in weaning patients from prolonged invasive ventilation and providing domiciliary invasive and non-invasive ventilatory support. Tracheostomy tube change is regularly undertaken for both patient groups. Review of our current clinical practice and complications related to this procedure was needed due to the risks involved.