Methods Case notes of all patients admitted with CAP over a 3 month period were requested and 175 were obtained. Information was gathered on the presence of underlying chronic lung conditions, CAP severity/mortality markers (SIRS and CURB65 scores) and mortality.

Results At least one underlying chronic pulmonary condition was found in 45.1% (n = 79), the commonest being COPD (n = 56). CURB65 score was 0 to 1 in 39.4% (low risk), 2 in 27.4% (moderate risk), 3–5 in 17.2% (high risk) and not done in 16% (n = 28). SIRS criteria were met in just under half of the cases (48.5% n = 85).

An in-patient mortality review during this study period showed that 8% (n = 14) CAP patients died in hospital within 30 days. An association of these patients with background lung condition, CURB65 and SIRS is shown in Table 1.

Abstract P210 Table 1 Characteristics of CAP patients who died in hospital within 30 days (n = 14)

Mortality	Chronic lung disease		CURB65		SIRS		SIRS and/or CURB65 2–5	
	Yes	No	0–1	2–5	Yes	No	Yes	No
Numbers	10	4	1	7	5	9	8	6
%	12.6%	4.2%	1.4%	9%	5.9%	10%	9%	7%

Conclusion We showed an improvement in mortality figures compared with the BTS National CAP adult audit 5 years ago (8% vs 18.3%). A significant number of these patients have an underlying chronic lung disease which predisposed them to developing CAP. The highest mortality was seen in patients with a high CURB65 score with SIRS response.

P211 IMPACT OF DOOR-TO-RADIOGRAPH TIME ON PNEUMONIA MANAGEMENT

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Introduction Pneumonia continues to be associated with significant mortality.[1] The diagnostic gold standard remains the Chest X-Ray (CXR). Quality indicators such as door-to-antibiotic or door-to-radiograph time are monitored as surrogate outcome measures.

Objective To assess the impact of CXR availability at first clinician contact in cases where initial antibiotics were delayed.

Methods We interrogated the time of initial consultation, radiographs and diagnosis for 57 CAP patients between March 2013 and February 2014 whose initial antibiotics were delayed beyond 4 h.

Results The median age was 77 (interquartile range 67–85), 32 (53%) were female. Presentation was to the ED in 45 (79%) and to the GP assessment unit (GPAU) in 12 (21%) cases. 37 (65%) cases had SIRS, 45% had a CURB-65 score of 3 or above.

CXR reports were compatible with pneumonia in 44 (77%) cases, but only 11 (19%) had a CXR at time of first doctor contact. Interestingly, a reported consolidation was not associated with an initial diagnosis of pneumonia (p = 1.0000, Fisher's exact test, two-tailed p).

Median time to first clinician contact was 2:14 h (ED 2:03 h, GPAU 4:33 h). Overall, 20 patients (35%) had a diagnosis of pneumonia after the initial consultation, 7 (58%) in GPAU and 13 (29%) in the ED. CXRs were obtained within 4 h in 49 (86%) cases. Median time to diagnosis was 7:06 h (ED 8:35 h, GPAU 5:54 h). CXR availability at first clinician contact differed significantly – GPAU 50%/6 vs ED 11%/5 (p = 0.0068, Fisher's exact test, two tailed p).

Discussion There were significant delays to diagnosis, despite most CXR reports indicative of pneumonia. The absence of a CXR on initial clinician contact may contribute to the poor diagnostic accuracy seen in this case series. Notably the 4 h door-to-radiograph target set by BTS was largely met. We will deploy the GPAU pneumonia care bundle in the ED, which was shown to improve door-to-radiograph time (CURECAP, reported previously[2]). The efficacy of this intervention will be the subject of further studies.

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P212 MICROBIOLOGICAL SAMPLING IN COMMUNITY-ACQUIRED PNEUMONIA: DO WE FOLLOW THE GUIDELINES AND DOES IT HELP OUR PATIENTS?

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Introduction Community-acquired pneumonia (CAP) is a common cause for hospital admission and carries a high mortality rate. Choosing the correct antibiotic can be challenging and "atypical" pathogens, such as *Mycoplasma pneumoniae* and *Chlamydophila pneumoniae*, are not eliminated by some first-line empirical agents. Identification of the infecting organism through microbiological sampling can help to tailor antibiotic therapy and substantially improve patient outcomes. Guidelines exist (NICE, BTS, trust) that recommend which patients should undergo microbiological sampling. We wished to determine whether these guidelines were followed in our trust in patients admitted with CAP.

Methods We reviewed the notes of adult patients admitted over a 15-week period (February–May 2014) with a clinical code of pneumonia. Further information was derived from hospital systems, including Telepath (used by the Microbiology department) and from 'Advancing Quality' data available for these patients.

Results 175 patients were identified with CAP. Blood cultures (BCs) were indicated in 89 patients according to trust guidelines (based on Systemic Inflammatory Response Syndrome (SIRS) criteria, CURB-65 score, immunocompromised; data sufficient in 147) and appropriately collected in 55 (61.8%). However, only 4 had positive (clinically significant) BC results. Sputum samples were sent for 31 patients (17.7%, n = 175) and only 19% had significant bacterial growth. All patients transferred to intensive care (ITU; 3.4%) were screened appropriately for urinary pneumococcal antigen (UPA) and urinary legionella antigen (ULA), with 1 positive UPA result. 6 (of 10) UPA and 7 (of 12) ULA samples appeared to be sent inappropriately for non-ITU patients and were rejected by the laboratory. Serum samples were sent for Mycoplasma testing in 7 patients, despite this