

Correction

Jayadev A, Mcvinnie K, Moonsie I. P74 Non-invasive ventilation delivered on a standard respiratory unit compared to use in level 2 care setting: is there an ideal service delivery model? *Thorax* 2016;71:A125. doi:10.1136/thoraxjnl-2016-209333.217

Corrections have been made to the 'Methods', 'Results' and 'Conclusions' section of this abstract. The changes are in **bold**.

Methods

An electronic search was performed to find patients on PCU whom received NIV between 1st January and 30th November 2014. Inclusion criteria were patients that had received NIV for COPD exacerbations solely. Data from the physician led respiratory unit between Jan–Nov 2011 was prospectively collected, and the two datasets compared.

Results

In the respiratory unit **75 patients were admitted for NIV of which 39** met the criteria for inclusion in the analysis. In the PCU group 110 patients were admitted between Jan–Nov 2014 of which 55 were included for analysis. Samples were matched in gender, with no significant difference between groups. The average age of patients treated in PCU was 69.8 years, and **69 years on the respiratory unit** (Mann–Whitney U Test, $p=0.012$). The in-hospital mortality on PCU was 27.2% compared to 15% on the respiratory unit ($p=0.15$). Mean pH on PCU was 7.31 and **7.24 on the respiratory unit** ($p=0.186$, not significant). Mean pCO₂ was lower at 9.16 kPa on PCU compared to 10.7 ($p=0.0703$) on the respiratory unit, which is not statistically significant. Average length of stay was equal in both units at 12 days.

Conclusions

NIV delivered on a physician-led respiratory unit was not inferior in mortality and length of stay compared with a closed, ITU-led service in our hospital. Interestingly, the ward patients were sicker, with a lower mean pH and higher mean pCO₂ but had a lower mortality, although not statistically significant. This supports a model where acute COPD patients needing NIV can be managed safely in a respiratory ward area with enhanced staffing as outlined in BTS guidelines. This could have continuity of care and cost benefits.

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