

was 0.02 CRBSI/1000 catheter days in the 2-year period assessed. This compares with a rate in patients not suffering occlusions of 0.91 CRBSI/1000 catheter days.

Abstract PMO-066 table 1

Occlusion type	Detail	Methods used
Partial: n=11	Cause	11 Lipid
	Success rate	10/11 (91%)
	Failure	Used: M, SF, HC, A
Full: n=27	Cause	9 Fibrin
		6 Lipid
		1 Both
		11 Unknown
	Success rate	22/27 (81%)
	Failures	2 Fibrin
		1 Lipid
		1 Both
		1 Unknown
		Used: 5M, 4U, 3SF, 2U, 1A

Conclusion CVC salvage is often possible with line manipulation and persistent pulsatile flushing. Hub clearout with a needle is also safe and effective. Alcohol and urokinase have an occasional role but are often not required and may not work without additional measures. Post-salvage complications are rare. The apparent negative association between occlusion and infection runs contrary to the belief that infection and occlusion are linked, and warrants further study.

Competing interests None declared.

PMO-067 A RESPONSE TO NCEPOD (NATIONAL CLINICAL ENQUIRY INTO PATIENT OUTCOME AND DEATH 2010) REPORT—PRACTICE IN PROVISION OF PARENTERAL NUTRITION (PN) IN A REGIONAL REFERRAL CENTRE

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Introduction The externally peer-reviewed NCEPOD report into the provision of PN alarmingly identified suboptimal care in 81% of patients receiving PN. We audited the quality of care received by parentally fed patients at a specialist regional centre for intestinal failure and home parenteral nutrition.

Methods Data were collected retrospectively for 100 inpatients seen between April and December 2011 on an NCEPOD modified audit tool; case notes were reviewed. Type I and II intestinal failure patients were included; home parenteral nutrition patients were excluded from the study.

Results Mean number of days patients were fed on PN was 12.2 (NCEPOD 13.2) and the range was 1–276 days (NCEPOD 1-212). 10% of patients were fed for 3 days or less (NCEPOD 10%) and 93% were fed for 30 days or less (NCEPOD 61%). The top two specialities referring patients were Colorectal 27% and Oncology 18% as compared to 22% from general surgery and 20% started in ICU in NCEPOD report. 12% referrals were deemed inappropriate and not started PN (NCEPOD 15%).

Conclusion Our hospital is a regional centre for intestinal failure and PN is prescribed exclusively through the nutrition support team (NST). Thus in comparison with the NCEPOD findings, the PN service at UCLH is of a high standard. Data collection were suffi-

cient for direct comparison with most NCEPOD report parameters. The NST appeared to prevent inappropriate use of PN by not starting 12% of referred patients. Although a similar proportion of our patients (10%) were fed for 3 days or less as found in the NCEPOD report, half of these patients were commenced on TPN in ICU. We found much lower rates of PN-related metabolic and catheter-related complications compared with the NCEPOD report because of active NST monitoring and good quality nursing care. Retrospective data collection on IV fluid prescribing was not possible, but it was perceived that there was some inappropriate use of IV fluids. A comprehensive database is being developed to enable prospective data collection to evaluate and develop the service further.

Abstract PMO-067 Table 1

Outcome	NCEPOD	UCLH
Nutrition support team (NST) involvement	52.7%	100%
Appropriate first prescription	85%	100%
Adequate consideration of EN	67%	100%
Adequate biochemical/nutritional assessment prior	46%	100%
Documentation of nutritional assessment	48%	100%
Appropriate indication for PN	71%	95%
Adequate monitoring of PN patients	56.7%	100%
PN-related metabolic complications	40%	5%
Catheter-related complications	26%	5%

Competing interests None declared.

REFERENCE

1. NCEPOD. *A Mixed Bag: The 2010 Report of the National Confidential Enquiry into Parenteral Nutrition*. London: NCEPOD, 2010.

PMO-068 TIMING OF PARENTERAL NUTRITION ADMINISTRATION SET CHANGES: IMPACT ON INCIDENCE OF CATHETER ASSOCIATED INFECTIONS

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Introduction Preparations of total parental nutrition (TPN) are stable for 48 h. For patients with requirements <2.5l/24 h individual bags of TPN are delivered for more than 24 h, resulting in cost savings and less frequent manipulations of the administration set. The epic2 guidelines recommend that administration sets exposed to lipids must be changed every 24 h to reduce possible line sepsis, effectively prohibiting the delivery of TPN bags over a period >24 h. The objective of this study is to determine whether the incidence of central venous catheter (CVC) associated infection is increased by running TPN over a period of >24 h compared to <24 h.

Methods We analysed the CVC infection rate for 550 patients receiving TPN over a 3-year period, a total of 8339 line days. We assigned each CVC line into two groups; those through which at least one bag of TPN had been run for more than 24 h (1063 CVC lines) and those in which every bag was changed within 24 h (166 CVC lines). CVC-associated infection was confirmed when the same organism was grown on central and peripheral blood cultures, or blood culture and CVC tip culture. Information on CVC line position, duration and complication rate was also collected.

Results The CVC infection rate was 3.26/1000 line days in the >24 h group (95% CI 3.0 to 3.5) and 3.14/1000 line days in the <24 h group (1.6 to 4.7). There was no significant difference in the infection rate between the two groups (χ^2 , p=0.84).