Abstract PTU-113 Figure 2 Performance indicators for management of decompensated cirrhosis

We achieved the 100% target for sepsis management and investigating precipitants of hepatic encephalopathy. All patients with SBP received antibiotics and albumin.

GI bleeders were only identified in the third cycle; all variceal bleeds. They were all adequately resuscitated and underwent timely endoscopy. Only 40% received both terlipressin and antibiotics.

Venous thromboembolism (VTE) prophylaxis prescription showed no improvements in latter cycles compared to the first. Management of alcohol withdrawal showed a slight decline in both cycles.

Conclusions Introduction of the care bundle led to clear improvements in the initial assessment (blood tests, ascitic tap and abdominal ultrasound), management of encephalopathy and timely specialist input. These were sustained, albeit with room for improvement. We believe that using IT and involving nursing staff in assessment areas have helped to embed these improvements.

Sepsis was recognised and treated appropriately in 100% of audited patients. This may reflect concomitant sepsis awareness campaigns.

We were less successful with prescribing for VTE prophylaxis, alcohol withdrawal and variceal bleeds. This may reflect turnover of junior doctors and system factors, including patient flow and availability of specialty cover on 'base wards' (not 7 days). Our education programme needs to be ongoing. We propose incorporating the care bundle into our Junior Doctors' Handbook.

PTU-114 SAFETY OF ACCELERATED INFliximab INFUSION IN INFLAMMATORY BOWEL DISEASE IN A DISTRICT GENERAL HOSPITAL

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10.1136/gutjnl-2018-BSGAbstracts.492

Introduction Our district general hospital serves a population of around 330 000 with 1325 active Inflammatory Bowel Disease (IBD) patients. A small percentage of these patients receive infliximab infusions for disease control. The British National Formulary states that infliximab infusion should follow the following infusion schedule: 5 infusions over 2 hours (hr) with 2 hour of post-infusion monitoring, with subsequent infusions

delivered over 1 hour with 1 hour of monitoring. With published data supporting an accelerated infusion regimen, after 10 incident-free infusions we administer infliximab over 30 min (min) with 30 min observation. Recently a patient established on infliximab from another centre challenged our practice seeking assurance of its safety. Our primary endpoint was to assess the safety of accelerated infusion protocol, with secondary assessment of efficiency.

Methods Using the local patient management system which supports the IBD registry data tool, we retrospectively identified all patients with IBD who underwent infliximab infusions in 2017. All followed our standard protocol of five infusions over 2 hour with 2 hour of monitoring, the next five over 1 hour with 1 hour monitoring and subsequent infusions over 30 min with 30 min of post-infusion monitoring.

Results Over the 12 months, 202 infusions were given to 39 patients with IBD (30 Crohn's, 1 Ulcerative Colitis, 1 unclassified). Fifty nine induction infusions were administered over 2 hour and 10 over 1 hour, with 133 infusions over 30 min. Only 1 infusion reaction was reported in the induction phase (1.4%). The reaction occurred within 10 min of commencement of the infusion and was anaphylactoid in nature. The patient was taken off infliximab and is now on ustekinumab. The remaining 201 infusions were reaction free, including all of the accelerated infusions. The accelerated infusions saved a total of 1 hour per patient visit to the infusion unit. As well as the benefit to patients, this has allowed the Trust to free up 13 days of infusion time per annum on our current case load.

Conclusions Accelerated infliximab infusions over 30 min were safe and the time saved enhances our unit's capacity, consistent with the wider evidence available in the literature. If other units across the country also share the same safety profile of accelerated infliximab infusions, then the guidance can be updated, resulting in an overall increase in the efficiency of infusion units.

PTU-115 INTRAVENOUS IRON IS EFFECTIVE IN REDUCING THE NEED FOR BLOOD TRANSFUSION IN ACUTE MEDICAL SETTINGS

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10.1136/gutjnl-2018-BSGAbstracts.493

Introduction Blood transfusions are necessary for patients with significant symptomatic anaemia in acute medical settings. However, the increasing use and availability of intravenous (IV) iron in these patients may reduce the frequency of blood transfusion and its attendant risks. Our aim was to evaluate this.

Methods The following IT systems were interrogated: Electronic Patient Record (EPR), Integrated Clinical Environment (ICE) (requests and results) and E-Prescribing and Medicines Administration (EPMA).

A list of inpatient episodes was generated for the years 2014–2016 whose discharge summaries included one of the following coded diagnoses: anaemia, menorrhagia or gastrointestinal bleeding (GIB) (using respective anatomical terms). These records were then reviewed to identify those who received packed red cell (PRC) transfusions or IV iron preparations and their respective doses.