On review of the patients whose cause of death were attributed to cancer, 12 did not have malignancy as initial HPN indication. Regarding mortality not linked to HPN, respiratory complications including pneumonia were the commonest causative factor (8/29, 28%).

Conclusions This study showed that mortality was associated with the underlying disease condition resulting in the need for HPN or other co-morbidities rather than direct complications of HPN itself.

REFERENCE

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PWE-016 DELIVERING PARENTERAL NUTRITION– REAL WORLD CHALLENGES

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Introduction Parenteral nutrition (PN) is widely used to intravenously deliver nutrition to patients with non-functioning or inaccessible gut. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report in 2010, “A Mixed Bag” found good practice regarding PN in only 19% of cases. It recommended an urgent need to deliver high quality nutrition to all patients in hospital.

Aim This audit was designed to evaluate our Parenteral Nutrition Service against NCEPOD review. The primary aim was to establish whether the key recommendations of the NCEPOD report are being adhered to: documentation of indication and its appropriateness, consideration of enteral options, clinical and biochemical monitoring during PN, duration of PN and any complications.

Methods All adult inpatients who received PN at Darlington Memorial Hospital and University Hospital of North Durham between June– August 2018 were identified from 2 electronic databases viz. referrals to dietetics and electronic prescribing software. Data collection was done from case notes, inpatient electronic prescription charts and pathology results. Baseline demographics, documented indication for PN, anticipated and actual duration of PN, reason for discontinuing PN and associated complications were recorded and analysed using Excel®.

Results 49 in-patients were identified over the 3 month period, an annualised PN workload of approx. 200 pts/yr. Mean age was 69.2 y(4–3), mean weight prior to commencing PN 75.3kg(41–14.8kg). 22/49 pts were surgical, 1/49 medical and 16/49 on intensive care. 25/49 pts had a clearly documented indication (ITU 5/16, medicine 10/11, surgery 10/22) but only 1 patient had a documented anticipated duration for PN. Mean duration was 10 days(–2) and mean length of inpatient stay was 21 days(–3). Only 7/49 pts were reviewed by a Nutritional MDT team, although all pts were regularly reviewed by Dietitians. **Reasons for discontinuing PN:** oral feeding resumed in 28 pts, death/end of life care commenced in 10 pts, NG/NJ/PEG feeding commenced in 6 pts, patient refusal in 2 pts and 3 pts transferred to a tertiary service.

Complications: Abnormal LFTs in 3 pts, abnormal electrolytes in 33 pts and 1 midline associated thrombophlebitis. 16/49 pts had daily testing of serum biochemistry. 30 day all-cause mortality from commencing PN was 18% (9/49).

Conclusion Our study shows the need for a quality improvement program for PN including documentation of indications and goals of PN treatment. Patients commencing PN should be reviewed by a Nutrition MDT to improve initial assessment and monitoring. A decreased compliance with daily serum biochemistry correlates with an increased incidence of electrolyte abnormality.

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PWE-017 A MULTI-DISCIPLINARY APPROACH TO PERCUTANEOUS ENDOSCOPIC GASTROSTOMY INSERTION IN MOTOR NEURONE DISEASE

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Weight loss and bulbar dysfunction is common in motor neurone disease (MND). Gastrostomy placement is complex in this cohort. Percutaneous endoscopic gastrostomy (PEG) is reported as the favoured approach in patients without chronic respiratory failure with radiologically inserted gastrostomy insertion reserved for patients with severe respiratory compromise. The aim of this study was to evaluate the outcome for patients with MND receiving PEG insertion as part of a multidisciplinary team approach in a respiratory intensive care unit setting.

A retrospective observational study was conducted on MND patients on non-invasive ventilation (NIV) who were admitted for PEG insertion between September 2014 and April 2018. PEG were inserted with intravenous anaesthesia and analgesia (propofol infusion and fentanyl boluses) plus local anaesthesia to skin (lidocaine 1%) using non-invasive mechanical ventilation on pressure-control mode.

Fifty-nine PEG insertions were performed successfully in MND patients requiring NIV and all patients discharged from hospital. Subjects (37 males) had age 65±11 years. Six (10%)

Abstract PWE-017 Figure 1 Survival of MND patients who had a PEG insertion in terms of compliance to non-invasive ventilation.