frontline paediatric clinical care providers (Consultants in Paediatric Medicine, Paediatric Nurses, Pharmacists, Dieticians, Hospital Senior Management and Non-Consultant Hospital Doctors). At a series of face-to-face sessions, teams receive mentoring in QI methodology by RCPI QI Faculty, through the IHI Breakthrough Series Collaborative Model, to develop local SAFE improvement projects impacting on

- Reducing avoidable error and harm to acutely unwell children
- Improving communication between all individuals involved in a child's care
- Improving working culture for healthcare staff providing care to children
- Increasing involvement of parents, children and young people in their care.

The teaching faculty includes active patient representation through parent involvement. Participating teams are encouraged to engage with children, parents and carers to guide their improvement efforts.

Teams collect a concise monthly dataset to facilitate aggregate and comparative measures on paediatric clinical outcomes. Teams are encouraged to use this data, and to collect other necessary data to inform the outcome, process and balancing measures pertinent to the areas upon which they are focusing their improvement efforts.

The National SAFE Improvement Collaborative is in its early stages. However, at this point, experience with similar national collaborative projects indicates that QI methodology will be used effectively to generate improvements to positively impact paediatric patient safety outcomes, through site specific changes.

P200 MANAGEMENT OF HENOC SCHONLEIN PURPURA (HSP)

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Introduction HSP is a common vasculitis of childhood. It is immune mediated. Aetiology is unknown but the history often identifies a preceding throat/URTI infection.

Agreed criteria for HSP diagnosis are:

Palpable purpura (mandatory) in the presence of atleast one of the following;

Diffuse abdominal pain

Acute arthritis or arthralgia

Renal involvement (haematuria +/- proteinuria)

Renal biopsy showing predominantly IgA deposition.

Diagnosis is usually on clinical grounds. Bloods are needed to rule out other diagnoses. All patients need BP, urine dipstick, weight and height measurements.

General supportive measures and simple analgesia is all that is required. HSP is usually self limiting. 33% will have relapses/recurrence of symptoms. HSP accounts for 3% of all patients with end-stage renal failure.

Aim To look at management of HSP in our unit during the last six months, develop local guidelines and then re audit to monitor compliance with guidelines.

Method We carried out a retrospective observational charts review of all children presenting with HSP.

Results No standard guidelines were being followed. Followup practices differed between teams. We developed local guidelines for the management of HSP.

If the initial urinalysis is normal or only reveals microscopic haematuria, follow up involves: clinical review, BP measurement and early morning urinalysis at these recommended time intervals:

1. Weekly for the first month
2. Fortnightly from weeks 5 to 12
3. Single review at 6 and 12 months
4. Return to (1) if there is disease flare up

Referral to Paediatric Nephrologist is warranted if there is: Macroscopic haematuria more than 5 days.

Persistent microscopic haematuria beyond 12 months.

Persistent proteinuria.

Hypertension

Abnormal renal function

Nephrotic syndrome

Nephritic syndrome

We carried out retrospective charts review again in the following six months. There were 7 cases of HSP noted. 5 patients had HSP with no renal involvement and were followed according to local protocol. It was noted that three of these patients had unnecessary blood tests done including Coagulation profile. One patient was not followed up after the initial presentation due to miscommunication but later reviewed at 3 months.

One patient has mild HSP Nephritis with persistent proteinuria and macroscopic haematuria and was referred to the nephrologist. Her symptoms resolved completely.

We will continue to audit our practice. In addition to monitoring renal status we also aim to avoid unnecessary blood tests. Streamlining our followup may identify early markers of renal disease in this group of children.

P201 AN AUDIT OF THE COMPLIANCE WITH A NEWLY INTRODUCED 'ELECTRONIC PATIENT DISCHARGE' SYSTEM IN THE DEPARTMENT OF PAEDIATRICS, UNIVERSITY HOSPITAL LIMERICK (UHL)

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Background Electronic discharge application is a multi-tenant based application (any hospital in the country can use it if desired). It first started in June 2017. The primary reason for introducing it was to aid communication between the hospital and General Practitioners (GP). The focus of this project was to provide a streamlined method for Non-Consultant Hospital Doctors (NCHDs) to easily generate a patient discharge summary letter in an electronic format that can be reviewed and signed off by their Consultants. This discharge summary is then available for sending to a patient's GP via electronic means or in printed hardcopy.

These requirements are based in part on the HIQA 'National Standard for Patient Discharge Summary' information document. This helps in terms of ensuring that all relevant data is captured and fed back to the patients GP in a clear, concise and timely manner. In addition to supporting the primary goal, this will further support a myriad of

additional areas such as reconciliation for insurance purposes, ease of access to data without having to constantly rely on paper charts and for HIPE in capturing high quality data regarding inpatient stays.

Objectives To check the compliance in terms of completion of patient discharge summaries both electronically and in printed format in the charts since the introduction of the new electronic discharge system in the UHL Pediatric Department on July 6th 2018.

Methodology Retrospective review of a random selection of charts of 50 Paediatric patients who were admitted to our Paediatric wards during the 3 month period of 06-07-2018 and 06-10-2018 to assess if both the electronic version on the Electronic discharge system has been completed and a printed version filed in the charts.

Results A total of 50 charts from the 3 months period were examined. Of these, electronic discharges were completed on 24 patients (48 percent). Out of 24 electronic discharges, the number of printed versions of the discharges was 20 (83.3 percent).

Abstract 201 Figure 1

Conclusion Suboptimal compliance in the first three months of the newly introduced electronic discharge system both electronically and in terms of a printed form filed in charts was noted. For 100 percent compliance it is recommended to complete the electronic discharge on the day when the patient being discharged as it is fresh in terms of memory.

P202

DIETARY MANAGEMENT OF CHYLOTHORAX IN CONGENITAL HEART DISEASE

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Background Chylothorax can be defined as the presence of chyle in the pleural cavity resulting from impeded flow in the thoracic duct. In childhood chylothorax is a potentially challenging postoperative complication of cardiothoracic surgery. It may have a detrimental effect on a patient's nutritional and immunological state. Conservative treatment includes the use of a minimal LCT diet or total parenteral nutrition.

Aim The aim of this audit was to determine the incidence of chylothorax and dietary management post congenital heart surgery in OLCHC from January 2017 – December 2018.

Method The number of cardiac surgeries was provided by the cardiac data manager for OLCHC. The number of patients diagnosed with postoperative chylothorax and dietary management data was collated from medical records, product information system and dietetic notes.

Results In 2017, 32 patients received dietary treatment out of a total of 395 patients (8%) post cardiac surgery in OLCHC. The number of Trisomy 21 cases were 11 out of the total 32, 34%.

In 2018, 24 patients received dietary treatment out of a total 382 patients (6%) post cardiac surgery in OLCHC. The number of Trisomy 21 cases were 11 out of the total 24, 46%.

21 infants were receiving breast milk pre surgery, 10(48%) returned to breast milk post-surgery of which 9 were breastfeeding.

In 2017 and 2018 respectively, only 3 and 5 patients required parenteral nutrition. The majority of patients were managed on oral or enteral nutrition.

Conclusion The results show a reduction of 2% in dietary management of chylothorax in OLCHC in 2018 compared to 2017. Incidence rates reported relate to those that received dietary management, the audit also provides an analysis on the actual incidence rates including those not treated.

The incidence of chylothorax in OLCHC is high in comparison to other countries. However, complexity of surgery's and the population group may not be comparable. Of note a high percentage of chylothorax cases had a diagnosis of T21, up to 46% in 2018. Further research to understand the mechanisms of chylothorax in T21 is warranted.

Dietary management of chylothorax appears to effect maintenance of breast milk feeding. Of concern 52% of infants did not return to breast milk post management of chylothorax.

There is ongoing consultation with surgeons and the cardiology team to review OLCHC's protocol aiming to standardise care.

P203

FEEDING THE MODERATE TO LATE PRETERM INFANTS IN A TERTIARY NEONATAL CENTRE. THE CWIWH EXPERIENCE. A RETROSPECTIVE REVIEW OF THE FEEDING HISTORY IN THE MODERATE-TO-LATE PRETERM INFANT, WEIGHING ≥ 1500 G

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Our neonatal unit nutrition policy supports breastfeeding and/or expressed mother's milk feeds. In this audit of practice over a six month period in 2018, we retrospectively review the type of feed received by moderate to late premature