P348 PROVIDING COST-EFFECTIVE AND COORDINATED CARE FOR CHILDREN WITH MEDICAL COMPLEXITY

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Introduction Many paediatric hospitals are treating increasing numbers of children with medical complexity (CMC), diagnosed with chronic life-limiting illnesses and requiring life-sustaining home medical technology. These medically fragile children and families are at risk of fragmented care, sub-optimal continuity and high healthcare resource utilization due to their multiple medical issues and care needs. Consequently, the Children's Complex and Home Care Services (CCHS) was established in our institution in April 2016 with the primary aims of providing coordinated, cost-effective and patient- and family-centered care to CMC and their families. This service is run by a multi-disciplinary team of pediatricians, nurses, allied health and administrative staff.

CMC in our context have a chronic life-limiting condition that involves at least three body systems and are often technologically dependent with limited mobility. In view of the numerous healthcare professionals involved in their care, multiple medical appointments are often scheduled which result in significant caregiver stress and fatigue. One of the key service implementations was multidisciplinary clinics whereby children are seen over the course of 1–3 hours by multiple clinical, nursing and allied health specialists. The purpose of this study is to describe CCHS service implementations, characterize CCHS patient characteristics and evaluate how multidisciplinary clinics have reduced their healthcare resource utilization.

Methods 55 patients who were enrolled in the CCHS between April 2016 and October 2018 were studied.

Results Patient ages ranged from 2 months to 14.3 years old at time of enrolment. The majority of patients had underlying primary genetic diagnoses (47.2%), and other patients had either the primary diagnosis of cerebral palsy (20%), congenital cardiac disease (5.4%), neuromuscular disease (3.6%) or another or undiagnosed underlying condition (23.6%). Medical technology required at time of enrolment included enteral devices such as nasogastric/nasojejunal tubes or gastrostomies (94.5%), suctioning machines (54.5%), ventilator support (34.5%) and tracheostomies (16.4%).

CCHS multidisciplinary clinics managed to reduce the number of outpatient attendances by 6.8 visits per patient-year for CMC enrolled into the service. This saves caregivers from an equivalent number of workdays of lost salary, and translates to €450 of savings per patient per year on just transportation costs alone.

Conclusion CMC are heterogeneous in conditions but similar in care needs, and reducing outpatient attendances and healthcare costs is possible with coordinated multi-disciplinary clinics.

P349 'UNRAVELLING THE DNA' – AUDIT OF NON-ATTENDANCE AT GENERAL PAEDIATRIC OUTPATIENT CLINICS

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Aim 'Did not attends' (DNAs) are a frequent occurrence at outpatient clinics. These affect waiting list times, cost the hospital money, and may mean children are not receiving the medical care that they require. The Health Service Executive (HSE) DNA targets for 2016 were 12% for new attendance DNA rates¹, and for 70% of consultants to have a DNA rate of <10%. This study aimed to audit current DNA rates in two General Paediatric clinics, and also to identify reasons for non-attendance and possible ways to overcome these.

Method The scheduled patients and non-attenders of two General Paediatric clinics were included from January to April 2017. Parents of children who did not attend were contacted to participate in a telephone questionnaire. These responses were analysed.

Results Twenty-two clinics were included, amounting to 329 patients. There were 59 (17.93%) DNAs giving an average of 2.68 DNAs per clinic. There was no significant difference in DNA rates between sexes, appointment times or new vs return patients. There were higher DNA rates in children aged 11 or older.

Twenty-seven (45.76%) parents responded to the questionnaire. Thirty (51%) parents' contact numbers were not working or unavailable. The most common reasons for not attending were: not aware had appointment (n=9, 33%), child now well (n=4, 15%), parent working (n=3, 11%). Many parents suggested appointment times outside of office-hours or on Saturdays so their child would not miss school. Parents prefer text as method of appointment reminder. Each DNA cost the hospital €250.

Conclusion 'Did not attends' are a frequent occurrence at General Paediatrics clinics. This is costly and affects waiting-list times. Children are dependent on their caregiver to bring them to outpatient appointments. Potential solutions are multiple reminders, appointment times outside of office hours and a hospital appointment mobile phone app. Lack of up-to-date caregiver contact details is a major issue to be overcome.

P350 CHILDREN DISCHARGED DIRECTLY HOME FROM THE PAEDIATRIC INTENSIVE CARE UNIT

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Background The process of discharging a patient directly home from the paediatric intensive care unit is distinctly different from discharging a patient to a hospital ward or another hospital. Whether these differences increase the risk of communication errors or increased mortality has not been previously investigated in a paediatric cohort. For adult populations the discharge of select patients directly home from the intensive care unit is not associated with increased healthcare utilisation or increased mortality. Whether discharge directly home from the Paediatric Intensive Care Unit is associated with increased mortality has not been previously investigated in the literature.

Aim To describe cases presenting for admission to the Paediatric Intensive Care Unit (PICU) but who are sufficiently recovered to be discharged directly home.

Methods This single centre retrospective descriptive study was conducted from the 1st July 2012 to 1st July 2018. Data was extracted from the PICU Clinical Information Portfolio system.