were excluded. Of the remaining 552 electrocardiograms, 30 were identified by the emergency clinicians as abnormal and sent for cardiology review. 13/30 of these were considered normal by the consultant cardiologist and the patients discharged. The other 17 patients were allocated to cardiology outpatient clinic. Only 3/17 required ongoing follow-up. Of the 522 electrocardiograms deemed normal by the emergency department clinicians, cardiology disagreed in 8 (1.4%). In these cases, there was either incorrect lead placement or the checklist had been applied incorrectly. All 8 patients were seen in cardiology outpatient clinic but subsequently discharged. Use of the checklist demonstrated an excellent negative predictive value of 98.47% [CI 97.32% to 99.13%]. Following implementation, time from emergency department attendance to outpatient clinic decreased from a median of 89 to 45 days ($P<0.001$) and survey respondents reported increased confidence in interpreting paediatric electrocardiograms.

Conclusions The use of a simple checklist and guideline allows confident and accurate detection of electrocardiogram abnormality by emergency department staff and speeds referral to cardiology clinic for patients with electrocardiogram abnormalities.

British Association of Child and Adolescent Public Health

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EMERGENCY DEPARTMENT UTILISATION BY HOMELESS CHILDREN IN DUBLIN, IRELAND

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Background Families represent the fastest growing homeless population in Europe. From 2014–2021, a 165% increase was observed in families accessing emergency homeless accommodation in Ireland, causing a 211% increase in child homelessness. In March 2021, there were 913 homeless families in Ireland, with children ($n=2,326$) accounting for 28% of homeless people. Over-represented vulnerable groups include Irish Travellers, the Roma, and international protection applicants.

Homeless populations are more likely to use emergency departments (EDs) rather than primary care, with higher admission rates and durations. Most literature pertains to lone adult homelessness.

Objectives To compare emergency presentations between homeless and non-homeless children, to investigate differences in demographics, vaccination, service usage, medical acuity, diagnoses and outcomes.

Methods We performed a retrospective review of homeless children attending a tertiary paediatric emergency department in Dublin, Ireland, from 01/01/2017 - 31/12/2020. Homelessness was defined as those with addresses of no fixed abode, government homeless accommodation, direct provision, women's refuges, drug rehabilitation centres, children's residential

homes, and prison. Those who provided residential addresses but were functionally homeless were also included.

Comparison was made with non-homeless children attending in 2019. Data was extracted from electronic healthcare records, and analysed using SPSS. Hospital ethical approval was obtained.

Results From 01/01/2017–31/12/2020, 3,138 homeless children presented, representing 1.6% of total attendances. Compared to non-homeless ($n=1,500$), homeless children were younger (29 vs 60 months, $p<0.001$; proportion ≤ 12 months: 25.7% vs 16.3%, $p<0.001$).

Homeless children were less likely to have Irish ethnicity (37.4% vs 74.6%, $p<0.001$), or have been born in Ireland (82.3% versus 96.2%, $p<0.001$). Ethnicity varied between homeless and non-homeless (White Irish: 34.5% vs 73.7%; Irish Traveller: 3% vs 0.8%; Roma: 22.5% vs 2.4%; Black: 21.1% vs 4.2%; Asian: 8.6% vs 8.8%; White European 5.9% vs 9%; $p<0.001$).

Homeless children were more likely to re-present (15.9% vs 10.5%, $p<0.001$), use ambulances (13.2% vs 6.7%, $p<0.001$), and have ≥ 4 ED attendances in 6 months (9.7% versus 5.4%, $p<0.001$), while being less likely to have registered GPs (89.7% versus 95.8%, $p<0.001$).

Compared to non-homeless, homeless children were over-represented in lower triage categories (4: 48.5% vs 41.5%; 5: 2% vs 0.8%; $p<0.001$), ED discharges (93.6% vs 91.1%, $p=0.002$), and leaving prior to assessment (5% vs 3.7%, $p=0.046$), while having longer admissions (median duration: 3 vs 2 days, $p=0.001$).

Vaccination status varied between homeless and non-homeless children (complete: 73.6% vs 81.9%; incomplete 18.5% vs 13.7%; unvaccinated: 3% vs 0.9%, $p<0.001$).

There were no differences in gender or past medical history.

Conclusions Although homeless children were less likely to have Irish ethnicity, 82.3% had been born in Ireland, with over-representation of Irish Traveller, Roma and black ethnicities, which compares with national data.

Homeless children were less likely to have GPs, and be fully vaccinated. They had increased use of emergency services despite having lower triage categories, higher discharge rates, and no differences in past medical history.

Vulnerable groups remain over-represented in the Irish paediatric homeless population. As with adults, paediatric homeless populations rely heavily on emergency services, being less likely to engage with primary healthcare.

British Association for Community Child Health

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ROUTINELY USED INTERVENTIONS FOR IMPROVING ATTACHMENT IN INFANTS AND YOUNG CHILDREN: AN UPDATED SYSTEMATIC REVIEW AND COMPREHENSIVE UK SURVEY

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