vs 54% (97/181) respectively ($p=0.59$). The commonest comorbidity in this study cohort were respiratory conditions, followed by neurological and oncological conditions.

The proportion of children who tested SARS-CoV-2 positive was similar between the clinically vulnerable and non-vulnerable groups. (13.5% [7/52] vs 13.9% [22/158]; $p=0.85$).

Conclusions In our study cohort, there was no single symptom or cluster of symptoms predictive of a positive SARS-CoV-2 test. The only association that we found with SARS-CoV-2 positivity was belonging to a BAME group. Having comorbidities or being clinically vulnerable did not increase the likelihood of a children being SARS-CoV-2 positive.

As presenting symptoms are not accurately predictive of SARS-CoV-2 detection, our study suggests that cohorting children based on clinical symptoms alone, could potentially increase the risk of transmission of infection within healthcare facilities. Until rapid and accurate point-of-care testing is widely available, a shift of emphasis from symptom-based cohorting towards measures such as physical distancing and use of face coverings, will enable better protection.

Association of Paediatric Palliative Medicine

1050

INTEGRATING A MODIFIED PAEDIATRIC PALLIATIVE CARE SCREENING (MPAPAS) TOOL AS A STEP TOWARDS GOAL-CONCORDANT CARE AT A PAEDIATRIC CARDIORESPIRATORY UNIT

¹Chaitanya Balloji, ²Grecy Mungenga, ³Jennifer Sims, ¹Diana Freitas, ¹Amy Chan-Dominy.
¹Royal Brompton Hospital; ²Royal Brompton Hospital; ³Royal Brompton Hospital

10.1136/archdischild-2021-rcpch.359

Background Goal-concordant care for children with complicated critical illness requires balancing multidisciplinary teams (MDT) input, decisional conflicts, and communication challenges that are team-based (opportunities, effectiveness) and family-based (goals, understanding).

The Paediatric Palliative care Screening scale (PaPaS) for stratifying palliative care benefit in children was originally designed for a general paediatric population.

Objectives To help us navigate relationship with specialist MDT and families, we developed a modified (mPaPaS) tool in 2019 to communicate our multidisciplinary assessment. Three domains were modified relevant for our patient cohort with complex cardiorespiratory diagnoses and treatments, reflecting length of stay in hospital, category of life-limiting or life-threatening conditions, and institution of extracorporeal-membrane-oxygenation (ECMO) resuscitation in the event of cardiac arrest.

We describe our pilot use of integrating mPaPaS tool with our multidisciplinary assessment proforma (MAsPro) from focus group discussions to define holistic needs under 5 domains of disease burden, treatment burden, life expectancy, symptom burden and patient/parent preference.

Methods We examined domains of illness from mPaPaS and outcome, indicating stepwise approach to monitor needs, explore understanding or refer for palliative care.

Qualitative data on WHO performance status, Lansky Play Performance scale, phase of disease process, estimated life expectancy, category of life-limiting and life-threatening condition and involvement of subspecialties were referenced from MAsPro to signpost therapies for holistic care.

Results From September 2019 to January 2021 (excluding the March-July 2020 pandemic period), 90 children have been discussed at our weekly complex care meetings.

26 children, median age 7.6 months (range 5days to 16years), had completed mPaPaS. In-hospital stay was over 30 days in 13 (50%) patients, of whom 3 were beyond 6 months length of stay.

Treatment burden was high in 31% ($n=8$), which included ECMO, multi-organ support for chronic lung disease of infancy or staged palliative surgery. These treatments were clustered within first 2 weeks of hospital admission, and 180-day survival was 75%.

Of the 5 children where the screening question '*would you be surprised if the child were to suddenly die in 6 months' time*' replies were '*no*', 2 died by 90 days, 1 had lung transplant at 4 months, 1 died at 14 months (accrued time at home less than 6 months) and 1 was discharged home by 18 months.

Psychological distress of parents relating to child's symptoms scored moderate-high in 65% ($n=17$), and 3 parents expressed wish to formulate needs that are best met by palliative care.

Based on high mPaPaS score, 5 patients were referred for specialist palliative care, one subsequently received lung transplant as part of parallel planning, 1 referral to hospice for carer respite and 3 advanced care plans were completed.

Integrating mPaPaS with MAsPro led to clinical psychology input for parents and/or patient as part of anticipatory care for withdrawal of life support ($n=2$), and enhance engagement with therapists for rehabilitation ($n=1$) with play therapy.

Conclusions For children with complex and/or multistage interventions, including palliative surgery and potential long-term organ support, the framework of integrating mPaPaS tool with focus on multidisciplinary assessment can help distil complex needs into achievable goals to be responsive to patients and families.

Quality Improvement and Patient Safety

1051

PREHOSPITAL PAEDIATRIC BURN CARE: A RE-AUDIT. THE ADEQUACY OF COOL RUNNING WATER FIRST AID

Kathryn Mullan, Susie Lenfesty, Tudor Oman, Elizabeth Dalzell, Stephen Mullan. *RBHSC*

10.1136/archdischild-2021-rcpch.360

Background Appropriate initial management of paediatric thermal burns is key to the prevention of complications and improvement in patient outcomes. Interestingly, research revealed significantly poorer knowledge of burns first aid (FA) management among healthcare workers, when compared with non-healthcare workers. Guidelines recommend all patients receive twenty minutes of cool running water up to three hours following injury. The administration of cool running water not only serves an analgesic function but is also associated with significantly reduced odds of skin grafting. The present re-audit evaluates the FA care of paediatric burn patients with a focus on the adequacy of cool running water.

Objectives Our aim is to determine the adequacy of cool running water FA provided in the management of children with thermal burns. The FA treatment of paediatric burns was specifically examined in the context of pre-hospital and