potential diagnostic dilemma which could impact on treatment based on the trust guidelines.

Clinically relevant urinary contamination was defined as:
1. the presence of bacterial pure growth (defined as one or two UTI causing pathogens in the urine based on SOP of the trust laboratory) with urine microscopy white blood cells (wbc’s) <10/ccmm in the urine, absence of leucocyte esterase and nitrite on dipstick as well as serum CRP <20 mg/L
2. urine specimens which grew mixed pathogens and had urine microscopy wbc’s >20/ccmm with/without positive dipsticks

The proportion of those who had mixed growths was added to the first group of the clinically relevant contaminated urine samples to determine the likely contaminated urine rate.

Data was analyzed with IBM SPSS v.23 using frequency tables to analyze the relevant quantitative data

Results The total number of urine specimens analyzed was 304. The distribution of those with pure bacterial growths, mixed growths, skin perineal flora and no growth is as shown in the attached table below. Of the 79 with pure bacterial growths, all the children had concomitant urine microscopy for wbc’s, 55 had CRP testing while 62 had urine dipstick testing. Sixteen (20.3%) of 79 urine specimens with pure growths had negative urine dipstick results for leucocyte esterase and nitrites, negative urine microscopy (<10wbc/ccmm), and serum CRP < 20mg/L. In addition, 107 had mixed growths totaling 123 contaminated urine specimens making the proportion of likely contaminated urine specimens 40.5%. Three (3.8%) of the patients with pure bacterial growths, who had <10 wbc’s/ccmm of urine, CRP < 20mg/L and negative urine dipsticks had ≥3 day-course of antibiotics. None of these three had a positive blood culture result. Two (2.5%) of these had renal ultrasonography.

Five (4.7%) of the 107 children with mixed growths had urine microscopy of >20wbc’s/ccmm; three of these had positive urine dip for leucocyte esterase

Conclusion The rate of likely contaminated urine samples using clean-catch urine was high, and could potentially have negative clinical implications.

We therefore recommend that similar audits be done in other CEDs and if high, it is suggested that the method of urine collection be reviewed to more specific methods such as routine use of in-out-cather urine collection. We also recommend some discretion be exercised in starting antibiotics in well babies with negative urine and sepsis screen[1]

REFERENCE

Abstracts

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**PARENTAL ATTITUDES REGARDING SAFE HANDLING OF HAND SANITIZERS AND MANAGEMENT OF CHILDREN WITH SANITIZER POISONING AMONGST A COHORT OF CHILDREN ADMITTED TO A TERTIARY CARE CENTER IN SRI LANKA**

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Aims Unsafe storage and use of sanitizers are increasingly associated with local and systemic effects on children and can rarely lead to severe complications including death. Therefore, caregivers need to be aware of the potential risks and dangers associated with improper use of hand sanitizer products among children. The main objective of the current study was to assess the attitudes regarding safe handling of hand sanitizers and management of children with sanitizer poisoning amongst a cohort of parents of children admitted to a tertiary care center in Sri Lanka.

Methods This observational cross-sectional study included all parents admitted to North Colombo Teaching Hospital, Sri Lanka. Data were collected prospectively from 153 parents regarding parental attitudes and practices of safe handling of hand sanitizers and management of children with sanitizer poisoning. Data were collected by medical graduates over a period of six months (August 2021 to January 2022) using an interviewer administered structured questionnaire. All data were analysed using SPSS 17.0.

Results Seventy-eight (51%) parents had been used to buy sanitizers with no description about the containing chemicals. Only 41 parents (26.8%) attempted to find out what chemicals were contained in hand sanitizers they used whilst only 119 parents (77.8%) took measures to keep sanitizer bottles out of reach to their children. Sixty-three parents (41.2%) believed that soap and water are not a good substitute for sanitizer solution. Fifteen parents said that they will not take any action if their child ingests sanitizers accidentally as they were harmless. Parents also admitted that they will practice home remedies if their child is to ingest hand sanitizers and they included: insertion of finger in mouth (48, 31.4%), induce vomiting by soap water (9, 5.9%), cow’s milk (7, 4.6%), coconut milk (23, 15%), and water (36, 23.5%). A number of parents believed that following measures would prevent accidental ingestion of sanitizers at home: making them taste bad (105, 68.6%), introducing screw capped lids (132, 86.3%), safe storage (143, 93.5%), and using sanitizers only when soap is not available (103, 67.3%) while the remaining were in disagreement. Thirty parents (19.6%) said that they will make their own sanitizers at home whilst 49 parents (32%) said they would dispose sanitizer bottles to kitchen waste bin as a means of reducing access of sanitizer bottles to children at home.

Conclusion The effectiveness of parent education programs to raise awareness regarding safe use and disposal of hand sanitizers is a timely need given the higher prevalence of use of harmful remedies and unsafe use and disposal of hand sanitizers.

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**PAEDIATRIC MAJOR INCIDENT TRIAGE AND THE USE OF MACHINE LEARNING TECHNIQUES TO DEVELOP AN ALTERNATIVE TRIAGE TOOL WITH IMPROVED PERFORMANCE CHARACTERISTICS**

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Aims There are limited studies comparing the performance characteristics of an alternative triage tool with the Modified Clinical Priority Score (MCPS) which is currently being used as a common triage tool for paediatric major incident triage. This study is to evaluate the performance characteristics of an alternative triage tool.

Methods This was a retrospective study, and an alternative triage tool based on machine learning techniques was developed and was compared to the modified clinical priority score.

Results The alternative triage tool produced an area under receiver operating characteristics (AUROC) of 0.91 (95% CI: 0.85-0.97), which was significanly different from that of the MCPS (AUROC: 0.79, 95% CI: 0.72-0.85). This alternative triage tool also identified more septic patients with a sensitivity of 0.89 (95% CI: 0.78-0.96) compared to MCPS (sensitivity: 0.53, 95% CI: 0.36-0.71).

Conclusion The alternative triage tool used in this study was found to be more accurate than the MCPS. Further studies are needed to evaluate the effectiveness of the alternative triage tool in a real-time setting.