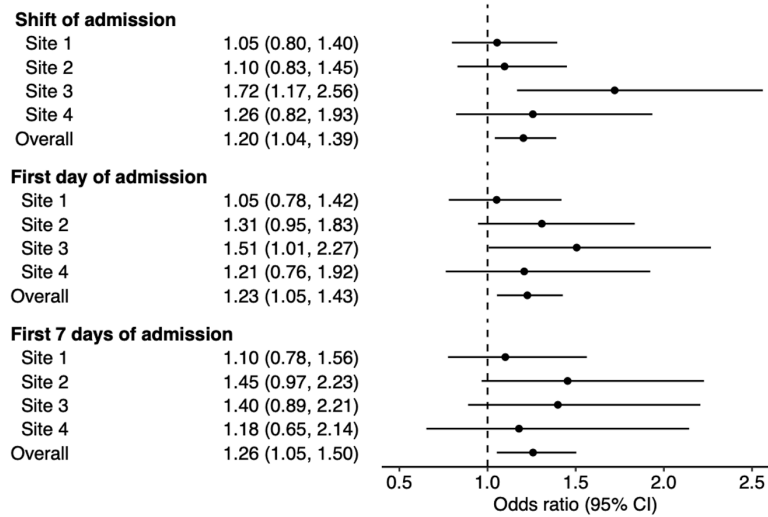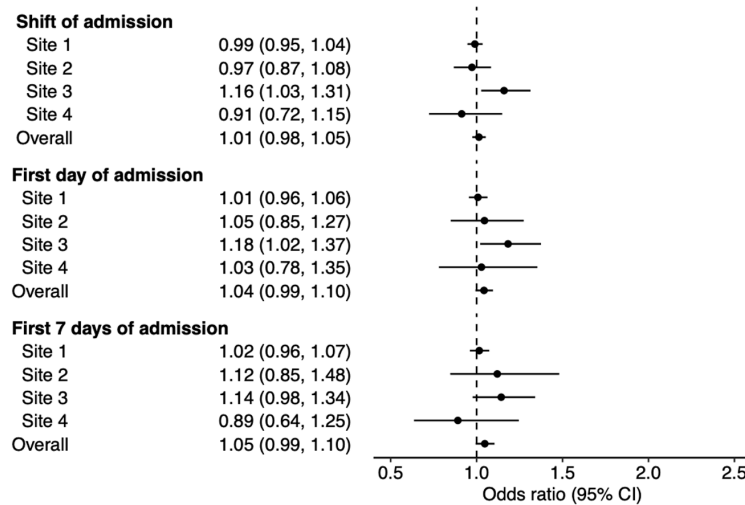**Figure 1.** Adjusted odds ratio for association of unit occupancy on the shift of admission, first day of admission, first seven days with mortality or major morbidity by site

Shift of admission	
Site 1	1.05 (0.80, 1.40)
Site 2	1.10 (0.83, 1.45)
Site 3	1.72 (1.17, 2.56)
Site 4	1.26 (0.82, 1.93)
Overall	1.20 (1.04, 1.39)
First day of admission	
Site 1	1.05 (0.78, 1.42)
Site 2	1.31 (0.95, 1.83)
Site 3	1.51 (1.01, 2.27)
Site 4	1.21 (0.76, 1.92)
Overall	1.23 (1.05, 1.43)
First 7 days of admission	
Site 1	1.10 (0.78, 1.56)
Site 2	1.45 (0.97, 2.23)
Site 3	1.40 (0.89, 2.21)
Site 4	1.18 (0.65, 2.14)
Overall	1.26 (1.05, 1.50)

Odds ratio (95% CI)

Footnote: Adjusted for covariates (gestational age, small for gestational age, sex, outborn, SNAPII > 20 and, mode of delivery), nursing provision ratio and site (random effect).

Figure 2. Adjusted odds ratio for association of nursing provision on the shift of admission, first day of admission, first seven days with mortality or major morbidity by site

Shift of admission	
Site 1	0.99 (0.95, 1.04)
Site 2	0.97 (0.87, 1.08)
Site 3	1.16 (1.03, 1.31)
Site 4	0.91 (0.72, 1.15)
Overall	1.01 (0.98, 1.05)
First day of admission	
Site 1	1.01 (0.96, 1.06)
Site 2	1.05 (0.85, 1.27)
Site 3	1.18 (1.02, 1.37)
Site 4	1.03 (0.78, 1.35)
Overall	1.04 (0.99, 1.10)
First 7 days of admission	
Site 1	1.02 (0.96, 1.07)
Site 2	1.12 (0.85, 1.48)
Site 3	1.14 (0.98, 1.34)
Site 4	0.89 (0.64, 1.25)
Overall	1.05 (0.99, 1.10)

Odds ratio (95% CI)

Footnote: Adjusted for covariates (gestational age, small for gestational age, sex, outborn, SNAPII > 20 and, mode of delivery), unit occupancy and site (random effect).

and maintaining adequate resources need to be considered as strategies to improve patient outcomes.

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COVID-19 IN CHILDREN: A CASE SERIES

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PRIMARY SUBJECT AREA: Community Paediatrics

BACKGROUND: The COVID-19 pandemic has had an overwhelming impact worldwide. Studies on pediatric populations remain limited, as the burden of disease in pediatric patients appears to be low at this time.

OBJECTIVES: To further describe clinical characteristics and severity of disease of confirmed pediatric COVID-19 patients seen and evaluated in a community-based hospital.

DESIGN/METHODS: A retrospective chart review of positive COVID-19 patients ≤ 18 years seen in COVID clinic or in the Emergency Department (ED) between April and December 2020 was performed. The results of nasopharyngeal swabs were confirmed using real-time reverse-transcription-polymerase chain reaction (RT-PCR) assays. A descriptive analysis of illness severity, performed via Excel 2019, was based on clinical presentation, laboratory data, and chest x-ray imaging. The categories of illness severity were: asymptomatic, mild, moderate, severe or critical.

RESULTS: A total of 53 positive COVID-19 patients were enrolled in this study, which consisted of 24 (45.3%) males and 29 (54.7%) females.

Table1 Demographics

Age median (IQR) years	7.5 (2.4, 12.8)
Age group(Y)	%
<1	5.7 (3)
1-5	39.6 (21)
6-10	24.5 (13)
11-17	30.2 (16)
Sex	%
Male	45.3 (24)
Female	54.7 (29)
Presentation	%
*Asymptomatic	35.8 (19)
*Fever	37.7 (20)
*Cough	30.2 (16)
*Sore throat	15.1 (8)
*Running nose	7.5 (4)
*Abdominal pain	7.5 (4)
*Diarrhoea	13.2 (7)
*Headache	9.4 (5)
*Other	32.1 (17)
Exposure/contact information	%
Confirmed Family members	81.1 (43)
Suspected family members	0 (0)
Unknown	3.8 (2)
Others	1.9 (1)
Labs	%
WBCs	13.2 (7)
CRP	9.4 (5)
Ferritin	3.8 (2)
D-dimer	1.9 (1)
Xray done	17.0 (9)
Findings	**Normal**

Table2 Clinical course and outcome

Severity of illness	%
Asymptomatic	35.8 (19)
Mild	64.2 (34)
Moderate	0 (0)
Severe	0 (0)
Critical	0 (0)
Treatment/Intervention received	%
Antibiotics prescribed	5.7 (3)
Outcome	%
Discharged home	94.3 (50)
Admitted	3.8 (2)
Referred to Tertiary care center	3.8 (2)
Reasons for referral	Skin changes – "COVID toes"
	Appendicitis*

*Patient was both admitted and later transferred to tertiary care center

The median age was 7.5 years (2.4-12.8). The majority of patients presented with mild symptoms (64.2%), with fever and cough being the main symptoms in 20 (37.7%) and 16 (30.2%) cases, respectively. Other symptoms included sore throat (15.1%), diarrhea (13.2%), headache (9.4%), runny nose (7.5%) and abdominal pain (7.5%). The remaining patients (35.8%) were asymptomatic. Of note, one patient (1.9%) presented with COVID toes requiring referral to a tertiary centre, and one (1.9%) was diagnosed with acute appendicitis. A history of contact with a confirmed COVID-19-positive family member was present in 43 (81.1%) patients, and 6 (11.3%) reported a history of recent travel. Laboratory tests were performed in 7 (13.2%) patients, and chest x-rays were performed in 9 (17%). There were no abnormalities detected in either, other than an elevated CRP seen in one patient with appendicitis. Two (3.8%) patients were admitted, including the patient with appendicitis who developed a perforation and was later transferred to a tertiary care centre to undergo an appendectomy. The majority of patients (96.2%) were discharged home.

CONCLUSION: All patients either presented with mild symptoms or were asymptomatic. Fever and cough were the most common presenting symptoms. Due to this, the vast majority of patients were discharged home. The infection in the majority of patients could be traced to a positive family contact. Our findings are consistent with what has been observed previously in our centre as well as worldwide.

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ACCEPTABILITY OF A VIRTUAL MODEL FOR DIAGNOSIS FOR FETAL ALCOHOL SPECTRUM DISORDER (FASD)

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PRIMARY SUBJECT AREA: Community Paediatrics

BACKGROUND: A multidisciplinary team is required for diagnosis and recommendations of fetal alcohol spectrum disorder (FASD). The process involves assessments of growth and facial features, a caregiver interview with the physician, assessment of the patient by a psychologist, speech language pathologist and occupational therapist, and a multidisciplinary meeting of the above clinicians, clinic coordinators, school personnel and other support workers. A final meeting is held with the caregiver to debrief on the team findings, diagnosis, and recommendations.

A literature search supported the feasibility of a reliable and accurate assessment of patients that adhere to the recommended Canadian FASD diagnostic guideline. As a result, a "Virtual Model for FASD Diagnosis" was developed.

OBJECTIVES: 1. Pilot a project to assess a Virtual Model of FASD Diagnosis; 2. Promote the model, by webinars, to FASD diagnostic teams nationally and internationally; 3. Survey acceptability of the model among webinar attendees.

DESIGN/METHODS: A literature search revealed that teams used virtual platforms for some components of FASD diagnostic process, but a complete virtual process does not exist. Virtual assessment of motor skills domain was not completed because, in the project team's experience, this domain is rarely impaired. The project leaders developed a model and partnered with two diagnostic teams to complete a small pilot project of 6 patients, using Telehealth and Gotomeetings as a virtual platform to accommodate patients. Patients were scheduled as per the waitlist for each team. Support workers were trained to be with the patient and the caregiver to support any technological aspects, present testing materials, complete growth measurements and photographs for the photographic software for facial measurements.

The coordinator scheduled clinician assessments and caregiver interviews; a multidisciplinary team meeting to discuss findings, diagnoses, and recommendations, and a meeting with the caregiver to debrief. A project member analyzed the photographs to measure the sentinel facial features. A survey