

lopinavir/ritonavir and 53(66.2%) patients received standard of care. Median age of patients in both groups were 8 years. Most patients have no co-morbidity. 16(59.3%), 8(29.6%) and 3(11.1%) patients in treatment group while 33(62.3%), 20 (37.7%) and none of patients in control group have upper respiratory infections, asymptomatic infection and pneumonia respectively. The median days from symptom onset to admission was 1 (IQR 0–2) in treatment and 3(IQR 1–5) in control group. The median days from symptom onset to start of lopinavir/ritonavir was 1(IQR 1–3). The NPS viral load reduction from baseline to day 7 was greater in treatment group. Viral load dropped from mean 6.5 log¹⁰ copies/ml (SD 2.1) on admission to mean 4.6 log¹⁰ copies/ml (SD 2.1) on day 7 in patients treated with lopinavir/ritonavir. Viral load dropped from mean 6.4 log¹⁰ copies/ml (SD 1.8) on admission to mean 5.3 log¹⁰ copies/ml (SD 1.5) on day 7 in patient who did not receive lopinavir/ritonavir. However, the difference was not statistically significant. There was no significant difference in viral load on day 10 and day 14 between the two groups. There was also no significant difference in time to symptom resolution, PCR negativity or duration of hospitalization. No patient in the cohort require oxygen or intensive care. Among those received treatment, 7(25.9%) patients experienced gastrointestinal symptoms possibly drug adverse effects with self-limited nausea, vomiting or diarrhea, as compared to 9(17%) patients in control group. 1(3.7%) and 3(5.7%) patients in treatment and control group have mild deranged liver function. There was no significant difference in rate of gastrointestinal symptom or liver function derangement among the two groups. There was no QT interval prolongation or serious adverse effect noted in patients received treatment.

Conclusions There was no statistically significant difference in NPS viral load clearance, time to symptom resolution, PCR negativity and duration of hospitalization between paediatric COVID-19 patients treated with lopinavir/ritonavir and control. Self-limited gastrointestinal symptoms were common but use of lopinavir/ritonavir appeared to be safe in children with no serious side effect noted.

356

PSYCHOLOGICAL ILL-EFFECTS AND RESILIENCE OF PROVIDERS OF CHILDREN WITH DEVELOPMENTAL DISABILITIES DURING THE COVID-19 PANDEMIC

Ramkumar Aishworiya, Tammy SH Lim, Ying Qi Kang, Phyllis PL Lim, Shang Chee Chong, Mae Yue Tan. *Singapore*

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Background Providers of children with developmental disabilities (DD) had to rapidly innovate to translate face to face care to a virtual platform in order to continue to support the needs of their patients during the coronavirus 2019 pandemic. **Objectives** We aimed to explore the extent of psychological ill-effects, if any, and explore resilience in providers of children with DD.

Methods This was a voluntary cross-sectional study involving an anonymous questionnaire, administered via a secure online platform, between 13 May and 1 July 2020, coinciding with the Circuit Breaker (similar to a lockdown) period in Singapore. Participants included healthcare providers serving children with DD in various capacities at public and private healthcare settings in the country. Common diagnoses of DD included autism spectrum disorder and global developmental

Abstract 356 Table 1

Variable	Depression (N)	%	Anxiety (N)	%	Stress (N)	%
Prevalence of positive screen of traits on the DASS	13	13.7	40	42.1	54	56.8
<i>Among those who screened positive</i>						
Mild	7	53.8	6	15	8	14.8
Moderate	3	23.1	10	25	8	14.8
Severe	1	7.7	6	15	9	16.7
Extremely Severe	2	15.4	18	45	29	53.7

delay. The Depression, Anxiety, and Stress Scales (DASS-21) and Connor-Davidson Resilience Scale 25-item were administered. Descriptive statistics were conducted.

Results Ninety-five responses were received. Mean age of respondents was 37.4 years (SD 9.45), with 96.8% of them being female. A quarter (24.5%) were medical professionals (doctor, nurse, psychologists), a third (33.0%) were therapists (physiotherapists, speech therapists and occupational therapists), a third were school-based providers (teachers in mainstream or special-education schools, learning support educators), and the rest (8.5%) were working in administrative aspects of dealing with children with DD (case manager, social workers, administrative staff). A quarter (25.5%) worked in a hospital, 20.2% worked in a school setting, 37.2% at a therapy centre (e.g early intervention centres), while 17.0% worked in social community agencies.

On the DASS (table 1), more than half (56.8%) of the respondents had a positive screen for stress, of which half of these (53.7%) had levels which were in the 'extremely severe' range. Almost half (42.1%) of providers had anxiety, of which 45.0% of these were 'extremely severe'. Depression rate was lower, with a positive screen present in 13.7% in this group of providers, and half of these were in the 'mild' range. Chi-square analysis showed that providers in school-based institutions were more likely than providers in non-school-based institutions to have a positive screen for depression on the DASS-21 (36.8% vs 8.0%, $p=0.004$). Mean resilience scores on the CD-RISC 25 was 62.7 (range 36.0 to 88.0), lower compared to the published normative data for this scale.

Conclusions Providers of children with DD face significant psychological ill-effects during this pandemic, as well as lower resilience compared to the general population. Targeted institutional support for these providers and interventions to improve their resilience are both crucial to enhance the mental well-being of these providers. This will in turn facilitate continued provision of care for children with DD despite the pandemic.

361

OUTCOME OF FLASH GLUCOSE MONITORING- AN AUDIT

Nikitha Rajaraman, Fathima Haniffa, Dhaara Iyer. *UK*

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Background The use Flash Glucose Monitoring (FGM) is considered a useful technology for self-management of type 1 diabetes mellitus (T1DM).