United Kingdom who face significant barriers to accessing healthcare services. These children often face health risks and therefore have complex health needs. Hence, it is vital for healthcare professionals in the emergency department to adopt a holistic approach to their care as this can have widespread positive implications beyond their clinical presentation and may shape their transition into a new country. This opinion article was undertaken with the aim of highlighting and summarising current best practice recommendations for addressing the needs of this complex patient group.

**Method and Design** A step-by-step screening tool (figure 1), CCHILDSD (Communication, Communicable diseases, Health – physical and mental, Immunisation, Look after (safeguarding), Deficiencies, Sexual health) was formulated. This was created following a review of the literature, consultation with paediatric emergency clinicians and the use of current protocols in related disciplines (e.g. HEADDSS assessment tool). This tool can be used in the emergency setting by healthcare professionals in the assessment of refugee and asylum-seeking children and can serve as an aide memoire to cover the key aspects of a consultation.

**Results and Conclusion** This opinion article summarises three main aspects in the assessment of a refugee or asylum-seeking child in the paediatric emergency department. Firstly, the key considerations regarding the child’s background prior to entering the UK and the barriers they may encounter to accessing healthcare. Secondly, the healthcare assessment upon arrival to the emergency department and a framework that could be used for clinical assessment. Finally, the consideration of their long-term healthcare needs and the importance of empowering these young individuals to lead a healthy lifestyle.

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**1657**

**TRAUMA IMAGING APPROPRIATENESS IN PAEDIATRIC PATIENTS CONVEYED TO A TRAUMA UNIT COMPARED TO A MAJOR TRAUMA CENTRE – A RETROSPECTIVE OBSERVATION STUDY**

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Aims, Objectives and Background Appropriate and timely imaging improves trauma outcomes. In adults, the default is whole-body computed tomography (CT). However, in children more selective imaging should be used. In those requiring CT, the national standard is imaging ≤30mins of arrival. The aims of this study were to compare appropriateness of CT and time to initial CT in paediatric trauma patients conveyed directly to a major trauma centre (MTC) with those initially treated in a trauma unit (TU) and then transferred to an MTC.

Method and Design A retrospective observational study in the East of England MTC (2015–2020). All paediatric trauma patients meeting Trauma Audit Research Network (TARN) criteria who arrived at the MTC ≤24hr of injury and underwent CT imaging within 12 hours of arrival were included.

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**Abstract 1657 Table 1 CT appropriateness and timing associated with transfer status at a single MTC**

<table>
<thead>
<tr>
<th>Primary Attendance to MTC</th>
<th>Secondary Transfer to MTC</th>
</tr>
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<tbody>
<tr>
<td>Age ≥12 years/median [IQR]</td>
<td>CT whole body (% of CT at TU/MTC)</td>
</tr>
<tr>
<td>Male sex/n (%)</td>
<td>58 (62%) 96 (71%)</td>
</tr>
<tr>
<td>Hospital arrival to first CT interval (minutes)/median [IQR]</td>
<td>35 [26 – 75] 75 [47–108]</td>
</tr>
</tbody>
</table>

Data were obtained from the MTC trauma office and clinical records were independently reviewed by two authors. The Royal College of Radiologists guideline for paediatric trauma was used to assess the appropriateness of the CT imaging strategy. Combined data were stored in a Microsoft Excel sheet and analysed in Prism 9 for macOS (GraphPad). Data are reported as number (percentage), and median (inter-quartile range). Proportions were compared with a Chi-square test; differences between median values were compared with a Mann-Whitney U test.

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**1804**

**SURVEY OF DISCHARGE PRACTICE AND REVIEW OF SAFETY-NETTING INSTRUCTIONS FOR CHILDREN ATTENDING EMERGENCY DEPARTMENTS IN THE UK & IRELAND WITH ACUTE WHEEZE OR ASTHMA: A PERUKI STUDY**

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Aims, Objectives and Background Acute wheeze is one of the commonest reasons for childhood Emergency Department (ED) attendances. Ongoing recovery following discharge should be supported with robust safety-netting advice including advice for ongoing bronchodilator use. Evidence for recovery bronchodilator dosing is lacking, likely leading to variation in advice across the UK and Ireland.