South Thames Paediatric Network

South Thames Retrieval Service

v 2.0
Updated: 06/21

NHS
Thames Valley & Wessex Paediatric Critical Care Operational Delivery Network

STOPP! Safe Transfer Of the Paediatric Patient!

For use on ALL non STRS transfers of children BETWEEN Hospitals. The referring Hospital is responsible for the completion of this form prior to and during transfer. **Please make 2 copies**, original: remains at patient destination, 2nd returned to referring hospital patient notes, 3rd kept for audit at referring hospital. **Please give the 3rd copy to your trust's audit lead.**

PATIENT DETAILS:	**Weight (Kg)** **True/Est**
First name	**Date of birth**
Surname	**Age** **ALLERGIES**
Address	
Post Code	**GP Details**
Hospital number	**Social worker details**
NHS number	**Safeguarding concerns**
Parents/Carer	No
Name & Contact	

Date & Time of referral:	**Call made to:** Name, role and contact number
Call made by: Name, role and contact number	

REFERRING Consultant:	**RECEIVING Consultant:**
Hospital	**Hospital**
Ward/Location	**Ward/Location**
Contact no	**Contact no**

SUMMARISED CLINICAL DETAILS:

Presenting Complaint

Current problem + Reason for Transfer

Organ support required

Past Medical History

Medication History

DISCUSSION/ADVICE FROM RETRIEVAL TEAM:

TRANSFER INDICATION: Escalation of treatment ☐ **Investigations** ☐ **Repatriation** ☐ **Palliatio** ☐ **Bed Status** ☐

RISK ASSESSMENT RESULTS: Perform Patient risk assessment p.2 and transfer risk assessment p.3

Transfer Category

- ☐ Transfer no longer required
- ☐ Ward level (level 0)
- ☐ **Basic critical care (HDU, level 1)**
- ☐ **Intermediate critical care (level 2)**
- ☐ **Advanced critical care (level 3)**
- ☐ **AND/OR Time critical**

ASSESSMENT COMPLETED BY:

Nurse:
(Name, Role & Signature)
Doctor:
(Name, Role & Signature)

Recommended Transfer Team

Referring Hospital Personnel:

- ☐ **Parents**
- ☐ **Nurse/ODP**
- ☐ **Anaesthetist/Paediatrician**

Transport:

- ☐ **Patient Transport Service**
- ☐ **LAS/South East Coast Amb – standard crew**
- ☐ **LAS/South East Coast Amb – paramedic crew**
- ☐ **Patients own transport**

PICU Trained:

- ☐ **STRS**
- ☐ **Other retrieval team (NETS, CATS, SORT etc)**

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STOPP! Perform Patient Risk Assessment prior to transfer:

Category	Assess To fill		Triggers	1st attempt Circle	2nd attempt Circle
A			Is there any risk of Airway Compromise? (e.g. stridor, foreign body, burns)	Yes	Yes
B	RR		Is the Respiratory Rate outside the normal age-adjusted range?	Yes	Yes
	Sats		Any evidence of respiratory distress/increased work of breathing/prolonged apnoeas /exhaustion	Yes	Yes
	FiO_2		> 2L/min O_2 to maintain sats > 94%, Presence of Empyema, Use of High Flow Oxygen / CPAP / BIPAP	Yes	Yes
	EtCO2		Intubated and Ventilated?	Yes	Yes
C	BP		Is the systolic BP or HR outside the normal age-adjusted range?	Yes	Yes
			Are there signs of poor peripheral perfusion, e.g. CRT > 2 secs?	Yes	Yes
	HR		ABG: Lactate > 2 or BE > -2	Yes	Yes
			Fluid boluses: > 40mls/kg within 6 hours	Yes	Yes
D	GCS		GCS low <8/fluctuating or AVPU (P or U)	Yes	Yes
	AVPU		Signs of raised ICP?	Yes	Yes
	Pupils		Newly-diagnosed Inborn Error of Metabolism	Yes	Yes
E	Temp		Is patient pyrexial>38.5 despite intervention?	Yes	Yes
			Is temperature unrecordable/ warming required to maintain normothermia?	Yes	Yes
Additional for Surgical	Fluid Bolus Requ		Is the patient shocked/inadequately resuscitated or actively bleeding?	Yes	Yes
			Does pain control remain an issue?	Yes	Yes
	Pain score		Does the child have communication difficulties impairing assessment?	Yes	Yes
			Is this Time critical? (Ischemic gut or testicular torsion)	Yes	Yes
Additional for Neuro	Concerns		Risk of progressive intracranial event?	Yes	Yes
			Is there suspicion of a blocked ventricular shunt?	Yes	Yes
			Mechanism of injury high risk? (e.g. High velocity, LOC)	Yes	Yes
Additional for Trauma	Concerns		Is the mechanism of injury high risk: - head, abdominal or spinal injury?	Yes	Yes
			Fracture to Pelvis or femur?	Yes	Yes
			Burns partial thickness>2%, Full thickness>1%, Inhalation injury signs?	Yes	Yes

Did you answer YES to any of the above triggers?or Concerned by any other elements of the assessment? If so you must…

1. Treat immediate findings appropriately with support of Paediatric registrar and re-assess ☐
2. If transfer is due to capacity consider transferring an alternative patient ☐
3. If transfer is still required perform Transfer risk assessment over page ☐
4. Ensure Paediatric consultant is aware of the triggers, the plan and the transfer team choice ☐
5. IF INDICATED CONTACT STRS (Tel: 0207 188 5000) FOR ADVICE BEFORE PROCEEDING ☐

Summarise clinical plan below to respond to triggers and/or reduce patient risk associated with triggers

Name of Consultant plan discussed with:

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STOPP! Perform Transfer Risk Assessment prior to transfer:

TRANSFER CATEGORY	ANY TRIGGERS	STAFF REQUIRED	DISCUSS WITH STRS
Level 0 (Ward Level) Children not requiring continuous monitoring	NO	Parent/Carer* +/or Nurse Ambulance: Standard crew/transport *Parent can use own transport if deemed safe by clinical team	NO
Level 1 (Basic Critical Care) Children needing continuous monitoring or iv therapy Or any PCC Level 1 Care	NO	Competent Nurse or Doctor OR Appropriately trained ambulance crew	NO
	YES	Nurse/ ODP AND Senior Doctor (paeds resus-trained) AND appropriately trained ambulance crew OR STRS Transfer (if agreed jointly)	Discuss with your Consultant
Level 2 (Intermediate Critical Care) Level 1 + single system support requirements (e.g. CPAP, NIV)	YES	Nurse/ODP AND Senior Doctor (airway + paeds resus- trained) AND Appropriately trained ambulance crew OR STRS Transfer (if agreed jointly)	YES
Level 3 (Advanced Critical Care) Intubated and Ventilated	YES	STRS Transfer - UNLESS time critical (SEE BELOW)	YES
Time Critical (Level 2-3) e.g. ACUTE NEUROSURGICAL EMERGENCY LIFE/LIMB-THREATENING INJURY ISCHEMIC GUT Ensure receiving surgical team are aware	YES	Local Team: Nurse/ODP + Senior Doctor (airway + paeds resus-trained) AND Appropriately trained ambulance crew Tell Ambulance operator: *"this is a paediatric time critical transfer"* **patient must leave within 30mins**	YES
Time Critical but care level 0 or 1 e.g. Testicular torsion	YES	The Clinical team may assess the risk and deem it appropriate for parent/carer to transfer patient **Patient Must leave within 30 mins**	NO

STOPP! Communicate and equip:

Personnel:

- ☐ Doctor 1 (name, specialty & grade) _____
- ☐ Doctor 2 (name, specialty & grade) _____
- ☐ Nurse/ODP (name, specialty & grade) _____
- ☐ Parent/Carer details (if accompanying) _____

Communication:

- ☐ Bed in destination hospital identified and availability confirmed _____
- ☐ Consultant in destination hospital has agreed transfer (Name) _____
- ☐ Referral made to receiving surgical team if required (Name)_____
- ☐ Parent/Carer informed of transfer and any parental concerns discussed
- ☐ Parent/Carer invited to accompany child (Name) _____

Equipment:

- ☐ Hospital Grab bag available with size appropriate emergency equipment
- ☐ Suction unit available and batteries fully charged
- ☐ Sufficient oxygen in portable cylinder available and mask for delivery
- ☐ Appropriate restraint device available
- ☐ Batteries on monitor and/or infusion pumps fully charged
- ☐ Infusion devices rationalized and secured

Drugs/Fluids:

- ☐ Analgesia
- ☐ Intubation drugs
- ☐ Emergency drugs
- ☐ IV Fluids
- ☐ Blood
- ☐ 3% Saline

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STOPP! Plan ahead:

Transport:

- ☐ **Time ambulance service called**: _____
- ☐ Ambulance reference no: _____
- ☐ **Ambulance arrival time at referring hospital**: _____
- ☐ Transfer staff have a mobile phone available
- ☐ Money/cards available for emergencies
- ☐ Return travel arrangements confirmed & Team have contact details e.g.: taxi/ward numbers

Patient Specific Instructions for transfer: (please tick)

- ☐ Temperature monitoring
- ☐ Nil by Mouth/consider NG tube for surgical patients
- ☐ Blood glucose monitoring
- ☐ Maintenance IV fluids
- ☐ Well-secured IV access (x 2 if required)
- ☐ ID bracelet x2

Other:

Paperwork for transfer (photocopy the following): (please tick)

- ☐ Referral letter
- ☐ Copy of Current medical, nursing notes and investigations (recent clinic letter for long-term patients)
- ☐ Copy of Current drugs chart, PEWs chart and fluid charts
- ☐ Upload/transfer radiology onto relevant IT system
- ☐ 3 Copies STOPP Tool on arrival (for patient notes in referring and receiving hospitals and audit in referring)
- ☐ **Local Observation chart/PEWS chart to be used for transfer for familiarity**

STOPP! Monitor and document:

Patient monitoring, assessment and intervention on transfer

Use local Observation and PEWS chart to document findings on transfer. Any additional findings, concerns, interventions, actions to be documented here:

Summary of transfer

Transfer team

Name:	Role	Signature	Date/Time
Name:	**Role**	**Signature**	**Date/Time**

Receiving team

Name:	Role	Signature	Date/Time
Name:	Role	Signature	Date/Time