South Thames Paediatric Network
Transforming Healthcare for Children and Young People

V4.0: Nov 2023
Not recommended for local modification
Enquiries to England.STPN@nhs.net

Adapted from the STOPP tool created by TVW ODN, with thanks
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. **3 copies are required**, original to travel with the patient and remains at destination, one returned to referring hospital patient notes and one to be kept for audit and given to your STOPP tool lead.
*This tool is for **guidance only** and it is important that clinical judgement by senior clinicians is always used.*
Please use the comments section to clearly document decisions as necessary.

PATIENT DETAILS:

First name _____
Surname _____
Address _____
Post Code _____
Hospital Number _____
NHS Number _____
Parents/Carer...
Name _____
Contact Number _____

Weight (Kg) _____ **True/Est** _____
Date of birth _____
Age _____ **ALLERGIES:**

GP Details _____
Social worker details _____
Safeguarding concerns
Yes: ☐ **No:** ☐

Date & Time of referral: _____
Call made by:
(Name, role & contact number) _____

Call made to:
(Name, role & contact number)

REFERRING Consultant: _____
Aware of transfer: **Yes:** ☐ **No:** ☐
Hospital _____
Ward/Location _____
Contact no

Date & Time Referral Accepted: _____
ACCEPTING clinical team / specialty _____
ACCEPTING consultant _____
Hospital _____
Ward/Location **Contact no**

SUMMARISED CLINICAL DETAILS:

Presenting Complaint

Current problem + Reason for Transfer

Organ support required

Past Medical History

Medication History

Relevant infection control information: _____

DISCUSSION/ADVICE FROM RETRIEVAL TEAM: _____

TRANSFER INDICATION: **Escalation of treatment** ☐ **Investigations** ☐ **Repatriation** ☐ **Palliation** ☐ **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) & STRS contacted**
- ☐ **AND/OR Time critical - see page 3 for examples**

ASSESSMENT COMPLETED BY:

Nurse:
(Name and role)

Doctor:
(Name and role)

Recommended Transfer Team

Referring Hospital Personnel:
- ☐ **Parents**
- ☐ **Nurse/ODP**
- ☐ **Anaesthetist/Paediatrician**

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

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 Tick	2nd attempt Tick
A			Is there any risk of Airway Compromise? (e.g. stridor, foreign body, burns)	Y / N	Y / N
B	RR		Is the Respiratory Rate outside the normal age-adjusted range?	Y / N	Y / N
	Sats		Any evidence of respiratory distress / increased work of breathing /prolonged apnoeas / exhaustion / chest drain in situ?	Y / N	Y / N
	FiO_2		> 2L/min O_2 to maintain sats > 94% / Significant change on X-ray e.g. Empyema / Use of High Flow Oxygen	Y / N	Y / N
	EtCO2		Intubated and Ventilated / LTV / CPAP / BIPAP?	Y / N	Y / N
C	BP		Is the systolic BP or HR outside the normal age-adjusted range?	Y / N	Y / N
			Are there signs of poor peripheral perfusion, e.g. CRT > 2 secs?	Y / N	Y / N
	HR		ABG: Lactate > 2 or BE > -2	Y / N	Y / N
			Fluid boluses: > 40mls/kg within 6 hours	Y / N	Y / N
	Fluid Bolus?	Amount / Kg	Is the patient shocked/needing ongoing resuscitation or actively bleeding?	Y / N	Y / N
D	GCS		GCS low <8/fluctuating or AVPU (P or U)	Y / N	Y / N
	AVPU		Signs of raised ICP?	Y / N	Y / N
	Pupils		Recent Seizure activity?	Y / N	Y / N
	Neuro concerns:		Risk of progressive intracranial event?	Y / N	Y / N
			Is there suspicion of a blocked ventricular shunt?	Y / N	Y / N
			Mechanism of injury high risk? (e.g. High velocity, LOC)	Y / N	Y / N
			Any signs of Stroke? *To note* **Time requirements of some treatments**	Y / N	Y / N
	Pain Score		Does pain control remain an issue?	Y / N	Y / N
			Recent, or at risk of, Hypoglycemia	Y / N	Y / N
E	Temp		Is patient pyrexial>38.5 despite intervention?	Y / N	Y / N
			Is temperature unrecordable/ warming required to maintain normothermia?	Y / N	Y / N
Additional for Surgical	On the main triggers pay particular attention to C - Fluid and Shock and D - Pain		Is this Time critical? (if yes required to leave within 30 minutes)	Y / N	Y / N
			Newly-diagnosed Inborn Error of Metabolism	Y / N	Y / N
			Does the child have communication difficulties impairing assessment?	Y / N	Y / N
Additional for Trauma	Concerns		Is the mechanism of injury high risk: - head, abdominal or spinal injury?	Y / N	Y / N
			Fracture to pelvis or femur?	Y / N	Y / N
			Burns partial thickness>2%, Full thickness>1%, Inhalation injury signs?	Y / N	Y / N

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)** These include 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 These include 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: Matches the Personnel recommended on page 1? Yes ☐ No ☐ *If not expand in transfer summary*

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

Communication:

- ☐ Bed in destination hospital identified and availability confirmed _____
- ☐ Parent/Carer informed of transfer and any parental concerns discussed
- ☐ Parent/Carer in agreement and consent to transfer? (if no please seek further advice)
- ☐ Parent/Carer to accompany child (Name): _____

Equipment:

Ready for use	N/A	
☐	☐	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 - consider taking a spare
☐	☐	Appropriate patient monitoring and monitor fully charged with battery capacity
☐	☐	Infusion devices secured and/or infusion pumps fully charged
☐	☐	Appropriate restraint device available

Drugs/Fluids:

Y	N/A	
☐	☐	Analgesia
☐	☐	Intubation drugs
☐	☐	Emergency drugs
☐	☐	IV Fluids
☐	☐	Blood
☐	☐	3% Saline
☐	☐	Other:

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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) Date inserted:_____
- ☐ ID bracelet x2

Location of IV Access:

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
- ☐ **Local Observation chart/PEWS chart to be used for transfer**

Following transfer 3 copies of completed tool are required

STOPP! Monitor and document:

Additional Comments: Please use this space for documenting any additional information (this may include patient assessment, interventions on transfer and a summary of transfer including any adverse events)

Transfer team

Name: Role Signature Date/Time

Name: Role Signature Date/Time

Receiving team

Name: Role Signature Date/Time

Name: Role Signature Date/Time

Save Copy of Completed Form