STOPP Tool

Please use Safe Transfer of Paediatric Patient assessment tool for all inter-hospital transfers in North West (England) & North Wales

SYSTEM	RISK ASSESSMENT PRIOR TO TRANSFER	TRIGGERS
A	Stridor / Stertor or anticipated AIRWAY RISK ie foreign body / difficult airway Airway or facial burns, smoke or gas inhalation?	YES / NO
B	Respiratory Rate = ______ Above or Below normal age adjusted range?	YES / NO
	Respiratory distress of concern ie marked recession / ↑WOB or early exhaustion	YES / NO
	Oxygen Need > 2L/min to maintain SpO_2 > 94% OR High Flow Humid. O_2 / CPAP / BiPAP	YES / NO
	Intubated & Ventilated	YES / NO
C	Systolic & mean BP = ______ Outside normal age adjusted range? (NWTS sepsis guideline)	YES / NO
	HR = ______ Is it outside normal range OR Capillary Refill > 2 secs?	YES / NO
	Is Blood Gas Lactate > 2 OR Base Deficit > 2	YES / NO
	Fluid boluses > 40 ml/kg within last 6 hours + / - inotrope infusion	YES / NO
	Risk of cardiovascular collapse: enlarged liver, oliguria, abnormal heart rhythm	YES / NO
D	Level of consciousness USING A V P U = P or U / GCS < 9 or falling / fluctuating level	YES / NO
	Risk of progressive intracranial event or signs of raised ICP ie bradycardia; hypertension; abnormal breathing; unequal, dilated or fixed pupils	YES / NO
	Prolonged hypoglycaemia (not correcting) AND / OR raised ammonia	YES / NO
	Unrecognised injury / trauma eg laceration / punctures OR Trauma / probable NAI	YES / NO
E	Inadequate ability to maintain normothermia (despite treatment / intervention)	YES / NO

ARE ANY | A | B | C | D | E | CRITERIA TRIGGERED?

IF YES, PAEDIATRIC + / - ANAESTHETIC CONSULTANT (S) SHOULD REVIEW PATIENT AND AGREE A PLAN FOR TRANSFER WITH SENIOR NURSE ON DUTY. USE TABLE BELOW TO DETERMINE APPROPRIATE TEAM REQUIRED TO TRANSFER PATIENT

ONLY IF INDICATED FOLLOWING CONSULTANT REVIEW CONTACT NWTS : 08000 84 83 82 FOR ADVICE BEFORE TRANSFER

TRANSFER CATEGORY	ANY TRIGGERS	STAFF REQUIRED (examples only)	D/W NWTS
Time Critical (Level 1-3) Traumatic Brain Injury, Ischaemic gut, Life or Limb threatening diagnosis	Yes / No	Local Team: Nurse/ODP + Senior Airway + Paediatric resuscitation competent Doctor + paramedic crew TRAUMA / NAI / Burns: REFER TRAUMA TEAM LEADER REQUEST: CATEGORY 1 AMBULANCE	FOR TRANSPORT ADVICE
Level 0 (ward level) Child not on continuous monitoring	Non-anticipated	Parent / carer or Nurse or both Request standard ambulance crew / EMT	NO
PCC Level 1 (Basic critical care) Children needing continuous monitoring or iv therapy or any PCC Level 1 Care *Can be a difficult transfer: Joint decision /agreement between senior nurse & consultant (s) essential before transfer*	1. No	Competent nurse OR doctor (essential if on iv infusion fluids / drugs) OR paramedic ambulance crew	NO
	2. YES	Competent Nurse &/or Doctor + Paramedic crew	PROBABLY
	3. YES AND High Flow Oxygen, OR potential for airway or other compromise	Nurse/ODP AND Senior Airway and Paediatric resuscitation competent Doctor AND paramedic ambulance crew OR NWTS transfer only if agreed jointly with referring consultant + NWTS consultant	YES
PCC Level 2 (Intermediate critical care) PCC Level 1—acute intervention for more than 24 hours	YES / NO	Nurse/ODP AND Senior Airway and Paediatric Resuscitation competent Doctor AND paramedic ambulance crew OR NWTS transfer only if agreed jointly with referring consultant + NWTS consultant	YES
Level 3 (Advanced critical care) Intubated and Ventilated	Yes / No	NWTS transfer unless time critical (rare exception may be palliative care)	YES

Family name:	First name:	Date of referral:	D D M M Y Y Y Y
Date of Birth:	Age:	Time of referral:	H H M M
NHS No:		Weight: Kg Actual/Estimate	Age:
Hospital Number:			
Address:		Call made	(Name, signature, grade)
Post code:			
GP Name:	GP Practice:		

CONTACT DETAILS			
Referring Consultant		Receiving Consultant	
Referring Hospital		Destination Hospital	
Ward / Area		Ward / Area	
Ward phone number:		Ward phone number:	

Please describe details of case including any discussion with external specialists (SBAR format may be used if wished)

Problem:

ALLERGIES:	**Immunisations:**

INDICATION FOR TRANSFER (PLEASE INDICATE)	Specialist review/ treatment	Investigations	Repatriation	Bed Capacity	Palliation

For all bed capacity transfers you must follow your internal escalation policy and prioritise transfer of a level 0 patient wherever possible. Please document any discussion in patients' notes.

Consensus risk assessment

PERFORM RISK ASSESSMENT ON PAGE 2 THEN TICK RESULTS CATEGORY BELOW:
If Paediatric Consultant not aware: STOP AND INFORM ASAP

TRANSFER CATEGORY		TRANSFER TEAM	
TIME CRITICAL		LOCAL HOSPITAL TEAM	
Ward level (level 0)		NWAS + Parents +/- nurse only	
Basic critical care (HDU / PCC level 1)		Paediatric: medic/ANP + nurse	
Intermediate critical care (PCC level 2)		Anaesthetics: medic + nurse/ODP	
Advanced critical care (PCC level 3)		Hybrid Paediatric + Anaesthetic team	
Transfer no longer required		OTHER	
ASSESSMENT COMPLETED BY (date / time)		NWTS	
Nurse: (Name, Role, Signature) Doctor: (Name, Role, Signature)		Other transport team	PIC / Neonatal

TRANSFER DOCUMENTATION

PERSONNEL

Doctor 1 (name, speciality & grade)

Doctor 2 (name, speciality & grade)

Nurse / ODP (name, speciality & grade)

Parent /guardian details (including mobile no) Accompanying patient In ambulance: Yes / No

EQUIPMENT

EQUIPMENT	☐	DRUGS/FLUIDS:	☐
Appropriate drugs & equipment available	☐	Analgesia (as required)	☐
Suction unit & batteries fully charged	☐	Intubation drugs + equipment	☐
Sufficient oxygen in portable cylinder available	☐	Emergency / resuscitation drugs	☐
NB ALWAYS perform a tug test when plugging into ambulance oxygen supply or cylinder	☐	IV Fluids (including maintenance + bolus)	☐
Appropriate harness available eg ACR harness	☐	Blood Products	☐
Charged batteries for monitor and/or infusion pumps	☐	Other eg anticonvulsants / antibiotics etc	☐
Infusion devices rationalised and safely secured	☐		

PRE-DEPARTURE CHECKLIST

- Bed in destination hospital identified and availability confirmed (with nursing team / bed manager): ☐
- Consultant in destination hospital has agreed transfer: ☐
- Parents / Carers informed of transfer and any parental concerns discussed: ☐
- Parents / Carers given map/postcode & ward contact number if not travelling with the team ☐
- Parents / Carers invited to accompany the child or separate transport arranged to receiving unit: ☐
- ALERTS eg allergies, safeguarding, CAMHS etc clearly documented AND verbally communicated to receiving team: ☐

TRANSPORT

AMBULANCE reference number:

TRANSPORT			
Time ambulance called:		Patient secured using eg ACR harness	☐
Time ambulance arrived (referring hospital):		All equipment appropriately secured in ambulance	☐
Time transport team + patient left referring hospital:		- tug test done if require O_2 for ventilated patient	☐
Time of arrival at receiving hospital:		Transfer /own mobile phone available	☐
Time transport team arrived back at base hospital:		Return travel organised / confirmed & team aware:	☐
		Money /cards for emergencies (transfer team):	☐

PATIENT SPECIFIC INSTRUCTIONS FOR TRANSFER

- MINIMUM monitoring: ECG, SpO_2, NIV BP: ☐
- If intubated & ventilated monitor ET CO_2 ☐ IV access x 2: ☐
- Nil by Mouth / consider NG tube for surgical patients : ☐
- Blood glucose, temp & pupils checked before +/- after transfer: ☐
- Maintenance IV fluids +/- iv anti-emetics (esp. older child): ☐

LINES/CATHETERS/TUBES

1 Site/size:	Insertion date:
2 Site/size:	Insertion date:
3 Site/size:	Insertion date:
4 Site/size:	Insertion date:

PAPERWORK FOR TRANSFER (PHOTOCOPY THE FOLLOWING TO TAKE WITH PATIENT):

- Referral letter ☐
- Recent clinic letter / summary for all long term patients ☐
- Current medical & nursing notes including blood results, blood gases + copies ECG/rhythm strip (as appropriate) ☐
- Current drugs chart, PEWs/observation chart and fluid charts ☐
- Request radiology uploaded onto PACS or CD of radiology to be transferred with patient ☐

OBSERVATIONS RECORDED ON TRANSFER:

Observations completed & recorded just prior to departure ☐	Continuously monitor all observations during transfer & record (circle choice) MIN every 15min/30 mins, including on arrival
Pain assessment	Time last analgesia (drug / dose):

Date						Type/mode respiratory support:										
Time																
Temperature + site °C																
Heart Rate & Blood Pressure	200															200
	190															190
	180															180
	170															170
	160															160
	150															150
	140															140
	130															130
	120															120
	110															110
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	80															80
	70															70
	60															60
	50															50
	40															40
	30															30
	20															20
FiO_2																
SpO_2 +/- ET CO_2																
PIP/PEEP/Flow																
Rate																
Tidal Volume																
Neurological Assessment	AVPU															
	Pupil R / L															

Allergies:	Weight	Last dose & time of antibiotics / antiepileptic	

Date	Time	Drugs / Fluid Bolus	Dose	Route	Total Volume	Over / duration	Prescribers' Signature	Print	GMC No	Check/ Admin	Time Administered

Date	Time	Continuous Infusion Medicine	Total amount of drug	Diluent	Total Volume	Route	Rate range (ml/hr)	Dose Range	Prescribers' Signature	Print	GMC No	Check/ Admin	Time Start	Time Stop

Details of any problem(s) or incident(s) en-route:

Handed over to (name / grade): **Handover by (name / grade):** **Time handover:**

2 copies STOPP form (for patient notes at referring and receiving hospitals) ☐ **Patient documentation handed over:** ☐

All drugs/fluids/blood products handed over / disposed: Signed: