

Directions for using the Pre-transport Stabilization Self-Assessment Form

1. Either during pre-transport stabilization care, or immediately after the infant is transported, complete the demographic information in the Patient Information section of the form.
2. Under Indications for Referral, select all of the suspected or confirmed diagnoses that apply at the time of referral.
3. Times A, B, and C are used repetitively on the first and second pages of the form. The idea is to record the vital signs, physical exam, and stabilization procedures that were performed:
 - At the time the transport team was called (transport was requested) = Time A
 - Upon arrival of the transport team in your nursery = Time B
 - Upon departure of the transport team = Time C
 - The transport team should help complete the Time C items, unless the infant is unstable and time does not allow. In that case, if at all possible, ask the team to leave a copy of their stabilization record so you can complete the Time C items.
4. The overall idea is to evaluate stabilization care by looking at three specific time intervals:
 - What stabilization actions were taken at the time it was determined the infant was ill?
 - What stabilization actions were taken while awaiting the team's arrival?
 - What stabilization actions were completed by the team? The following scenarios are possible:
 - The team arrives and stabilization is complete so they do not need to do more than assess the baby, attach the transport equipment and move the baby into the incubator.
 - The team arrives quickly and completes the stabilization procedures that you did not have time to complete.
 - The team arrives and determines that additional care is needed, and therefore, additional actions are taken (such as intubating the patient, inserting lines, changing an ET tube, administering certain medications, etc.).
 - By recording these actions, it is hoped that the nursing and medical leadership team will be able to assess adequacy of pre-transport (or transfer) stabilization care.

If you have trouble filling out the form, or you need additional expertise to answer the questions on the third page of the form, then the transport team should be consulted for assistance. It would not be presumptuous to say that transport teams would love the opportunity to help their community hospitals to improve their ability to provide optimal pre-transport stabilization!

Pre-transport Stabilization Self-Assessment Tool (PSSAT)

PATIENT INFORMATION

Birth weight: grams Birth order: _____ of _____

Growth: AGA SGA LGA Gender: Male Female Ambiguous

Estimated Gest. Age: - weeks/days (ex: 34-3/7)

Baby admitted from: Labor & Delivery Mother-baby unit
 Nursery Emergency room

Indications for referral (circle all that apply)

Prematurity Respiratory distress Sepsis Cardiac Metabolic Genetic Neurologic Hematologic Surgical Birth depression

Other (explain): _____

Resuscitation at birth: Suction Blow-by oxygen CPAP
 CPAP & PPV Intubation & PPV Chest compressions

Resuscitation meds (list): _____

Other meds (list): _____

Apgar at 1 minute: 5 min: 10 min:
 15 min: 20 min:

TIME

Age of baby in Days and Hours after birth – at time transport team called _____ Days _____ Hours

A Transport team called _____ AM PM **B** Transport team arrived at nursery _____ AM PM **C** Transport team departed nursery _____ AM PM

Note: these times will be used throughout this form. When answering questions, evaluate the parameter closest to time A, B, and C

Time patient died; transport aborted _____ AM PM (complete remainder of form even if patient died)

VITAL SIGNS

	Temperature °C °F	Axillary or Rectal	Heart Rate	Respiratory Rate	Blood Pressure Systolic/Diastolic	Mean	Method (RA, LA, RL, LL) or Arterial
Time A	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/>	_____
Time B	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/>	_____
Time C	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/>	_____

PHYSICAL EXAM

Perfusion/Pulses	Capillary Refill Time (sec.) over chest	Capillary Refill Time (sec.) over knee	Pulses	Pulses equal upper & lower	(If no, explain)
Time A	_____	_____ sec.	Normal Decreased Increased	YES NO	_____
Time B	_____	_____ sec.	Normal Decreased Increased	YES NO	_____
Time C	_____	_____ sec.	Normal Decreased Increased	YES NO	_____

Retractions	Severity (circle all that apply)	Location (circle all that apply)	O ₂ Saturation	FiO ₂
Time A	Mild Moderate Severe Gasping	Substernal Intercostal Subcostal	<input type="text"/> %	<input type="text"/> %
Time B	Mild Moderate Severe Gasping	Substernal Intercostal Subcostal	<input type="text"/> %	<input type="text"/> %
Time C	Mild Moderate Severe Gasping	Substernal Intercostal Subcostal	<input type="text"/> %	<input type="text"/> %

Level of consciousness	Response to noxious stimuli (circle all that apply)	Other (explain)
Time A	Withdraws/good tone, cries Lethargic, no cry Seizure(s) No response, comatose	_____
Time B	Withdraws/good tone, cries Lethargic, no cry Seizure(s) No response, comatose	_____
Time C	Withdraws/good tone, cries Lethargic, no cry Seizure(s) No response, comatose	_____

Paralytic used (i.e. pavulon)? Yes No Reason given: _____

Time/dose of all Opioids given past 24 hrs (list type) _____

Time/dose of all Sedatives given past 24 hrs (list type) _____

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Use Time A B C from page 1	Time A _____	Time B _____	Time C _____
IV in place?	Y N Location _____	Y N Location _____	Y N Location _____
IV fluid infusing?	Y N Type _____ Rate ml/kg/day _____	Y N Type _____ Rate ml/kg/day _____	Y N Type _____ Rate ml/kg/day _____
UVC in place?	Y N Tip location _____	Y N Tip location _____	Y N Tip location _____
UAC in place?	Y N Tip location _____	Y N Tip location _____	Y N Tip location _____
Glucose – closest to 15 – 30 minutes of this time	Y N Value mg/dL _____	Y N Value mg/dL _____	Y N Value mg/dL _____
Glucose bolus given?	Y N Fluid _____ Amount _____	Y N Fluid _____ Amount _____	Y N Fluid _____ Amount _____
Oxygen in use?	Y N % _____	Y N % _____	Y N % _____
Pulse oximetry on?	Y N O ₂ sat _____	Y N O ₂ sat _____	Y N O ₂ sat _____
CPAP in use?	Y N Type _____ Pressure _____	Y N Type _____ Pressure _____	Y N Type _____ Pressure _____
PPV provided?	Y N Pressures _____ Rate _____	Y N Pressures _____ Rate _____	Y N Pressures _____ Rate _____
Tracheal intubation?	Y N Cm at lip _____	Y N Cm at lip _____	Y N Cm at lip _____
ET tube properly secured?	Y N	Y N	Y N
Chest tube in place?	Y N	Y N	Y N
Chest needle or cath placed?	Y N	Y N	Y N
Volume bolus?	Y N Type _____ Amount _____	Y N Type _____ Amount _____	Y N Type _____ Amount _____
On dopamine?	Y N Dose mcg/kg/min _____	Y N Dose mcg/kg/min _____	Y N Dose mcg/kg/min _____
CBC with differential done?	Y N	Y N	Y N
Blood culture drawn?	Y N	Y N	Y N
Antibiotics given?	Y N	Y N	Y N Additional antibiotic or dose given?
On radiant warmer on ISC?	Y N	Y N	Y N
In incubator on ISC?	Y N	Y N	Y N
In incubator on air temp?	Y N	Y N	Y N

Time	Indicate CBC, ABG, Venous	Ventilation settings			Rate	FiO ₂	Method B/M? Prongs? Hood? Intubated?		
		PIP/PEEP							
AM PM	<input type="checkbox"/>	pH _____	pCO ₂ _____	pO ₂ _____	HCO ₃ _____	BE _____	_____ / _____	_____ %	_____
AM PM	<input type="checkbox"/>	pH _____	pCO ₂ _____	pO ₂ _____	HCO ₃ _____	BE _____	_____ / _____	_____ %	_____
AM PM	<input type="checkbox"/>	pH _____	pCO ₂ _____	pO ₂ _____	HCO ₃ _____	BE _____	_____ / _____	_____ %	_____

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SPECIFIC INTERVENTIONS

Airway

ET tube location (cm marking **at the lip**) when Team arrived: _____ cm

Was ET tube location readjusted **prior** to the transport team arrival? Y N Explain: _____

Was ET tube location readjusted **after** transport team arrival? Y N Explain: _____

Was patient **re-intubated** by the transport team? Y N Explain: _____

Other: _____

Antibiotics

Time _____^{AM}/_{PM} Order for antibiotics given Order was (Circle one) Written Verbally given

Time _____^{AM}/_{PM} Blood culture obtained

Time _____^{AM}/_{PM} Antibiotic 1 begun (name/dose) _____

Time _____^{AM}/_{PM} Antibiotic 2 begun (name/dose) _____

Other stabilization efforts not yet described: _____

SELF-EVALUATION QUESTIONS

Healthcare providers involved with this stabilization

(to be completed by initial healthcare facility providers). Healthcare provider who requested the transport: Family practice Pediatrician Neonatologist Midwife Nurse Practitioner Physician Assistant

Was physician or primary healthcare provider PRESENT at patient's bedside or in nursery at the time of transport team arrival?

Yes No (If no, explain): _____

TIME consultations made: _____^{AM}/_{PM} Family practice called _____^{AM}/_{PM} Pediatrician called _____^{AM}/_{PM} Neonatologist called

Provide name or initials of other healthcare providers involved with this stabilization:

Nurse (RN) _____

RT _____ LPN _____ Nurse Assistant _____ Other: _____

1. We feel our strengths with this stabilization effort were: _____

The following people should be commended: _____

2. We feel our weaknesses with this stabilization effort were: _____

3. We encountered the following barriers that altered our ability to work as a team: _____

4. We wish we had the opportunity to learn more about (list all educational needs): _____

5. We encountered the following problems that affected our ability to perform the stabilization we would like to perform (include equipment malfunction or equipment not available, slow response times from other healthcare departments, uncertainty about the diagnosis, communication issues, etc). _____

6. The next time we have to stabilize a sick neonate, we would change the following: _____

NAME OF PERSON completing this form & date: _____