Paediatric retrieval services: is it better to 'stay and play' or 'scoop and run'?

Paediatric intensive care retrieval teams have been established in UK practice since the reorganization of paediatric intensive care in 1998 (Ratcliffe, 1998). This service model has been replicated across the country, providing advice and support to district general hospitals as well as retrieval and transfer of critically unwell patients.

All patients need to be deemed stable enough for transfer although some clinicians would advocate a 'scoop and run' approach where speed of transfer is prioritized over stabilizing the patient. Others deploy a more comprehensive management strategy involving further interventions before transfer which has been described informally as 'stay and play'. There is little evidence to favour one strategy over the other, but both have a series of advantages and disadvantages.

'Stay and play'

The benefits of this philosophy are that further diagnostic testing and/or simple procedures in unstable patients can be performed at the bedside. Some consider this to be the standard of care and that delivery of paediatric intensive care at the bedside will maximize stability and minimize risk during the transfer. This inevitably requires the retrieval team to work alongside the local team in an unfamiliar environment, offering specific advanced paediatric skills. This may reduce further deterioration during the transfer or prevent further interventions needed en route, which would inevitably be more challenging and less safe (Henning, 1992). Reducing instability and increasing safety is always beneficial for the patient and the transfer. However, it can delay transfer and the ultimate need for specialist input and definitive treatment.

'Scoop and run'

The objective of this approach is to make speed of transfer the priority so that the patient receives definitive specialist treatment as soon as possible. This strategy was examined by Haas and Nathens (2008), looking at the initial management of trauma patients in the community. The evidence examined from patients receiving prehospital care is mixed. The results of the care received depend heavily on the type of intervention offered, the distance of the transfer, and the skills of the transfer team (Haas and Nathens, 2008).

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While some comparisons can be drawn with prehospital care, retrieval from other hospitals is considered to be a different situation. Although trained medical and nursing personnel are already providing care to these patients in a hospital setting, these patients ultimately require a higher level of care or specific interventions that necessitates further transfer. It is vital that these patients are moved quickly so that they that can receive specific expertise or technology, e.g extracorporeal membrane oxygenation or specialist airway management from a paediatric ear, nose and throat surgeon. Other situations requiring specialist intervention that should not be delayed include neurosurgical emergencies. Advice on the urgency of the transfer should be sought from the neurosurgical team (Winton, 2005).

Conclusions

It is well recognized that patient outcomes depend on technology, equipment and expertise of the personnel available within each hospital. Inter-hospital transfer is frequently required to move critically unwell patients to a paediatric intensive care unit where they can receive definitive treatment. All patient transfers carry some risk but these must be balanced against the need for further essential treatment. When carried out by specially trained transport teams, ongoing stabilization can be delivered at the bedside to mitigate the risk of transfer but this can cause further delay in definitive treatment.

It would be difficult ethically and logistically to conduct a trial comparing the 'stay and play' *vs* the 'scoop and run' strategies. Each patient situation is individual and as such every decision needs to be on a case-by-case basis with the team balancing all the risks and benefits for the patient. Although pre-transfer stabilization can mitigate the risks of transfer, there are select situations where rapid access to tertiary care is essential. In these cases, the risk of transfer is lower than the risks of ongoing stabilization in the referring centre and the subsequent delay in receiving definitive treatment. **BJHM**

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