NHS Shetland

# Resuscitation Policy

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| --- | --- |
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| Author: | Resuscitation Committee |
| Review date: | October 2025 |
| Security classification: | OFFICIAL – Green: unclassified information |

If you would like this document in an alternative language or format, please contact Corporate Services on 01595 743069.

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## NHS Shetland Document Development Coversheet*

| Name of document | Resuscitation Policy | | |
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| Document reference number | MDPOL013 | New or Review? | Review |
| Author | Resuscitation Committee | | |
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| Executive lead | Kirsty Brightwell, Medical Director | | |
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| Proposed groups to present document to: | | |
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| | | | | |

| Examples of reasons for presenting to the group | Examples of outcomes following meeting |
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| • Professional input required re: content (PI) | • Significant changes to content required – refer to Executive Lead for guidance (SC) |
| • Professional opinion on content (PO) | • To amend content & re-submit to group (AC&R) |
| • General comments/suggestions (C/S) | • For minor revisions (e.g. format/layout) – no need to re-submit to group (MR) |
| • For information only (FIO) | • Recommend proceeding to next stage (PRO) |
| • For proofing/formatting (PF) | • For upload to Intranet (INT) |
| • Final Approval (FA) | • Approved (A) or Not Approved, revisions required (NARR) |

***To be attached to the document under development/review and presented to the relevant group**

**Please record details of any changes made to the document in the table below**

| Date | Record of changes made to document |
|---|---|
| 27/07/22 | Historical policy (CSPOL002) transferred to new template and new reference number issued. Links and guidance updated in line with new guidance from Resuscitation Council UK website. Addition of training requirements for neonatal care. |
| 07/06/2024 | P13 Updated with recent Maternity Flow chart in the event of a 2222 call. |
| 07/06/2024 | P17 Updated with the recent version of the event log. |
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## 1. Purpose

1.1. The purpose of this policy is to ensure there is a standardised approach to resuscitation practice and training within Shetland NHS Board and to clearly identify key roles and responsibilities for equipment, training and responses to patient care needs.

## 2. Introduction

2.1. Shetland NHS Board supports:

- The joint statement from the Royal College of Anaesthetists, the Royal College of Physicians of London, the Intensive Care Society, and the Resuscitation Council UK relating to Cardiopulmonary Resuscitation.
- The joint statement from the British Medical Association, the Resuscitation Council UK and the Royal College of Nursing describing Decisions relating to Cardiopulmonary Resuscitation.

## 3. Maintaining an effective resuscitation service

3.1. The Board's Resuscitation Committee is responsible for all resuscitation issues within the hospital and community, including operational polices governing resuscitation practice and training; advising on the purchase, maintenance and positioning of resuscitation equipment and will advise on the composition of the Cardiac Arrest Team.

3.2. Departmental Managers are responsible for ensuring all resuscitation equipment is checked and in working order according to the check lists provided by the Resuscitation Committee; this should be undertaken daily in acute areas and weekly in non-acute areas. Medical Physics are responsible for the testing and maintenance of the defibrillators and suction/oxygen apparatus found on the resuscitation trolleys and should be contacted in the event of a fault. The Resuscitation Training Advisor will undertake periodic audit of the checking procedure and contents of the trolleys or bags and report results to the Resuscitation Committee.

3.3. It is the responsibility of managers (or the staff member in charge) to ensure that the Resuscitation Trolley (or bags) are restocked and checked as a priority after use in an emergency.

3.4. The Board's Resuscitation Training Advisor(s) and Resuscitation Trainers are responsible for delivering a range of training in resuscitation techniques to NHS Shetland employees in accordance with the latest Resuscitation Council UK guidelines

3.5. Shetland NHS Board recognises that clinical staff should undergo resuscitation training to a level compatible with their expected clinical responsibilities; however, all staff will be encouraged to participate in basic life support training.

3.6. Clinical staff who care for adults and/or children and/or neonates must possess the skills and competencies as outlined in Appendix 1 & 2 at the level appropriate to their expected responsibilities.

3.7. Managers are responsible for ensuring their staff are made aware of available training and can attend at appropriate intervals to ensure they can fulfil their expected clinical responsibilities.

3.8. The Board's Resuscitation Training Advisor will undertake work requested by the Resuscitation Committee in order to maintain and improve standards of care.

3.9. The minimum members of the Cardiac Arrest Team are: -

**9am – 5pm daily**

On-call Medical Junior Doctor

On-call Surgical Junior Doctor

Nurse holding 2222 bleep

Consultant Anaesthetist

Resuscitation Training Advisor (when available)

**5pm – 9am daily**

On-call Medical Junior Doctor

On-call Surgical Junior Doctor

(Until shift change over time then one on call junior doctor overnight)

Nurse holding 2222 bleep

Consultant Anaesthetist

3.10. Reception staff will rotate to perform a 2222 test call and will be responsible for the maintenance of cardiac arrest bleeps and systems.

3.11. The 2222 call is used for cardiac arrest, peri-arrest and psychiatric emergencies where help is needed quickly. Additional members of the team can be requested as required for example, midwife, anaesthetist, trauma team, managing violence and aggression team.

3.12. Health professionals carrying the 2222 bleeps must hold a current advanced life support provider certification.

## 4. Prevention of Cardiopulmonary Arrest

4.1. Early warning scoring systems aid the identification of patients who are exhibiting signs of clinical deterioration and at risk of cardiopulmonary arrest, and should be used in all clinical areas.

4.2. Nursing, medical and consultant staff should be familiar with the early warning scoring system and associated escalation plan currently in use.

4.3. Treatment escalation and limitation plans should be considered where deterioration can be anticipated but that certain tests and treatments would not be of benefit.

## 5. Cardiopulmonary Resuscitation (CPR)

5.1. **CPR is undertaken immediately and in full**, in an attempt to restore breathing (sometimes with support) and spontaneous circulation in a patient in cardiac and/or respiratory arrest. CPR is a relatively invasive medical therapy usually including external chest compressions, attempted defibrillation, and ventilation of the lungs and injection of drugs.

5.2. CPR does not include measures such as analgesia, antibiotics, drugs for controlling symptoms, feeding or hydration (by any route), investigation and treatment of a reversible condition, seizure control, suction, consultation with patient and relevant others on the basis of clinical need whether a Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) order is in place or not.

5.3. If the patient concerned is risk assessed as having, or being likely to have, an infectious disease, then this should be stated when the cardiac arrest call is made.

5.4. CPR should be started immediately and in accordance with the current Resuscitation Council UK guidelines. Appropriate personal protective equipment should be worn.

5.5. If there is no explicit decision made in advance about CPR and the wishes of the patient are unknown there should be a presumption that health professionals will commence CPR in the event of a cardiopulmonary arrest. (See Appendix 5 for more information)

5.6. The receiving consultant (physician or surgeon) must be informed as soon as possible of all cardiac arrests in patients under their care.

5.7. In the main hospital building, it is expected that defibrillation will be attempted, if appropriate, within 3 minutes of the collapse.

5.8. It is recognised that in a remote & rural setting trained assistance and equipment may not be easily available, and NHS Shetland supports the efforts of lone practitioners in these difficult situations.

5.9. Once trained assistance arrives a Team Leader must be determined. Who this is depends on clinical knowledge, skills and experience in addition to current Advanced Life Support provider status or equivalent.

5.10. The team leader is responsible for directing and co-ordinating the attempt, ensuring that current guidelines are followed, the safety of those present, ending the attempt when indicated, completion of documentation (including 2222 audit), communication with relatives and handover to clinical teams. This also includes diagnosis and documentation of death if appropriate. The team leader is responsible for initiating a team brief post event.

5.11. Advanced Life Support should be commenced as soon as practicable. Any risks to the rescuers, including infectious disease, should be communicated as early as possible, and appropriate personal protective equipment donned. See appendix 7 and 8 for ALS flowcharts.

5.12. Decisions about continuation of CPR must be made on the basis of an individual assessment of each patient's case and involve the team present.

5.13. There may be situations when CPR is initiated but during the attempt further information comes to light that makes continued CPR inappropriate. That information may consist of a DNA CPR decision, or a valid and applicable Advance Statement refusing CPR, or additional clinical information indicating CPR will not be successful. In such circumstances, continued CPR is inappropriate and should be stopped (See appendix 5).

5.14. The presence or absence of a DNA CPR form may not override clinical judgement about what will be of benefit to the patient in an emergency (e.g. Choking, anaphylaxis).

5.15. In the event of a successful resuscitation attempt, post resuscitation care should be provided within a critical care setting with appropriate monitoring, nursing staff ratios and medical support.

5.16. Patient transfers to critical care areas or to other hospitals should be undertaken after careful planning and with the patient accompanied by suitably competent and qualified staff.

5.17. Adult and Paediatric Retrieval services should be involved in care at the earliest opportunity.

5.18. Special considerations apply to maternal emergencies and when resuscitating children, neonates and victims of trauma. It is imperative that personnel with experience of such emergencies are present in the resuscitation attempt. Personnel call lists are held in reception for special circumstances when additional personnel are required. The caller needs to specify which members on the list are required (Appendix 3).

## 6. Avoiding inappropriate CPR attempts

6.1. Discussions and decisions relating to DNA CPR and ceilings of care should be considered as soon as possible during admission, and whenever deterioration takes place.

6.2. Decisions should be clearly documented in the medical notes, updated within current NHS database systems and be part of medical and nursing handovers. Decisions should be appropriately handed over when patients move between hospitals and between primary and secondary care.

6.3. Decisions made by other health providers should be reassessed as part of the ongoing care of the individual and when their condition changes, unless the decision is deemed appropriate until end of life.

6.4. When people are discharged home with active DNA CPR decisions, clinical staff should follow the National DNA CPR policy to ensure continuity of care and safe transfer.

## Appendix 1 – Resuscitation training provision

### Adult Resuscitation training:

Basic life-support (BLS). BLS courses will be run in Shetland at regular intervals. These will be open to all Shetland NHS Board staff.

Immediate life-support (ILS). The ILS course will be run in Shetland at regular intervals. These will be open to all Shetland NHS Board staff requiring additional skills to that covered in BLS training, e.g. junior hospital medical staff, registered nurses working in acute areas, general practitioners, nurses on non-doctor islands.

Advanced life-support (ALS). ALS courses will be run in Shetland periodically. Staff acting as cardiac arrest team leader, e.g. Hospital consultants, junior doctors and Nurse 2222 bleep holders must maintain ALS provider status.

### Paediatric Resuscitation training:

Basic life-support (BLS). Paediatric BLS is covered in all BLS courses (see above).

Advanced life-support. The Paediatric Immediate Life Support (PILS) course will be run in Shetland at regular intervals. This will be open to all NHS board staff requiring additional skills to those covered in the paediatric BLS training, e.g. Hospital medical staff, registered nurses working in acute areas, general practitioners, nurses on non-doctor islands.

Staff acting as cardiac arrest team leader, e.g. Hospital consultants, junior doctors and Nurse 2222 bleep holders must maintain APLS provider status.

### Neonatal Resuscitation training:

Newborn basic life-support (NBLS) and advanced life-support (NLS) training will take place in the Maternity Unit at the Gilbert Bain Hospital **when local trainers are available and when requested by staff.** This training is open to all Shetland NHS Board staff resuscitating neonates as part of their duties. **Additional neonatal resuscitation and stabilisation courses run by the SMMDP will also be made available locally at intervals**.

Neonatal courses (scottishmaternity.org)

### Pre-hospital resuscitation training:

BASICS courses will be run periodically in Shetland and focus on pre-hospital care of adult and child. These are aimed specifically at GPs, A&E staff, Health Centre/Practice Nurses, Non-Doctor Islands Nurses, Ambulance staff and Consultants.

## Appendix 2 – Competency requirements

### Adults:

| | | |
|---|---|---|
| BLS: | Assessment of conscious level<br>Airway opening manoeuvres<br>Assessment of breathing<br>Recognition of cardiac arrest<br>Exhaled air ventilation (including use of a pocket mask)<br>Cardiac compressions, technique, rate, rhythm, ratio<br>Recovery position and management of choking<br>Use of AEDs | Yearly update (**either** as standalone courses **or** within advanced course) |
| ILS: | BLS plus:<br>Patient assessment using ABCDE approach<br>Cardiac arrest cause and prevention<br>Airway management with adjuncts (including LMA)<br>Breathing management with Bag-valve mask<br>Monitoring, cardiac arrest rhythms plus safe defibrillation<br>ALS treatment algorithm<br>Drugs and delivery<br>Handover and DNA CPR | Yearly update<br>(even if holding a current ALS certification) |
| ALS: | BLS and ILS plus<br>Advanced airway management<br>Monitoring and rhythm recognition<br>12 lead ECG<br>Bradycardia and Tachycardia<br>Blood gases<br>Cardiac arrest in special circumstances | As stated on certification<br>Yearly practice via ILS or equivalent |

### Children:

| | | |
|---|---|---|
| BLS | As above for age groups under one, one to puberty | Yearly update |
| PILS | BLS plus<br>Cardiac arrest protocols and rhythm recognition<br>Airway management with adjuncts<br>Bag-valve mask ventilation<br>Vascular access (intra-osseous)<br>Introduction to the seriously injured child (plus spinal immobilization)<br>Introduction to the seriously ill child<br>Handover and CYPADM | As stated on certification<br>Yearly practice via PLS or equivalent |

| | | |
|---|---|---|
| APLS | BLS and PLS plus<br>Advanced airway management and vascular access<br>Immediate management of sick/injured child<br>Resuscitation and stabilisation of sick/injured child | As stated on certification<br>Yearly practice via PLS or equivalent |

**Neonates:**

| | | |
|---|---|---|
| BLS | Drying and covering of neonate<br>Assessment of neonate<br>Airway opening manoeuvres<br>Exhaled air ventilation<br>Pocket mask ventilation<br>Chest compressions<br>Calling for help | Yearly update |
| NLS | As above plus:<br>Advanced airway management (including suction for meconium)<br>Ventilation of the lungs with bag-valve-mask or Tom Thumb<br>Vascular access (including Umbilical vein catheter)<br>Administration of drugs | Yearly update |

**Pre-Hospital Care:**

| | | |
|---|---|---|
| BASICS | Up-to-date information available at www.basics-scotland.org.uk | As stated on certification<br>Yearly practice encouraged |

**Appendix 3 – Call out lists for special circumstances**

The responsibility for initiating a trauma team call out of hours out lies with the senior nurse in the accident and emergency department and the junior doctor on call.

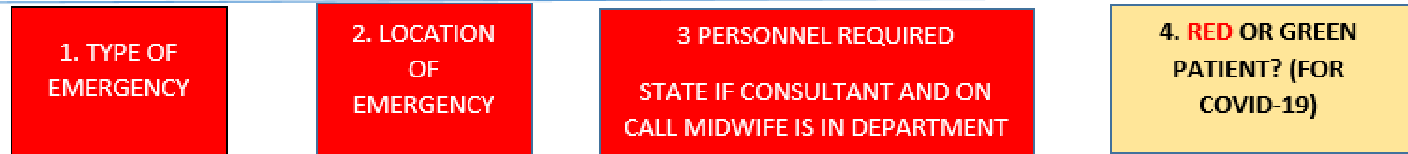
| **Trauma Team Call out List** |
| --- |
| CONSULTANT ANAESTHETIST |
| CONSULTANT SURGEON |
| ANAESTHETIC NURSE |
| A&E NURSE |
| RADIOGRAPHER |
| LAB TECHNICIAN |
| DUTY PORTER |
| **ASK THEM TO COME IN IMMEDIATELY FOR TRAUMA CASE** |

| **Paediatric Call out list** |
| --- |
| For emergencies and cardiac arrest call **2222** |
| In addition ask for: |
| ANAESTHETIST |
| ANAESTHETIC NURSE |
| CHILDREN’S NURSE (DAY TIME) |

# 2222 CALL FROM MATERNITY

PROCEDURE FOR EMERGENCY SITUATION IN MATERNITY DEPARTMENT

**MATERNITY PLEASE STATE:**




**4. RED OR GREEN PATIENT? (FOR COVID-19)**

**THE RECEPTIONIST WILL THEN CONFIRM THE TYPE OF EMERGENCY AND STAFF REQUESTED**

Maternity staff please stay on the line until the receptionist has confirmed the above

**THE RECEPTIONIST WILL THEN CALL LISTED PERSONNEL WITH THE MESSAGE:**

**Please come in now for "TYPE OF EMERGENCY" AND "LOCATION OF EMERGENCY"….."Red or Green Pathway"**

## OBSTETRIC EMERGENCY

**MATERNITY PLEASE SPECIFY required personnel for Receptionist to call**

1. Consultant Obstetrician required
2. On- call midwife required
3. Surgeon and theatre team required
4. Contact A&E
5. Call in anaesthetist and Anaesthetic Nurse
6. Surgical SHO (day)
7. On call nightshift SHO (night)
8. Night Sister (Hospital Coordinator 20:00 – 08:00
9. On-call lab staff if required

## NEONATAL EMERGENCY

**MATERNITY PLEASE SPECIFY required personnel for Receptionist to call**

1. Consultant Obstetrician required
2. On- call midwife required
3. Anaesthetist and Anaesthetic Nurse
4. Contact A&E
5. Night Sister (Hospital Coordinator 20:00 – 08:00)
6. On-call lab staff if required

## CATEGORY 1 CAESAREAN SECTION

### BETWEEN 08:00-20:00

**MATERNITY PLEASE SPECIFY required personnel for Receptionist to call**

1. Consultant Obstetrician required
2. On- call midwife required
3. Theatre team (normally in weekdays (08.30 – 17.00) and may also be in 08.30 – 14.00 at weekend)
4. Anaesthetist
5. Contact A&E
6. Surgeon
7. Surgical SHO
8. Confirm if on call lab staff required

### BETWEEN 20:00 – 08:00

**MATERNITY PLEASE SPECIFY required personnel for Receptionist to call**

1. Consultant Obstetrician required
2. On- call midwife required
3. Contact A&E
3. Theatre team
4. Anaesthetist
5. Surgeon
6. Night shift SHO
7. Confirm if on call lab staff required

## CARDIAC ARREST

**RECEPTION PLEASE CALL**

CARDIAC ARREST TEAM

Anaesthetist

Consultant Obstetrician

## Category 2 Section

08.00 – 20.00 | 20.00-08.00

MATERNITY PLEASE SPECIFY required personnel for Receptionist to call

State clearly category of section

Personnel required is the same as for Category 1 Section

## Appendix 4 – Emergency bleep system

### Bleep & Pagers

There are different bleep and pager systems in operation at the Gilbert Bain Hospital. It is important that all bleeper/pager holders and users understand the way in which each system operates.

### Multitone bleep system - 2222 cardiac arrest procedure

Certain Multitone Bleep numbers have been programmed into the Multitone system as a 'group call'. This means that reception can contact these entire bleep holders with one call. Members of the cardiac arrest team should ensure they carry one of these bleeps.

### Test calls procedure

Test calls are used as a way of ensuring the receptionists have the opportunity to practice, to show that the system is functioning correctly and to highlight problems with individual bleeps.

The test call happens randomly once each week. This means there will be no set time or day – it could happen anytime between the hours of 9am and 11pm any day of the week.

When you receive the test call message from you bleep, please phone reception (dial 0) to register that you have received the call and heard the message.

This is **essential** if you are on-call when the test goes out. If you do not respond but are currently on-call then reception will bleep you again. This is to ensure that the 2222 bleep system and individual bleeps are working correctly. All test calls are subject to audit.

### How to contact any individual Multitone bleep holder procedure

Using any internal phone follow the procedure detailed below. For outside callers, and if you do not know the bleep number, please call reception on 0.

### Pagers

The pager system is entirely separate from the Multitone system. Each pager has its own unique number and can be contacted in two different ways. Either a programmed number being dialled or the pager number being dialled can activate the pagers from GBH reception. The receptionist has two options; either to dial a numeric number, or wait for an operator and leave a message which then appears on the pager.

If you wish to contact a pager please phone GBH reception giving the name or number you wish to contact.

**Making a 2222 cardiac arrest call**

- Dial 2222
- **Red phone** rings and receptionist answers
    - State the reason for the call and location.

      Example:

      'Cardiac Arrest, Ward 3, Gilbert Bain Hospital' If an infectious disease is suspected say…

      'Cardiac Arrest, Ward 3, possible infectious disease'. The receptionist will terminate the call.
- Receptionist enters protocol into console device and at the right time speaks the message into the microphone.

  **Voice Message** is heard giving location

**Contacting an individual multitone bleep holder**

1. Dial 5000
2. When prompted enter three digit bleep number (user number)
3. When prompted enter your phone number (4 digit number)- Wait for confirmation
4. End call & wait

**Appendix 5 – Scottish national policies**

- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – integrated adult policy: guidance
- Resuscitation Planning Policy for Children and Young People (under 16 years) – Children and Young People Acute Deterioration Management (CYPADM)

## Appendix 6 – 2222 Event Log

### Event Log

Number of nursing staff: ☐ Number of Doctors: ☐
(Please tick) Senior Nurse: ☐ Anaesthetist: ☐ Consultant: ☐

| TIME | ACTION/Rhythm/drug admin |
|---|---|
| | |
| | |
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### PAUSE – debrief tool...

1. • People
   • Thank all for participation in 2222. Check everyone is **ok** and **willing** to participate in debrief. Participation from all is encouraged but not essential.
2. • Analyse
   • Member of the team best placed to share a summary of event should briefly run through scenario.
3. • Understand
   • Does anyone have any questions/require clarity on any points?
4. • Safety
   • Were there any challenges? Any particularly good practice? Learning points?
5. • Evaluate and summarise event. Close debrief.
   • The team leader should complete the **2222 audit** form
   • **document learning points.**

| Learning Point 1 | Learning Point 2 |
|---|---|
| | |

(Office use) Discharge information:

Discharge date: ☐☐ / ☐☐ / ☐☐
In-hospital death date: ☐☐ / ☐☐ / ☐☐

Alive at 6 months: YES/NO

**Adverse Event Reporting (Via Datix)**
**Should be completed for each 2222 call**
Send a copy of this form to:
shet.practiceeducation@nhs.scot &
shet.datix@nhs.scot

### 2222 calls/Resuscitation Audit Form version 8

TEAM leader: ____________________ Department: ____________________

Location of arrest: Out of Hospital ☐ A&E ☐ Ward 3 ☐* Ward 1 ☐* Other ____________

Date of call: ☐☐ / ☐☐ / ☐☐
Time of Collapse: ☐☐ : ☐☐
Time of call: ☐☐ : ☐☐

Reason for call:
Cardiac Arrest: ☐
Respiratory Arrest: ☐
Medical Emergency: ☐
False alarm: ☐

Patient label:
Hospital number
Age
Sex

Medical Emergency description/Additional Information:

Free text box:

Witnessed: YES ☐ NO ☐ CPR performed: YES ☐ NO ☐ Bystander CPR: YES ☐ NO ☐

Initial Rhythm:
VF ☐ VT ☐ PEA ☐ Asystole ☐

Subsequent Rhythms:
VF ☐ VT ☐ PEA ☐ Asystole ☐ Other ☐

Was perfusing rhythm achieved? YES ☐ NO ☐

**Airway/ventilation intervention attempted:**

Pocket mask/bag-valve mask: ☐
Airway inserted: ☐

LMA: ☐ ETT: ☐ OPA/NPA: ☐ ETCO2 ☐

Inserted By:

Paramedic/Nurse/Doctor/Anaesthetist/other

**Defibrillation:** YES ☐ NO ☐

Manual: ☐ AED: ☐

Time of first shock: ☐☐ : ☐☐

First shock performed by:
Paramedic/Nurse/Doctor/other

Total number of Shocks: ☐☐

**IV/IO access:**

IV access attempts ☐ Successful YES ☐ NO ☐
IO access attempts ☐ Successful YES ☐ NO ☐

Number of DRUGS USED:

Adrenaline: 1mg ☐☐

Amiodarone: 300mg ☐☐

Other: ____________________

____________________

**Outcome:**

Time stopped: ☐☐ : ☐☐

**Successful** (Return of Spontaneous circulation): ☐

Transfer destination: HDU/Ward3/ARI

***Not successful** (attempt stopped): ☐

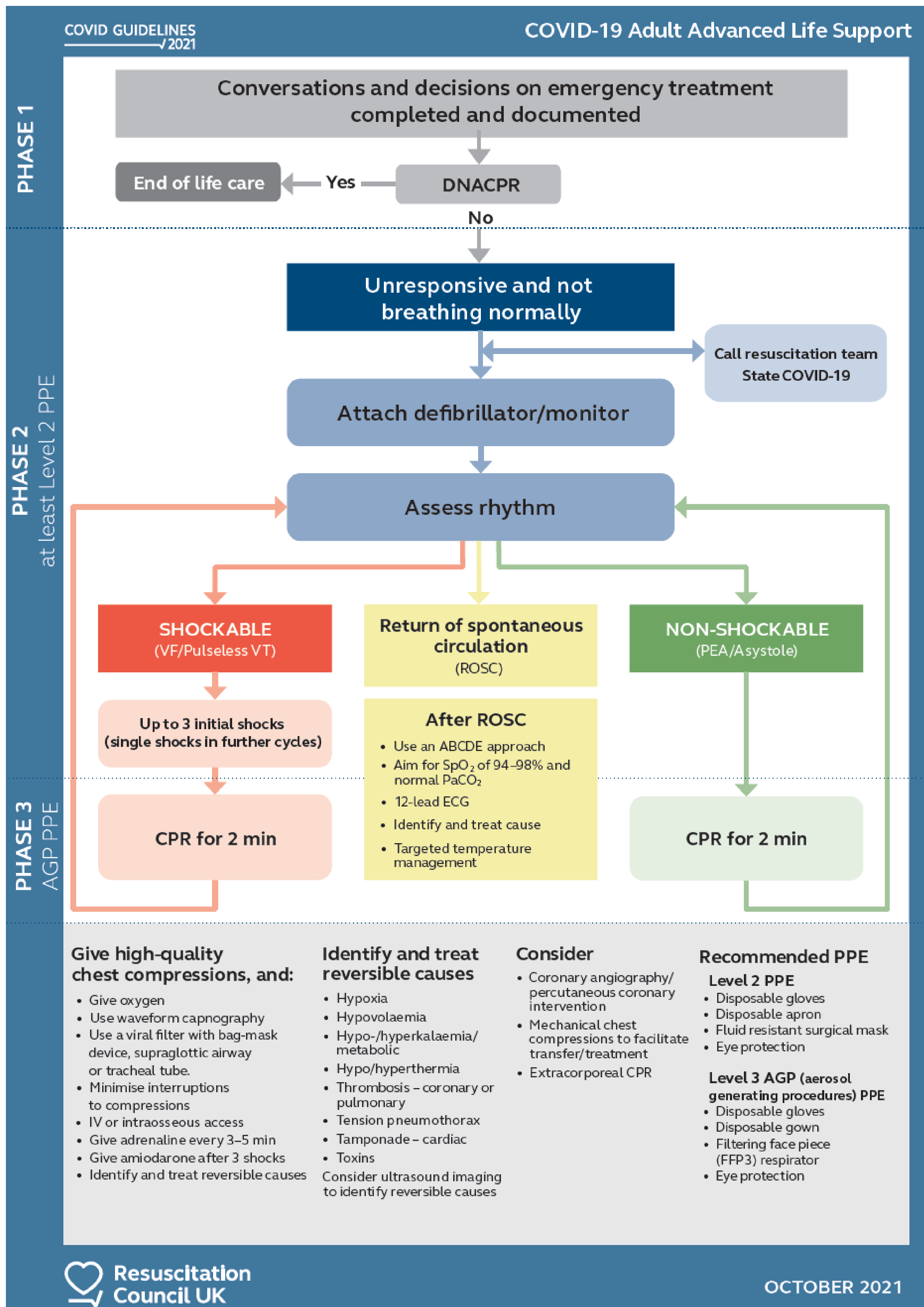
*In your opinion, should a decision not to attempt cardiopulmonary resuscitation have been made in advance? Yes ☐ No ☐

*Scottish Patient Safety Programme – qualifying cardiac arrests are required to be reviewed and any learning points shared. If this event ticks ALL the following boxes Tracy Lavelle will send you a Review Tool to complete with the team caring for the patient.

Was this: A true cardiac arrest? ☐ Ward 1 or 3? ☐ 2222 call made? ☐
CPR performed? ☐ Attended by Cardiac Arrest Team? ☐

## Appendix 7 – Infectious Diseases: Adults Advanced Life Support

(right-click and 'Open Hyperlink' to view original)



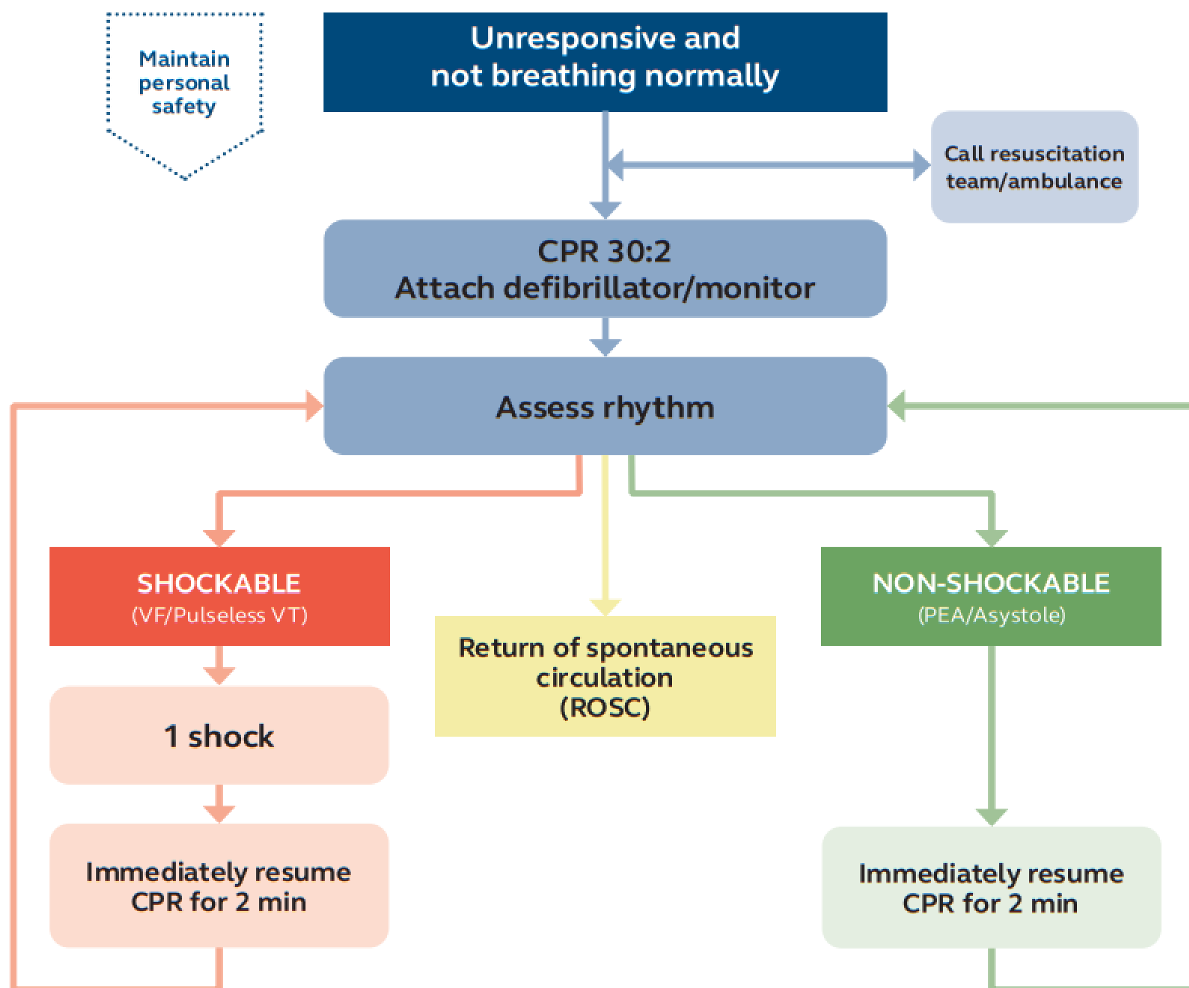
**Appendix 8 – Adult advanced Life Support Algorithm**

(right-click and 'Open Hyperlink' to view original)

Resuscitation Council UK

GUIDELINES 2021

# Adult advanced life support




### Give high-quality chest compressions, and:

- Give oxygen
- Use waveform capnography
- Continuous compressions if advanced airway
- Minimise interruptions to compressions
- Intravenous or intraosseous access
- Give adrenaline every 3–5 min
- Give amiodarone after 3 shocks
- Identify and treat reversible causes

### Identify and treat reversible causes

- Hypoxia
- Hypovolaemia
- Hypo-/hyperkalaemia/metabolic
- Hypo/hyperthermia
- Thrombosis – coronary or pulmonary
- Tension pneumothorax
- Tamponade – cardiac
- Toxins

Consider ultrasound imaging to identify reversible causes

### Consider

- Coronary angiography/percutaneous coronary intervention
- Mechanical chest compressions to facilitate transfer/treatment
- Extracorporeal CPR

### After ROSC

- Use an ABCDE approach
- Aim for $SpO_2$ of 94–98% and normal $PaCO_2$
- 12-lead ECG
- Identify and treat cause
- Targeted temperature management

**Appendix 9 – Rapid Impact Checklist for resuscitation policy 2022**

An Equality and Diversity Impact Assessment Tool:

<table>
<tr><td colspan="2">

**Which groups of the population do you think will be affected by this proposal?***<br>
**Other groups:**
<ul>
<li>Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers)</li>
<li>Women and men</li>
<li>People with mental health problems</li>
<li>People in religious/faith groups</li>
<li>Older people, children and young people</li>
<li>People of low income</li>
<li>Homeless people</li>
<li>Disabled people</li>
<li>People involved in criminal justice system</li>
<li>Staff</li>
<li>Lesbian, gay, bisexual and transgender</li>
</ul>
*the word proposal is used as shorthand for the policy, procedure, strategy or proposal that is being be assessed
</td></tr>
<tr><td colspan="2">In the following sections, please consider what positive and negative impacts you think there may be and which specific groups will be affected by impacts?</td></tr>
<tr><td>What impact will the proposal have on lifestyles?<br>For example, will the changes affect:
<ul>
<li>Diet and nutrition</li>
<li>Exercise and physical activity</li>
<li>Substance use: tobacco, alcohol and drugs</li>
<li>Risk taking behaviour</li>
<li>Education and learning or skills</li>
</ul></td><td>No impact</td></tr>
<tr><td>Will the proposal have any impact on the social environment?<br>Things that might be affected include:
<ul>
<li>Social status</li>
<li>Employment (paid or unpaid)</li>
<li>Social/Family support</li>
<li>Stress</li>
<li>Income</li>
</ul></td><td>Policy aims to promote improvements in communication between Shetland Health Board staff and patients, family, carers and significant others when deciding about issues relating to cardiopulmonary resuscitation.</td></tr>
</table>

| Will the proposal have any impact on the following? | This policy seeks to clarify decision making about cardiopulmonary resuscitation and includes the National Scottish NHS Policy 'Do Not Attempt Cardio-Pulmonary Resuscitation Decision-making and communication (2010). |
|---|---|
| • Discrimination?<br>• Equality of opportunity?<br>• Relations between groups?<br>• Fairer Scotland Duty | |
| **Will the proposal have an impact on the physical environment?**<br>For example, will there be impacts on:<br>• Living conditions?<br>• Pollution or climate change?<br>• Accidental injuries or public safety?<br>• Transmission of infectious disease? | None |
| **Will the proposal affect access to and experience of services?**<br>For example:<br>• Health care<br>• Transport<br>• Social services<br>• Housing services<br>• Education | Provision a DNA-CPR form applicable across all health care institutions across Scotland seeks to improve the patients experience and reduce the number of inappropriate CPR attempts |

**Summary Sheet**

<table>
<tr><td>Positive Impacts (Note the groups affected)<br>Clear policy allows:<br>Avoidance of inappropriate CPR<br>Patient experience improved<br>Improved communication between health agencies. As far as possible all agencies informed of DNA CPR decision<br>Reducing stress and anxiety around end of life care for patients, staff, relatives and carers<br>Decision made in advance avoids dilemmas and decisions for front line staff reducing stress</td><td>Negative Impacts (Note the groups affected)<br>If fair and full representation of patients who are incompetent to make own decisions has not been fully addressed<br>If policy is not clearly understood by those for whom first language is not English.<br>If full consideration to staff and patients moral or religious beliefs has not been addressed<br>If safeguards to protect vulnerable adults are not in place</td></tr>
<tr><td colspan="2">Additional Information and Evidence Required</td></tr>
<tr><td colspan="2">Recommendations<br>Policy addresses possible negative impacts. All answered ( in tandem with advanced directive policy document)</td></tr>
<tr><td colspan="2">From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?<br>No unresolved negative issues</td></tr>
</table>

Signature(s) of Level One Impact Assessor(s) A. McDermott

Date: 9/8/22