### Name of document
Resuscitation Policy (including Training)

### Registration Reference Number
CSPOL002  New  Review

### Author
Julie Redpath
Resuscitation Training Advisor

### Executive Lead
Medical Director

### Proposed groups to present document to:
- Resuscitation Committee
- ANMAC
- AMC
- CSMT
- ACF

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<td>Simon Bokor-Ingram and Dr Diggle</td>
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### Examples of reasons for presenting to the group
- Professional input required re: content (PI)
- Professional opinion on content (PO)
- General comments/suggestions (C/S)
- For information only (FIO)

### Examples of outcomes following meeting
- Significant changes to content required – refer to Executive Lead for guidance (SC)
- To amend content & re-submit to group (AC&R)
- For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
- Recommend proceeding to next stage (PRO)
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<td>Comments and suggestions generated by approval process with Resuscitation Committee members are incorporated resulting in version 7.2 Points 1.1.1 and 1.1.2 added. Formatting improved. Timescales added to appendix 2: Competency requirements.</td>
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<td>24th January 2012</td>
<td>Minor revisions. Appendix 2 updated to include BASIC’s courses. Yearly training in resuscitation practice regardless of ALS certification – to promote retention of skills. Version 7.3</td>
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**Outcome of consultation period**

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<td>Resus. Committee</td>
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<td>7.2</td>
<td>ANMAC</td>
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<td>Feb 2012</td>
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Resuscitation Policy

Date: June 2013
Version number: 7.4
Author: Julie Redpath, Resuscitation Training Advisor
Date of Approval: February 2014
Review Date: February 2019

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

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### Impact Assessment:

- July 2010

### Engagement & Consultation Groups:

- Resuscitation Committee: December 2010
- AMC and ANMAC: January 2011

### Approval Record:

- Resuscitation Committee: December 2010
- Clinical Governance Committee: 31/02/2011
- **Implementation Date:** February 2011
- **Review Date:** February 2012

### Version Control:

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- Version 7.2: December 2011
- Version 7.3: January 2012

### Impact Assessment:

- November 2011

### Engagement & Consultation Groups:

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- ANMAC: February 2012
- CSMT: February 2012
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- CGCG: August 2013

### Approval Record:

- Clinical Governance Committee: February 2014
- **Implementation Date:** February 2014
- **Review Date:** February 2019

### Abbreviations:

- **AED** Automated External Defibrillator
- **AMC** Area Medical Committee
- **ANMAC** Area Nursing & Midwifery Advisory Committee
- **CPR** Cardiopulmonary Resuscitation
- **DNA_CPR** Do Not Attempt Cardiopulmonary Resuscitation
- **CYPADM** Child and Young People Acute Deterioration Management
Contents:

<table>
<thead>
<tr>
<th>Purpose &amp; Introduction</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of the Policy</strong></td>
<td>--</td>
</tr>
<tr>
<td>1. Maintaining an effective resuscitation service for patients and employees</td>
<td>5</td>
</tr>
<tr>
<td>2. Prevention of Cardiopulmonary Arrest</td>
<td>6</td>
</tr>
<tr>
<td>3. Prompt commencement of Cardiopulmonary Resuscitation (CPR) when appropriate to the patient’s condition</td>
<td>7-9</td>
</tr>
<tr>
<td>4. Avoidance of inappropriate CPR attempts</td>
<td>10</td>
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</table>

Documents to be read...

| Appendix 1: Resuscitation training provision | 12 |
| Appendix 2: Competency requirements | 13 |
| Appendix 3: Call out lists for special circumstances | 15 |
| Appendix 4: Emergency bleep system | 17 |
| Appendix 5: Scottish National DNA CPR policy | 19 |
| Appendix 6: Cardiac Arrest Audit Form | 20 |
| Rapid Impact Assessment | 22 |
Resuscitation Policy

Purpose:

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.

This policy is an amalgamation of the Resuscitation Policy version 7 and the Resuscitation Training Policy which was due for review in 2009.

Introduction:

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 Resuscitation¹

- The joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing describing Decisions relating to Cardiopulmonary Resuscitation²

The following policy document is based on the advice stated within the above statements taking into account the particular needs and circumstances of Shetland NHS Board.

Summary of the Policy

1. To ensure Shetland NHS Board maintains an effective resuscitation service for patients and employees
2. To ensure systems are in place to aid prevention of cardiopulmonary arrest
3. To ensure prompt commencement of Cardiopulmonary Resuscitation (CPR) when appropriate to the patient’s condition
4. To avoid inappropriate CPR attempts

1. **Maintaining an effective resuscitation service for patients and employees**

1.1 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.

1.1.1 It is the responsibility of departmental managers to ensure 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.

1.1.2 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.

1.2 The Board’s Resuscitation Training Advisor(s) and Resuscitation Trainers are responsible for delivering a range of training in resuscitation techniques to hospital and community staff in accordance with the latest Resuscitation Council (UK) guidelines.

1.3 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.

1.4 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.
1.5 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.

1.6 The Resuscitation Committee encourages participation in a range of resuscitation training courses delivered by Trainers from outwith Shetland.

1.7 Where clinical responsibility requires a higher level of training than that provided within Shetland NHS Board, staff should be supported in attending national training courses outwith Shetland.

1.8 The Board’s Resuscitation Training Advisor will undertake work requested by the Resuscitation Committee in addition to auditing resuscitation events and medical emergencies using the 2222 call system in order to maintain and improve standards of care.

1.9 The minimum members of the Cardiac Arrest Team are:

<table>
<thead>
<tr>
<th>9am – 5pm daily</th>
<th>5pm – 9am daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call Medical Junior Doctor</td>
<td>On-call Medical Junior Doctor</td>
</tr>
<tr>
<td>On-call Surgical Junior Doctor</td>
<td>On-call Surgical Junior Doctor</td>
</tr>
<tr>
<td>Nurse holding 2222 bleep</td>
<td>(Until shift change over time then one on call junior doctor overnight)</td>
</tr>
<tr>
<td>Resuscitation Training Advisor (when available)</td>
<td>Nurse holding 2222 bleep</td>
</tr>
</tbody>
</table>

1.10 Additional members of staff can be contacted via reception; for example anaesthetist, trauma team, midwife (appendix 3)

2. **Prevention of Cardiopulmonary Arrest**

2.1 Identification of patients at risk of a cardiopulmonary arrest and timely treatment may prevent cardiopulmonary arrest. 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.

2.2 Nursing, medical and consultant staff should be familiar with the early warning system used within their clinical area. Any system in place should have a clear and specific pathway for users to follow when a response is required.
2.3 Early consultation with and assessment of critically ill patients by the responsible Consultant and/or Anaesthetist is to be encouraged so that cardiopulmonary arrest can be prevented.

2.4 The 2222 cardiac arrest call should be used where help is required quickly in a medical emergency. (Appendix 4)

3. Prompt commencement of Cardiopulmonary Resuscitation (CPR) when appropriate to the patient’s condition

Definition:
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, ventilation of the lungs and injection of drugs.

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.

3.1 CPR should be performed competently and in accordance with the current Resuscitation Council (UK) guidelines.

3.2 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 make all reasonable efforts to attempt to revive the patient in the event of a cardiopulmonary arrest. (See Appendix 5 for more information)

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

3.4 If a patient has a cardiac or respiratory arrest staff can call all assistance they deem necessary.
3.5 Every clinician has a professional code of conduct and professional responsibilities and will meet the principles of safe and effective care in the event of an arrest or peri-arrest as set out by the regulatory body.

3.6 When a cardiopulmonary arrest occurs within the Gilbert Bain Hospital, staff should:

- Recognise the cardiopulmonary arrest
- Summon help using emergency call bells and phoning 2222 (See appendix 4)
- Start effective CPR, and where appropriate, attempt defibrillation using a manual defibrillator or AED within 3 minutes of collapse

3.7 When a cardiopulmonary arrest occurs in the community, staff should:

- Recognise the cardiopulmonary arrest
- Summon help – depending on location and available resources – and phone 999
- Start effective CPR, and where appropriate, attempt defibrillation with an AED as soon as is practicable
- Practitioners should always consider the option of getting help from the community groups who are trained in basic life support - e.g. Life Guards, Lifeboat crew, and retained firemen - in order to optimise their efforts while definitive help is on the way

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

3.8 When trained assistance (cardiac arrest team, GP and/or Ambulance personnel) arrives a Team Leader should be determined, this would usually be the most senior team member present, who is responsible for directing the continued resuscitation attempt.

3.9 Advanced Life Support techniques are commenced as soon as practicable.
3.10 When a decision to stop a resuscitation attempt is required the Team Leader has overall responsibility once discussion has taken place with all members of the team present. Decisions about continuation of CPR must be made on the basis of an individual assessment of each patient's case.

3.11 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 order, or a valid and applicable Advance Statement refusing CPR⁴, or additional clinical information indicating CPR will not be successful. In such circumstances, continued CPR is inappropriate and should be stopped (See appendix 5).

3.12 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).

3.13 The Team Leader should ensure all necessary documentation including a cardiac arrest audit form is completed as soon as possible after the resuscitation attempt (Appendix 6).

3.14 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.

3.15 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.

3.16 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 of the calls list are required (Appendix 3).
4. **Avoidance of inappropriate CPR attempts**

4.1 The Board and Resuscitation Committee recognises the importance of improving the process and practice of decision making concerning DNA-CPR orders to avoid inappropriate CPR attempts.

4.2 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.

4.3 Decisions should be reassessed as part of the ongoing care of the individual and when their condition changes.

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

4.5 NHS Scotland’s ‘Integrated Policy on Do Not Attempt Cardio-Pulmonary Resuscitation Decision-making and Communication’\(^5\), and ‘Resuscitation Planning Policy for Children and Young People (under 16 years)’\(^6\) directs the local protocols and procedures within Shetland NHS Board (Appendix 5).
References:


2. Decisions relating to cardiopulmonary resuscitation. *A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing describing Decisions* October 2007

3. Resuscitation Council (UK) – [http://www.resus.org.uk/SiteIndx.htm](http://www.resus.org.uk/SiteIndx.htm)

4. Policy and Guidelines for Health Professionals on Advance Statements about Medical Treatment (Shetland NHS Board 2007)


   Scottish Ambulance Service & Scottish Partnership for Palliative Care ‘End of Life Care Policy’ 27 October 2010


   Nursing and Midwifery Council code of Conduct

Appendix 1: Resuscitation Training Provision

**Adult** Resuscitation training:
- Basic life-support (BLS)
  BLS trainers will be trained for clinical areas when an identified need arises. These BLS trainers will complete a training course and assessment following which they will provide BLS training to all staff requiring training in that clinical area. 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 who require 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. Junior hospital doctors will receive training in advanced life-support skills during their induction programme.
  Staff who are required to act as cardiac arrest team leader, e.g. Hospital consultants, junior doctors and Nurse 2222 bleep holders must be encouraged to attend an ALS course or equivalent, if they have not already done so.

**Paediatric** Resuscitation training:
- Basic life-support (BLS)
  Paediatric BLS training sessions will be run in Shetland at regular intervals. These will be open to all Shetland NHS Board staff.
- Advanced life-support
  The Paediatric Life Support (PLS) course will be run in Shetland at regular intervals. This will be open to all NHS board staff who require additional skills to those covered in the paediatric BLS training, eg. hospital medical staff, registered nurses working in acute areas, general practitioners, nurses on non-doctor islands.
  Staff who are required to act as cardiac arrest team leader, e.g. Hospital consultants, junior doctors and Nurse 2222 bleep holders must be encouraged to attend an Advanced Paediatric Life Support Course (APLS) course or equivalent.

**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 requested. This training is open to all Shetland NHS Board staff who may be required to resuscitate neonates as part of their duties.

**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:

<table>
<thead>
<tr>
<th>Level</th>
<th>Competencies</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>BLS</td>
<td>Assessment of conscious level&lt;br&gt;Assessment of breathing&lt;br&gt;Recognition of cardiac arrest&lt;br&gt;Exhaled air ventilation (including use of a pocket mask)&lt;br&gt;Cardiac compressions, technique, rate, rhythm, ratio&lt;br&gt;Recovery position and management of choking&lt;br&gt;Use of AEDs</td>
<td>Yearly update</td>
</tr>
<tr>
<td>ILS</td>
<td>BLS plus:&lt;br&gt;Le patient assessment using ABCDE approach&lt;br&gt;Cardiac arrest cause and prevention&lt;br&gt;Airway management with adjuncts (including LMA)&lt;br&gt;Breathing management with Bag-valve mask&lt;br&gt;Monitoring, cardiac arrest rhythms plus safe defibrillation&lt;br&gt;ALS treatment algorithm&lt;br&gt;Drugs and delivery&lt;br&gt;Handover and DNA CPR</td>
<td>Yearly Update&lt;br&gt;Even if holding a current ALS certification*</td>
</tr>
<tr>
<td>ALS</td>
<td>BLS and ILS plus:&lt;br&gt;Advanced airway management&lt;br&gt;Monitoring and rhythm recognition&lt;br&gt;12 lead ECG&lt;br&gt;Bradycardia and Tachycardia&lt;br&gt;Blood gases&lt;br&gt;Cardiac arrest in special circumstances</td>
<td>As stated on certification&lt;br&gt;Yearly practice via ILS*</td>
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</table>

### Children:

<table>
<thead>
<tr>
<th>Level</th>
<th>Competencies</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS</td>
<td>As above for age groups under one, one to puberty</td>
<td>Yearly update</td>
</tr>
<tr>
<td>PLS</td>
<td>BLS plus:&lt;br&gt;Cardiac arrest protocols and rhythm recognition&lt;br&gt;Airway management with adjuncts&lt;br&gt;Bag-valve mask ventilation&lt;br&gt;Vascular access (intra-osseous)&lt;br&gt;Introduction to the seriously injured child (plus spinal immobilization)&lt;br&gt;Introduction to the seriously ill child&lt;br&gt;Handover and CYPADM</td>
<td>As stated on certification&lt;br&gt;Yearly practice via PLS</td>
</tr>
<tr>
<td>APLS</td>
<td>BLS and PLS plus:&lt;br&gt;Advanced airway management and vascular access&lt;br&gt;Immediate management of sick/injured child&lt;br&gt;Resuscitation and stabilisation of sick/injured child</td>
<td>As stated on certification&lt;br&gt;Yearly practice via PLS</td>
</tr>
</tbody>
</table>
### Neonates:

| BLS: | Drying and covering of neonate  
| | Assessment of neonate  
| | Airway opening manoeuvres  
| | Exhaled air ventilation  
| | Pocket mask ventilation  
| | Chest compressions  
| | Calling for help | Yearly update |

| NLS: | As above plus:  
| | Advanced airway management (including suction for meconium)  
| | Ventilation of the lungs with bag-valve-mask or Tom Thumb  
| | Vascular access (including Umbilical vein catheter)  
| | Administration of drugs | Yearly update |

### Pre-hospital care:

| BASICS: | Immediate Medical Care Course (part 1)  
| | As ILS/ALS plus:  
| | Sandpiper Bag familiarisation  
| | Assessment of trauma patient  
| | Advanced Airway management  
| | Spinal Immobilisation  
| | Pre-Hospital Paediatric Life Support Course (periodically) as above | As stated on certification  
| | Yearly practice encouraged | Yearly practice encouraged |

Up-to-date information available at [www.basics-scotland.org.uk](http://www.basics-scotland.org.uk)
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.

<table>
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<th>Trauma Team Call out List</th>
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<tr>
<td>CONSULTANT ANAESTHETIST</td>
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<tr>
<td>CONSULTANT SURGEON</td>
</tr>
<tr>
<td>ANAESTHETIC NURSE</td>
</tr>
<tr>
<td>A&amp;E NURSE</td>
</tr>
<tr>
<td>RADIOGRAPHER</td>
</tr>
<tr>
<td>LAB TECHNICIAN</td>
</tr>
<tr>
<td>DUTY PORTER</td>
</tr>
</tbody>
</table>

ASK THEM TO COME IN IMMEDIATELY FOR TRAUMA CASE

<table>
<thead>
<tr>
<th>Paediatric Call out list</th>
</tr>
</thead>
<tbody>
<tr>
<td>For emergencies and cardiac arrest call 2222</td>
</tr>
<tr>
<td>In addition ask for:</td>
</tr>
<tr>
<td>ANAESTHETIST</td>
</tr>
<tr>
<td>ANAESTHETIC NURSE</td>
</tr>
<tr>
<td>CHILDREN’S NURSE (DAY TIME)</td>
</tr>
</tbody>
</table>
Maternity call out list

a) **CARDIAC ARREST** – CALL OUT ARREST TEAM

b) **OBSTETRIC EMERGENCY**

NIGHT SISTER (2000 – 0800)
MATERNITY GP
On-call MIDWIFE (if not already in)
ANAESTHETIST

Also IF requested:
SURGEON
SURGICAL on-call junior doctor (2000-0000)
MEDICAL on-call junior doctor (0000-0800)
THEATRE TEAM
LAB STAFF

c) **NEONATAL EMERGENCY**

NIGHT SISTER (2000-0800)
On-call MIDWIFE (if not already in)
MATERNITY GP
ANAESTHETIST

d) **CAESAREAN SECTION** (CATEGORY 1 OR 2)

**DAY:**
THEATRE SENIOR NURSE (cascades to theatre team)
ANAESTHETIST
SURGEON
SURGICAL junior doctor
On-call MIDWIFE (if not already in)
MATERNITY GP (if not already in)

**NIGHT:**
NIGHT SISTER
On-call THEATRE TEAM
ANAESTHETIST
SURGEON
SURGICAL on-call junior doctor (till 0000)
MEDICAL on-call junior doctor (0000-0800)
On-call MIDWIFE (if not already in)
MATERNITY GP (if not already in)
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’
The receptionist will terminate the call

Receptionist enters protocol into Multitone console and at the right time speaks the message into the microphone.

Bleeps activated
(Rapid sequence of bleeps)
Voice Message is heard giving location

Contacting an individual multitone bleep holder

Dial 5000

When prompted enter two digit bleep number (user number)

When prompted enter your phone number (4 digit number)
– Wait for confirmation

End call & wait
Appendix 5: Scottish National Policies

NHS Scotland

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Integrated Adult Policy

See: http://www.scotland.gov.uk/dnacpr
(Link from home page of NHS Shetland Intranet)

Resuscitation Planning Policy for Children and Young People
(under 16 years)

See: http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/LivingandDyingWell/CYPADM
# Appendix 6: Cardiac Arrest Audit Form

## 2222 calls/Resuscitation Audit Form

<table>
<thead>
<tr>
<th>TEAM leader:</th>
<th>Department:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of arrest:</td>
<td>Out of Hospital [ ] A&amp;E [ ] Ward 3 [ ] Ward 1 [ ] Other [ ]</td>
</tr>
<tr>
<td>Date of call:</td>
<td>[ ] / [ ] / [ ]</td>
</tr>
<tr>
<td>Reason for call:</td>
<td>Respiratory Arrest [ ] Cardiac Arrest [ ] Medical Emergency [ ] False alarm:</td>
</tr>
<tr>
<td>Time of collapse:</td>
<td>[ ] : [ ] : [ ]</td>
</tr>
<tr>
<td>Time of call:</td>
<td>[ ] : [ ] : [ ]</td>
</tr>
<tr>
<td>Patient label:</td>
<td>Hospital number [ ] Age [ ] Sex [ ]</td>
</tr>
</tbody>
</table>

### Medical Emergency description

Free text box:

### Witnessed

- YES [ ]
- NO [ ]

### CPR performed

- YES [ ]
- NO [ ]

### Initial rhythm

- VF [ ]
- VT [ ]
- PEA [ ]
- Asystole [ ]

### Subsequent rhythms

- VF [ ]
- VT [ ]
- PEA [ ]
- Asystole [ ]
- Other [ ]

### Was perfusing rhythm achieved?

- YES [ ]
- NO [ ]

### Airway/ventilation intervention

- Pocket mask/bag-valve mask: [ ]
- Airway inserted: [ ]
- LMA: [ ]
- ETT: [ ]
- By inserted: [ ]
- 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/O access

- IV access attempts: [ ]
- Successful YES [ ] NO [ ]
- IO access attempts: [ ]
- Successful YES [ ] NO [ ]

### Number of DRUGS USED

- Adrenaline: 1mg [ ]
- Amiodarone: 300mg [ ]
- Other: [ ]

### Outcome

- Time attempt 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 [ ]

### (Office use) Discharge Information

- Discharge date: [ ] / [ ] / [ ]
- In-hospital death date: [ ] / [ ] / [ ]
- Alive at 6 months: YES/NO [ ]

Please return completed form to:

Julie Redpath
Staff Development, Montfeld Hospital
Phone (74) 3443 or Bleep 66

<table>
<thead>
<tr>
<th>Which groups of the population do you think will be affected by this proposal?</th>
<th>Other groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• minority ethnic people (incl. gypsy/travellers, refugees &amp; asylum seekers)</td>
<td>• people of low income</td>
</tr>
<tr>
<td>• women and men</td>
<td>• people with mental health problems</td>
</tr>
<tr>
<td>• people in religious/faith groups</td>
<td>• homeless people</td>
</tr>
<tr>
<td>• disabled people</td>
<td>• people involved in criminal justice system</td>
</tr>
<tr>
<td>• older people, children and young people</td>
<td>• staff</td>
</tr>
<tr>
<td>• lesbian, gay, bisexual and transgender people</td>
<td></td>
</tr>
</tbody>
</table>

N.B. The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.

<table>
<thead>
<tr>
<th>What positive and negative impacts do you think there may be?</th>
<th>Which groups will be affected by these impacts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No impact</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What impact will the proposal have on lifestyles? For example, will the changes affect:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diet and nutrition? No impact</td>
<td></td>
</tr>
<tr>
<td>• Exercise and physical activity?</td>
<td></td>
</tr>
<tr>
<td>• Substance use: tobacco, alcohol or drugs?</td>
<td></td>
</tr>
<tr>
<td>• Risk taking behaviour?</td>
<td></td>
</tr>
<tr>
<td>• Education and learning, or skills?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will the proposal have any impact on the social environment? Things that might be affected include</th>
<th>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) refers directly to other Board policies (Policy and Guidelines for Health Professionals on Advance Statements about Medical Treatment (2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social status</td>
<td></td>
</tr>
<tr>
<td>• Employment (paid or unpaid)</td>
<td></td>
</tr>
<tr>
<td>• Social/family support</td>
<td></td>
</tr>
<tr>
<td>• Stress</td>
<td></td>
</tr>
<tr>
<td>• Income</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will the proposal have any impact on</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Discrimination?</td>
<td></td>
</tr>
<tr>
<td>• Equality of opportunity?</td>
<td></td>
</tr>
<tr>
<td>• Relations between groups?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will the proposal have an impact on the physical environment? For example, will there be impacts on:</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Living conditions?</td>
<td></td>
</tr>
<tr>
<td>• Working conditions?</td>
<td></td>
</tr>
<tr>
<td>• Pollution or climate change?</td>
<td></td>
</tr>
<tr>
<td>• Accidental injuries or public safety?</td>
<td></td>
</tr>
<tr>
<td>• Transmission of infectious disease?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will the proposal affect access to and experience of services? For example,</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health care</td>
<td></td>
</tr>
<tr>
<td>• Transport</td>
<td></td>
</tr>
<tr>
<td>• Social services</td>
<td></td>
</tr>
<tr>
<td>• Housing services</td>
<td></td>
</tr>
<tr>
<td>• Education</td>
<td></td>
</tr>
</tbody>
</table>

CPR (Cardio-pulmonary Resuscitation)
DNA-CPR (No Not Attempt Cardio-pulmonary Resuscitation)
Rapid Impact Checklist: Summary Sheet

<table>
<thead>
<tr>
<th><strong>POSITIVE IMPACTS (NOTE THE GROUPS AFFECTED)</strong></th>
<th><strong>NEGATIVE IMPACTS (NOTE THE GROUPS AFFECTED)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear policy allows</td>
<td>If fair and full representation of patients who are incompetent to make own decisions has not been fully addressed</td>
</tr>
<tr>
<td>Avoidance of inappropriate CPR</td>
<td>If policy is not clearly understood by those for whom first language is not English.</td>
</tr>
<tr>
<td>Patient experience improved</td>
<td>If full consideration to staff and patients moral or religious beliefs has not been addressed</td>
</tr>
<tr>
<td>Improved communication between health agencies. As far as possible all agencies informed of DNACPR decision</td>
<td>If safeguards to protect vulnerable adults are not in place</td>
</tr>
<tr>
<td>Reducing stress and anxiety around end of life care for patients, staff, relatives and carers</td>
<td></td>
</tr>
<tr>
<td>Decision made in advance avoids dilemmas and decisions for front line staff reducing stress</td>
<td></td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION AND EVIDENCE REQUIRED**

Policy addresses possible negative impacts. All answered (in tandem with advanced directive policy document)

**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?**

No unresolved negative issues