

Provision of a Primary Percutaneous Coronary Intervention (PPCI) Service for patients presenting with Acute Myocardial Infarction (AMI) to the Oxford Heart Centre

Category:	Policy
Summary:	This policy aims to ensure the safe and timely delivery of a twenty-four hour PPCI service for those eligible patients presenting to, or referred to, the OHC with AMI. The policy outlines the clinical pathway for and the circumstances under which, those eligible patients presenting with AMI will be treated, from the point of presentation to the OHC, emergency medical services, community services or referring District General Hospital to completion of coronary intervention.
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Distribution:	Trustwide
Related Documents:	PPCI Activation guideline (appendix 5) PPCI Call Out Flow Chart (appendix 6) OHC Lift Breakdown Procedure. Care After Death Policy PPID Policy
Author(s):	Cardiology/ACCU Lead Nurse
Further Information:	Cardiothoracic Directorate
This Document replaces:	Provision of a PPCI Service for Patients Presenting with AMI to the OHC, Version 6

Lead Director: Clinical Director of Cardiology, Cardiac and Thoracic Surgery

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This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.

This document contains many hyperlinks to other related documents.

All users must check these documents are in date and have been ratified appropriately prior to use.

Document History

Date of revision	Version number	Author	Reason for review or update
Provision of a Primary Percutaneous Coronary Intervention (PPCI) Service for Patients Presenting with Acute Myocardial Infarction (AMI) to the Oxford Heart Centre (OHC)	Version 1 amended in October 2008 to become version 2	C White A Banning	The policy has been amended taking into consideration inclusion of the Horton General Hospital (HGH) inpatients/self-presenting patient and changes in service provision at local level. Additionally PPCI service delivery at the ORH JR site is no longer a pilot project. Inclusion of HGH inpatients and self-presenters HGH inpatient/self-presenting pathway Return of patient to CCU when no bed available Change in PPCI team call out system Any reference to a pilot project removed.
Provision of a PPCI Service for Patients Presenting with AMI to the OHC	Version 2 amended in May 2009 to become version 3	C White A Banning R Titchener	This policy has been amended and revised to a generic format, applicable to any tertiary centre wishing to use the Oxford heart centre to deliver a primary angioplasty service Removal of any reference to specific district general hospitals (DGH) within the body of the text Inclusion of DGH local PPCI pathways as appendices Changes to grammatical errors Subtle amendments of terminology as requested by member of the PPCI project group
Provision of a PPCI Service for Patients Presenting with AMI to the OHC	Version 3 amended in March 2010 to become version 4	C White	This policy has been amended and revised to include the South Central Ambulance Service (SCAS) protocol for emergency inter-hospital transfers (EIHT) (16/3/2010) and the receipt of patients directly into the OHC cardiac angiography suite (CAS) Inclusion of the SCAS EHIT policy 2010 Inclusion of admissions direct into CAS Amendments to patient flow due to OHC CAS opening Addition of patient management during severe inclement weather Terminology/abbreviation changes
	Version 4 amended in		This policy has been amended to include fully the patient pathway for direct delivery to CAS 24/7

Provision of a PPCI Service for Patients Presenting with AMI to the OHC	November 2010 to become Version 5	C White	Change of description of target users Expansion of admission direct into CAS – routine practice. Care of patient post procedure if no CCU bed available Patient management if CAS already undertaking procedure out of hours. Inclusion of relative's information leaflets Recognition of Cardiac, Vascular & Thoracic division name change
Provision of a PPCI Service for patients presenting with AMI to the OHC	Version 5 amended in September 2017 to become version 6	C White A Payne E Sutherland	This policy has been rewritten and amended to contain the use of the PPCI activation hotline and the PPCI call out flow chart. Contingency arrangements have also been added including: No bed availability on the CTCCU to care for the patient post PPCI (stable and unstable) Use of the CTCCU nurse as part of the PPCI team Activation of concurrent patients requiring PPCI PPCI Team activated but the patient does not meet criteria for PPCI Identification of the patient whose personal details are unknown Care of patient if death occurs during PPCI OHC Lift Breakdown procedure Support from the 'Cath Lab Response Team' or 'SWAT' team for those patients requiring airway support or who are in cardiac arrest. The template of the policy has been revised in line with the OUHFT policy for 'Developing and Managing Procedural Documents' Appendices have been removed and new relevant policies have been added including: PPCI Activation Guideline (2016) PPCI Call Out Flow Chart (2017)
Provision of a PPCI Service for patients presenting with AMI to the OHC	Version 6 amended to become version 7	K Konstanciak	This policy has been amended and revised to reflect the relocation of six CTCCU beds to Level 0 of the OHC to become the ACCU. Revisions have been made to reflect the change in practice due the COVID-19 pandemic

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
Emergency Department Senior Nurse and Consultant group	Sent to group and discussion with consultant cardiologists
South Central Ambulance Service	Sent to service lead
Oxford Heart Centre Staff	Sent to staff
Cardiology CSUs	Sent to all CSUs in Directorate and discussed at CSU meetings

Endorsement

Endorsee Job Title
Clinical Director of Cardiology, Cardiac and Thoracic Surgery

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Who should read this document?

1. This policy should be read by all clinical staff across the Trust.

Key Standards/Messages

2. The policy will outline the clinical pathway for, and the circumstances under which, patients presenting with STEMI will be treated from the point of presentation to the Oxford Heart Centre (OHC), emergency medical services, community services or referring District General Hospital to completion of coronary intervention.
3. The policy aims to ensure the safe and timely delivery of a Primary Percutaneous Coronary Intervention (PPCI) service for eligible patients with a maximum of 120 minutes call to balloon (CTB) time and 90 minutes door to balloon (DTB) time, as recommended by NIAP (2008) ¹. The local aim at the OHC is to achieve a 'Door to Wire' time of less than 60 minutes

Background/Scope

4. This policy is a revision of and replaces the previous 'Provision of a Primary Percutaneous Coronary Intervention Service for Patients Presenting with Acute Myocardial Infarction to the Oxford Heart Centre', Version 6, October 2018.
5. The policy was developed in line with recommendations from the National Infarct Angioplasty Project (NIAP, 2008)¹ that PPCI should be the treatment of choice for ST segment Elevation Myocardial Infarction (STEMI) in England, available twenty four hours per day, seven days per week. It is intended to guide staff with the delivery of a PPCI service within the Oxford University Hospitals NHS Foundation Trust (OUH) and specifically the OHC. Additionally this policy addresses the needs of patients managed within the South Central region using OHC as a designated PPCI centre.
6. The policy was originally formulated following discussions with staff within the OHC, South Central Ambulance Service (SCAS), across the OUH, and informed by evidence based medicine.
7. This document applies to the operation of the PPCI service at the OHC, incorporating all patients within the South Central region presenting to or referred to the OHC, all employees of the OHC and of the Trust, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff.

Key Updates

8. The policy has been revised to reflect the relocation of six CTCCU beds to Level 0 of the OHC to become the Acute Cardiac Care Unit (ACCU), located on the Cardiology Ward.
9. Revisions have been made to reflect the change in practice due to the COVID-19 pandemic.

Aim

10. The purpose of this policy is to ensure the safe and timely delivery of a twenty four hour PPCI service for eligible patients presenting to, or referred to, the OHC with AMI.

Operational Policy for the PPCI Service

Activating the PPCI Pathway

11. Patients within the John Radcliffe Hospital (JRH) Emergency Department (ED) and Emergency Assessment Unit (EAU):

- 11.1. Patients within the JRH ED and EAU who meet the criteria for PPCI will be assessed by the Emergency Department clinicians. Those clinicians who are competent in making the diagnosis of STEMI will call the PPCI hotline to activate the PPCI pathway (see Appendix 5). The PPCI pathway will then be activated by the ACCU nurse answering the PPCI hotline phone (see Appendix 6).
 - 11.2. If ED/EAU clinicians are unable to confirm the diagnosis of STEMI but suspect STEMI then they should refer the patient immediately to the on-call Cardiology Registrar for assessment for PPCI treatment. If the patient is eligible for PPCI, the Cardiology Register will contact the ACCU nurse and instruct them to activate the PPCI pathway.
12. **Patients on the medical and surgical wards in the JRH:**
 - 12.1. Patients on the medical and surgical wards in the JRH with suspected STEMI will be assessed by the clinicians in charge of their care and those clinicians who are competent in making the diagnosis of STEMI will call the PPCI hotline to activate the PPCI pathway. The PPCI pathway will then be activated by the ACCU nurse answering the PPCI hotline phone. If the clinicians on the medical or surgical wards are unable to confirm the diagnosis of STEMI but suspect STEMI then they should refer the patient immediately to the on-call Cardiology Registrar for assessment for PPCI treatment. If the patient is eligible for PPCI, the Cardiology Register will contact the ACCU nurse and instruct them to activate the PPCI pathway.
13. Patients in other medical facilities:
 - 13.1. Patients in any other OUH Hospital, (Churchill hospital, Nuffield Orthopaedic Hospital, Horton Hospital), District General Hospital, Community Hospital, General Practice Surgery or Minor Injury Unit who are experiencing chest pain and meet the criteria for PPCI will be assessed by the clinician responsible for their care.
 - 13.2. Those clinicians who are competent in making the diagnosis of STEMI will call the PPCI hotline to activate the PPCI pathway. The PPCI pathway will then be activated by the ACCU nurse answering the PPCI hotline phone.
 - 13.3. If those clinicians are unable to confirm the diagnosis of STEMI but suspect STEMI then they should refer the patient immediately to the on-call Cardiology Registrar at the JRH for assessment for PPCI treatment. If the patient is eligible for PPCI, the Cardiology Registrar will contact the ACCU nurse and instruct them to activate the PPCI pathway. The referring clinician should then arrange for the patient to be transferred to the JRH for PPCI.
 - 13.4. The PPCI patient group are classified as a **'time critical medical emergency transfer'** necessitating an immediate inter-hospital transfer.
14. Patients in the care of the Ambulance Services:
 - 14.1. For those patients with suspected AMI who meet criteria for PPCI, ambulance staff will contact the PPCI hotline and give the patients details and estimated time of arrival to the ACCU nurse. Where possible, they will transmit ECG evidence for confirmation of an AMI diagnosis. This may be done via the 'MobiMed' system if a suitable transmitter is available on the ambulance, or via the 'Fast ECG' mobile telephone app or via the SCAS Electronic Patients Records (EPR) system.
 - 14.2. There is no absolute requirement for an ECG to be transmitted as this is sometimes not possible and may be impractical. If the ambulance crew

member is competent in ECG diagnosis and physical history taking and believes the patient meets PPCI criteria, they will instruct the ACCU nurse to activate the PPCI pathway.

- 14.2.1. In the event of cardiac arrest during transfer by ambulance, following acceptance for PPCI: If the patient is stable following resuscitation, the ambulance crew will continue to the CAS in the OHC. If unstable, the ambulance crew will make a clinical judgement to either continue to the JRH or to divert to the nearest appropriate hospital ED. This decision will be based on the condition of the patient and distance to the nearest hospital. If already near Oxford, the crew will contact the ACCU nurse for advice on whether to admit the patient directly to the CAS in the OHC or to the JRH ED. If it is decided that the patient should go straight to the CAS in the OHC, the 'Cath Lab Response Team' should be pre-alerted so that they may be present when the patient is admitted to the CAS.
 - 14.2.2. Patients presenting in cardiac arrest: Patients presenting with OOHCA where an ischaemic event is suspected, and in whom there is ST segment elevation on ROSC, will be discussed with ACCU and activated as per the PPCI policy if appropriate. Patients presenting in OOHCA with no ST segment elevation on ROSC should be discussed with Cardiology and a decision made on a case by case basis. Patients in active cardiac arrest on a mechanical CPR device, where there is a history of chest pain and/or an ischaemic ECG, will need to be discussed urgently with Cardiology. If the decision is made to divert to the ED, the ED team should contact the Cardiology team and a consultant to consultant discussion may be necessary in these cases.
 - 14.2.3. Should there be uncertainty about the diagnosis (e.g. an old LBBB or a paced rhythm), the patient should be discussed with the ACCU nurse and/or on-call Cardiology Registrar and/or the Cardiology Consultant. A decision may then be made, based on the patient's history and ECG, to transfer to the nearest ED for further assessment (which may be at the JRH) or for transfer to the CAS in the OHC for PPCI.
 - 14.2.4. Should ACCU receive a SCAS EPR/Fast ECG transmission from the ambulance service which meets criteria for PPCI activation and do not receive a telephone call from the ambulance crew within 5 minutes of receipt, the ACCU nurse will attempt to contact the crew for further information about the patient via emergency ambulance control.
15. Once accepted for PPCI
- 15.1. The patient will be given 300mg of Aspirin and pre-loaded with 180mg Ticagrelor if available in the hospital setting, or with 600 mg of Clopidogrel by the ambulance crew, if it is available and they are appropriately trained.
 - 15.2. If the ambulance crew are unable to administer Clopidogrel, this will be documented and handed over to the PPCI team in the CAS. The CAS team will then ensure the patient receives 180mg Ticagrelor.
 - 15.3. The ambulance crew responsible for transporting the patient to the OHC should give an estimated time of arrival (ETA) to the ACCU nurse and then call the ACCU again when they are approximately 10 minutes away from the OHC to ensure that the PPCI team is ready to meet the patient on arrival.
16. Cascade of PPCI activation during CAS core working hours (08:00-16:00hrs): (see appendix)

- 16.1. When receiving a call from the paramedics to activate the PPCI pathway the ACCU nurse will call 4444. During this call, the operator will take some details from the ACCU nurse. These details will include the hospital site (JR), the emergency team required (PPCI Team) and the ETA of the patient (in minutes). The operator will then bleep all relevant staff (Cardiac bed manager, Cardiology Registrar on call, radiographer, CAS coordinator, OxAMI trial staff and the ACCU coordinator) to inform them of the PPCI activation and the ETA of the patient. The ACCU nurse will then telephone call the CAS to confirm that the CAS nurses, cardiac physiologists and the cardiology Consultant are ready to receive the patient. The ACCU staff will give patient details, including name and date of birth to the CAS team.
- 16.2. If a 10 minute pre-alert call from the ambulance is expected, the ACCU nurse will await this. Once received, the ACCU nurse will inform the CAS staff and the on-call Cardiology Registrar of the patient's imminent arrival.
- 16.3. If a patient is already an inpatient at the JRH (in ED, EAU or on one of the wards) or if the patient is in another hospital, then the clinician responsible for the patient will call the PPCI Hotline or the patient will be accepted for PPCI by the on-call Cardiology Registrar. The Cardiology Registrar will then contact the ACCU nurse so that the PPCI team may be activated as above.
- 16.4. The CAS co-ordinator is responsible for managing the routine case load of patients to ensure, where possible, that a Cath Lab is available to receive the patient immediately on their arrival to the OHC, or as soon as practicable if already within the JRH. Should this not be possible, the patient should be managed in the most appropriate safe location within the CAS, as agreed by the CAS co-ordinator and the on-call Cardiology Registrar. If the patient is already within the JRH, the on-call Cardiology registrar is responsible for deciding whether the patient should remain in their current location (e.g. the ED or EAU) until a Cath Lab becomes available to receive the patient, or whether they should be transferred to the CAS and managed there prior to PPCI.
- 16.5. The on-call Cardiology Registrar is responsible for the care of the patient until they are receiving treatment in the Cath Lab and throughout the procedure, unless it is agreed by the Cardiology Consultant responsible for the patient that their assistance is no longer required.
17. Cascade of PPCI activation outside of the CAS core working hours:
 - 17.1. When an ACCU nurse accepts a patient under the care of the ambulance staff for PPCI, they will call 4444. During this call, the operator will take some details from the ACCU nurse. These details will include the hospital site (JR), the emergency team required (PPCI Team) and the ETA of the patient (in minutes). The operator will then bleep all relevant staff to inform them of the PPCI activation and the ETA of the patient. Outside of CAS core working hours only the Cardiology Registrar on call and the radiographer will receive this bleep message. The ACCU nurse is then responsible for contacting the 'PPCI On-Call Team'.
 - 17.2. The 'PPCI On-Call Team' will consist of the designated Cardiology Consultant, the on-call & on-site Cardiology Registrar, a CAS trained Radiographer, a Cardiac Physiologist and the first on-call and second on-call CAS nurse. Names of and contact numbers for the on-call team are maintained by the CAS co-ordinator/CAS Sister/Charge Nurse on an Excel spreadsheet, accessible via the cardiac server. It is the responsibility of the CAS co-ordinator to ensure last minute changes to the rota are made on the spreadsheet. The CAS

Sister/Charge Nurse maintains responsibility for ensuring contact numbers are accurate. Each on-call team member should be made aware of the patient's ETA to the OHC. The ETA of each on-call team member should then be ascertained to facilitate appropriate planning for maintaining the patient's safety on arrival to the OHC.

- 17.3. If a 10 minute pre-alert call from the ambulance is expected, the ACCU nurse will await this. Once received, the ACCU nurse will inform the on-call Cardiology Registrar of the patient's imminent arrival.
- 17.4. When a patient is accepted for PPCI by the on-call Cardiology Registrar, for example from within the JRH or another medical facility, the Cardiology Registrar will contact the ACCU nurse to cascade the PPCI activation and contact the on-call team as above.
- 17.5. The ACCU nurse will consider contacting the OxAMI fellow if the activation occurs during a time period when the OxAMI team are recruiting patients. It is the responsibility of the OxAMI research team to ensure ACCU are aware of recruitment periods and which fellow is on call. This information is held on the ACCU and is updated as required by the research team.
- 17.6. Once the on-call team have been contacted, the ACCU nurse will open a Cath Lab in order for the on-call team to prepare for the PPCI procedure on their arrival. The Cath Lab keys will remain with the ACCU nurse until the arrival of a CAS nurse who can then receive them.
- 17.7. Should the patient already be on the JRH site, for example in the ED, the patient should be cared for in the most appropriate place of safety as determined by the on-call Cardiology Registrar until the arrival of the on-call PPCI team. It may be appropriate to transfer the patient to the CAS prior to the arrival of all team members and this decision will be the responsibility of the on-call Cardiology Consultant.
- 17.8. Once the 10 minute pre-alert call from the ambulance service has been received, the ACCU nurse will inform the on-call Registrar to ensure they are available to meet the patient in CAS. Should no other or insufficient members of the on-call team be on-site by the time of arrival of the patient, the ACCU nurse will arrange to meet the patient with the on-call Cardiology Registrar. Support from and effective communication with the ACCU co-ordinator at this point in time is required to ensure appropriate nursing cover for all patients on ACCU whilst the ACCU nurse is in the CAS. The patient will need to be cared for in a place of safety within the CAS until the Radiographer has completed mandatory equipment checks in the Cath Lab. The patient and team will need to wait outside the Cath Lab whilst x-ray equipment is tested. The patient must remain on the transfer trolley until these checks are completed.
- 17.9. The PPCI procedure will only commence when all members of the on-call PPCI team are present following instruction from the on-call Cardiology Consultant.

Contingency and additional arrangements

18. No bed availability on ACCU:

- 18.1. During core working hours, if a bed is not immediately available on ACCU, the patient will remain in the CAS whilst the ACCU bed is arranged. It is recognised that multiple patient transfers and bed moves may be required to accommodate the patient post PPCI on ACCU and the patient may need to spend some time in the CAS after the procedure has finished. The patient will be managed in the

most appropriate area in the CAS and a member of the CAS team will be assigned responsibility for their care until transfer to the ACCU can be arranged.

- 18.2. Outside of core working hours, if there are no beds available within ACCU, the Cardiology ward and Cardiothoracic ward co-ordinators will be contacted to ascertain the availability of empty beds. Should there be no empty beds on either of these wards, the co- coordinators will identify patients who may be safely relocated to other areas within the hospital. The on-call Operational Manager for the JRH will be contacted via the hospital switchboard to ascertain bed availability elsewhere within the hospital and if possible a patient from within the OHC relocated to another area. Again, it is recognised that multiple patient transfers and bed moves may be required to create an ACCU bed. If a bed is identified but not immediately available, the patient will remain in the CAS post PPCI with the on-call team.
- 18.3. If a nursed bed is not available, the ACCU nurse and the CTCCU coordinator will liaise with the CAS on call team to manage the patient in the most appropriate safe place. If there is a bed space available on the CTCCU this will be utilised and the coordinators will manage the staff available to them on shift to optimise safety for all, this may include requesting one of the on-call nursing team to remain on the CTCCU in exceptional circumstances. If there is no bed capacity identified, the on-call team, with support from the ACCU nurse and the CTCCU coordinator, will manage the patient in the CAS. In such circumstances the Matron for Cardiology or designated deputy should be contacted to advice the situation. The first available bed should be utilised thereafter.
19. Patient unstable post PPCI:
 - 19.1. Should the patient be in an unstable condition post procedure and there is no physical bed space empty on the ACCU, during core working hours the Cardiology Consultant will identify members of the Cardiology team who will remain with the patient and support the nurse caring for them in the CAS until an ACCU bed is available. Outside of core working hours the full on-call team will remain with the patient in the CAS. If an ACCU bed space is available, the patient may be transferred to the ACCU with the agreement of the CAS and the ACCU co-ordinator. The CAS nurse, and the on-call Cardiology Registrar or SHO if required, will remain on the ACCU until the ACCU nursing team are able to take over the care of the patient. In the event that a post PPCI patient cannot be cared for in the ACCU due to lack of beds or available staff, the patient should be considered for transfer to CTCCU. Post PPCI patients who require IABP support should be transferred to CTCCU.
20. Inability to contact on-call PPCI team member(s) despite numerous attempts:
 - 20.1. If unable to contact the on-call Cardiology Consultant, the ACCU nurse will attempt to contact other local Interventional Consultants, starting with the Consultant on-call for the following day, in consultation and agreement with the on-call Cardiology Registrar.
 - 20.2. If unable to contact the on-call Cardiac Physiologist, the ACCU nurse will attempt to contact other cardiac physiologists starting with the cardiac physiologist on-call for the following day.
 - 20.3. If unable to contact the on-call radiographer – Radiology will normally have a CAS trained radiographer on site. On bleep activation, radiographers on site will organise existing workload so as to be able to attend the PPCI procedure. Infrequently, extra cover may be provided by a radiographer from home. Radiographers on duty will call the allocated person and communicate to the

ACCU if any difficulties arise. In this situation, another team member may need to be contacted.

- 20.4. If unable to contact a member of the on-call nursing team, the ACCU nurse will contact the CAS Sister or designated deputies as per PPCI on-call rota, for further advice. In such circumstances, the on-call Cardiology Registrar will act as the scrub nurse and the ACCU nurse will make every attempt to assist with the PPCI ensuring, in collaboration with the ACCU co-ordinator, the safety of the patients on the ACCU. This may require utilising members of staff from other areas within the OHC.
- 20.5. The inability to contact a member of the on-call PPCI team will be monitored via the use of the Trust incident reporting system, which should be completed for every occasion a member of the team is not able to be contacted
21. Use of the ACCU nurse to assist with PPCI instead of the second on-call CAS nurse:
 - 21.1. A number of the ACCU nurses will have been trained as competent to act as a Cath Lab 'runner' for PPCI procedures. Should patient numbers, patient dependency and staffing levels on the ACCU allow, a decision may be taken to utilise the ACCU nurse to assist with the PPCI procedure rather than calling in the second on-call CAS nurse. This decision will be collaboratively made by the ACCU nurse and the ACCU co-ordinator.
22. Use of the ACCU PPCI nurse as additional assistance to the full on-call team:
 - 22.1. Should the on-call PPCI team feel the condition of the patient requires additional nursing assistance during the procedure, they may request the ACCU nurse to remain and act as a second 'runner' in the lab, in addition to the full on-call team. As above, this decision will be made collaboratively by the ACCU nurse and the ACCU co-ordinator. Consideration will be given to seeking assistance from other areas within the OHC. Should additional medical support be required, activation of the 'Cath Lab Response Team' will occur by calling 2222.
23. Attendance of an ACCU nurse 'in training' in addition to the full on-call team:
 - 23.1. Should patient numbers, patient dependency and staffing levels on the ACCU allow, a decision may be taken for an ACCU nurse or a nurse requiring training in PPCI, to observe/assist with the PPCI procedure in order to achieve and/or maintain skills and competence in performing this role. As above, this decision will be made collaboratively by the ACCU nurse and the ACCU co-ordinator. Consideration should be given to the use of the clinical education team to support training as required.
24. Activation of concurrent patients requiring PPCI:
 - 24.1. Outside of the COVID-19 pandemic, should a patient require PPCI whilst a PPCI procedure is already in progress, the following will occur:
 - 24.1.1. During core CAS hours this will be managed by the CAS co-ordinator and a Cath Lab made available as soon as possible to receive the patient, utilising appropriate members of the CAS Interventional Cardiology, nursing, physiology and radiography teams as required.
 - 24.1.2. Outside of the CAS core working hours it may be agreed to admit the second patient to the CAS. This decision will be taken by the on-call Cardiology Consultant and the Cardiology Registrar. The patient will remain on the ambulance trolley under the care of the ambulance crew and the on-call Cardiology Registrar until the on-call team are ready to

take over care of the patient. Should the patient become unstable whilst awaiting PPCI, call 2222 and request the 'Cath Lab Response Team'.

- 24.1.3. Should the second patient requiring PPCI already be on the JRH site, they will remain in a safe location under the care of their medical/surgical team as appropriate with advice from the on-call Cardiology Registrar.

24.2. During the COVID-19 pandemic, the following will occur:

- 24.2.1. The patient will be nursed in a 'COVID-Amber' bed until the PPCI team and lab are available. This should be within the ACCU if a bed is available. In the event that no ACCU bed is available, the safest 'COVID-Amber' option should be identified. This should be a side room within the OHC staffed by appropriately skilled staff. The patient will only be diverted to the JRH ED in extreme circumstances where no other safe option can be identified. In this instance, the ACCU nurse will pre-alert the ED and the patient will remain in ED until appropriate to transfer to the CAS for their procedure, or until a safe bed space within the OHC is identified.

25. Diversion of a patient requiring PPCI to the ACCU or the JRH ED:

- 25.1. In extreme circumstances, the ambulance crew may be asked to admit the patient to either the ACCU, CTCCU or the JRH ED, for example if there are already two patients receiving/awaiting PPCI or a TPW insertion is occurring within the CAS, or there is no-one available to receive the patient in the CAS due to another emergency elsewhere. In this situation the ACCU nurse in collaboration with the on-call Cardiology Registrar and/or Consultant will make a decision regarding which area the patient should be diverted to. The ACCU nurse will inform the receiving area, and the Cardiology Registrar will review on arrival. When appropriate, the patient will be transferred to the CAS for their procedure.

26. PPCI Team activated but the patient does not meet criteria for PPCI:

- 26.1. It is recognised that some patients may be admitted to the Cath Lab for PPCI but do not proceed to PCI after assessment of the patient on arrival to the Cath lab reveals an alternative diagnosis to AMI. In this situation it is up to the Consultant Cardiologist's team to refer the patient to the appropriate medical or surgical team. If the patient has been brought in by ambulance and the paramedics are still at the patient's side then it may be appropriate for those paramedics to take the patient to the ED via ambulance.

27. Extreme weather:

- 27.1. Should a situation arise where extreme weather conditions prevent members of the on-call PPCI team from being able to travel to the OHC, all efforts will be made to identify appropriate colleagues to replace them. This will be managed by the CAS Sister/Charge Nurse who will make the ACCU nurse aware of any changes that will have been made on the central rota or of any additional plans to manage the situation. If, despite these efforts a full on-call team is unavailable, a patient requiring PPCI will be managed according to the on-call Cardiology Consultant's instructions.

28. Patient identification and admission for emergency admissions direct to the CAS (i.e. not already within the OUH):

- 28.1. During core working hours, on the patient's arrival to the CAS, the CAS ward clerk will admit the patient via the EPR system.

- 28.2. Outside of core working hours, or when the ward clerk is unavailable, appropriately trained members of the CAS team will admit the patient via the EPR system. The CAS team will be responsible for ensuring the patient is appropriately labelled with an identification wristband.
- 28.3. Unknown and unconscious patients or those patients incapable of identifying themselves admitted to the CAS will need to be registered using a codified method that uses unique identifiers for the surname, first name and MRN to differentiate between several unknown patients. A unique hospital number will be generated by EPR and a wristband produced. The patient will then be investigated and treated using this data and wristband. The patients ID must only be updated once the critical phase of treatment is completed (after PPCI, Cardio thoracic surgery or any emergency blood transfusion).
- 28.4. Once the patient's identity is known, the decision to update the patients ID is the responsibility of the Lead Clinician for the patients care in hospital. Note: The patients ID must only be updated once the critical phase of treatment is completed (after PPCI, Cardio thoracic surgery or any emergency blood transfusion).
29. The death of a patient in the CAS after admission for PPCI:
 - 29.1. All deceased patients must be properly identified with two wristbands.
 - 29.2. In the event of the patient's name not being known, then the patient will need to be registered using a codified method that uses unique identifiers for the surname, first name and MRN to differentiate between several unknown patients. A unique hospital number will be generated by EPR and a wristband produced. The patient must be properly identified with two of these wristbands.
 - 29.3. If the NOK is known or unknown, all efforts made to contact the next of the Kin should be documented. Consider the use of the police to help with contacting the next of kin.
 - 29.4. Last offices will be performed in line with the OUH [Care After Death Policy](#)
 - 29.5. The deceased patient will be transferred directly from the CAS to the mortuary.
 - 29.6. A Trust incident report will be completed as in line with OUH CAS policies and procedures.
30. Oxford Heart Centre Lift Breakdown:
 - 30.1. If a patient requiring PPCI is brought in by ambulance from home, from another hospital or 'off the street', they will be admitted directly to the CAS via the automatic doors on level -1 of the OHC.
 - 30.2. If a patient is admitted to the CAS from elsewhere in the JRH (the wards or ED) they will require access to the CAS via either of the lifts, D4 and D5 on Level -1 of the OHC.
 - 30.3. In the event that both of the lifts are broken and a patient requires transfer to CAS from within the John Radcliffe Hospital then a 999 call to SCAS will be made for emergency transfer. The member of staff making this call should ensure they request a 'time critical transfer'.
 - 30.4. In the event that both lifts are broken and patients require transfer out of CAS to the main John Radcliffe Hospital then these patients will be cared for within CAS until one or both lifts are functioning.
 - 30.5. All staff will report faults through the Estates Helpdesk on extension 20600 (Mon- Fri 0700 to 1600) or by contacting the Estates Shift Electrician at any other time. The lift failure should also be reported to the OHC bleep holder

(bleep 4570) between 08:00-17:00 Monday- Friday and outside these hours to the Band 7 senior nurse on CTCCU. The Bleep holder/Band 7 senior nurse will monitor progress to restore either or both lifts back to full service and ensure that the senior nurse on duty in CAS is kept informed and the job number recorded within CAS for monitoring purposes.

Airway Support during PPCI

31. Patients may require airway support during the PPCI pathway in 3 scenarios:

31.1. Patients requiring airway support En route to the OHC:

Should the patient require airway support en route to the OHC having activated the PPCI pathway, the ambulance crew will treat as appropriate and make a clinical decision whether the patient is clinically stable enough to be admitted directly to CAS or whether diverting to the ED is more appropriate. This decision will take into account the time of day (within the CAS working hours or outside of them) and the distance from the OHC, therefore giving consideration to whether there will be a sufficient number of trained staff to deal with the patient on arrival in CAS. The crew should inform the ACCU nurse as soon as practicable of the patient's condition for advice regarding the most appropriate clinical area for admission. The patient's safety will be a priority and as such it is recognised that this call may not be possible to make until the patient has been admitted to the ED. The ACCU nurse is responsible for informing the CAS coordinator during core working hours and the on call Cardiology Registrar of the patient's condition. The nurse will also pre-alert the Cath Lab Response Team that their assistance may be required in CAS. Should the patient be directly admitted to the CAS, the CAS team will make a clinical assessment of the patient's condition and request the Cath Lab Response Team via a 2222 call if required. Whilst the Cath Lab Response Team are away from CTCCU, the AICU team will provide back-up cover to the CTCCU for the period required.

31.2. Patients requiring airway support within the CAS for both Peri and Cardiac Arrest: If the patient's condition should deteriorate, the Cath Lab Response Team should be called via 2222. The Cath Lab Response Team will be responsible for contacting and discussing ongoing care of the patient with the CTCCU intensivist and will provide ongoing support to the patient during the procedure. The Cardiology team in collaboration with the CTCCU intensivist will arrange ongoing care where it is most clinically appropriate. If the cardiothoracic surgeon is required then the SWAT team will be called via 2222.

31.3. Patients on the JR site who require airway support prior to transfer to CAS: Where the Cardiology team has been contacted regarding a patient on the JRH site (ED, EAU or the wards), and their clinical condition requires airway support, this will be provided in the ward/ED area via the Trust 2222 resuscitation process supported by the AICU Registrar. If the decision is made to proceed to PPCI, it is the responsibility of the AICU Registrar to contact the Cath Lab Response Team. The AICU Registrar and/or the Cath Lab Response Team will support the transfer of the patient to CAS. The patient's care will be taken over by the Cath Lab Response Team following a formal handover by the AICU registrar. The Cath Lab Response Team will be responsible for contacting and discussing ongoing care with the CTCCU Intensivist and will provide ongoing support to the patient during the procedure. The Cardiology team in collaboration with the CTCCU intensivist will arrange ongoing care where it is most clinically appropriate.

32. Contingency arrangements for Airway Support:

- 32.1. Cath Lab Response Team already committed in an emergency situation - If the Cath Lab Response Team are unable to support CAS then a 2222 call will be made for the adult resuscitation team.
- 32.2. Emergency on CTCCU/ CTW whilst team supporting CAS - Where the Cath Lab Response Team are supporting CAS and a patient on CTCCU or CTW requires their assistance (i.e. emergency chest opening) then the AICU team will be asked to take over the care of the CAS patient to allow the Cath Lab Response Team to return to CTCCU/CTW. Where appropriate the circulating nurse will support the anaesthetist if the SWAT bleep holder needs to leave.

On-call and compensatory rest

33. The on-call nursing and cardiac physiology teams will be provided with compensatory rest periods as in line with the OUH Theatre and Anaesthetics Directorate Local Agreement.

Maintaining normal service during the working day

34. The PPCI service under normal circumstances should not have an impact on the ability to deliver the scheduled service during the working day.
35. In unforeseen circumstances due to, for example, staff sickness where the scheduled service cannot be managed due to below minimal staffing numbers, a risk assessment of the service will take place. The Nurse in charge of the CAS service in conjunction with the multidisciplinary team will assess the clinical needs of the scheduled patients and prioritise the list accordingly, scheduling work within the capacity that can be managed with the remaining team.
36. Scheduling of work within the CAS aims for all work to be completed by 17:00 and scheduled cases should not be commenced where the anticipated finish time would be beyond 17:00. The service will be proactively managed through advanced scheduling of all laboratory lists in advance and actively managed to a 17:00 hrs finish throughout the day. This will be managed by the CAS coordinator in collaboration with the Consultant in charge on the day.

Review

37. This policy will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents*.

References

38. Treatment of Heart Attack National Guidance, Final Report of the National Infarct Angioplasty Project (2008)

Appendix 1: Responsibilities

1. The Clinical Director for the Cardiology, Cardiac and Thoracic Surgery Division has overall responsibility for the service.
2. The CAS Sister/Charge Nurse, Cardiology/ACCU Sister/Charge Nurse and Lead Nurse for Cardiology/ACCU have managerial responsibility for the service.

Appendix 2: Definitions (This is a mandatory heading)

1. **PPCI** Primary Percutaneous Coronary Intervention
2. **STEMI**
ST Elevation Myocardial Infarction
3. **AMI** Acute Myocardial Infarction
4. **OOHCA** Out of hospital cardiac arrest
5. **ROSC**
Return of spontaneous circulation
6. **OHC** Oxford Heart Centre
7. **OUH** Oxford University Hospitals Foundation Trust
8. **JRH** John Radcliffe Hospital
9. **ED** Emergency Department
10. **EAU** Emergency Assessment Unit
11. **SCAS** South Central Ambulance Service
12. **EPR** Electronic Patient Records
13. **ETA** Estimated Time of Arrival
14. **CTB** Call to Balloon
15. **DTB** Door to Balloon
16. **LBBB** Left Bundle Branch Block
17. **IABP** Intra-Aortic Balloon Pump
18. **CAS** Cardiac Angiography Suite
19. **Cath Lab** A Catheter laboratory (Cath Lab) within the CAS
20. **ACCU** Acute Cardiac Care Unit
21. **CTCCU** Cardiac and Thoracic Critical Care Unit
22. **OxAMI**
Oxford Acute Myocardial Infarction Research Project
23. **Cath Lab Response Team** CTCCU Anaesthetic Registrar and SWAT Nurse
24. **SWAT Bleep Holder** Surgical Ward Arrest Team Bleep Holder
25. **SWAT Team** CTCCU Anaesthetic Registrar, Cardiothoracic Surgical Registrar and SWAT nurse

26. **Eligibility for PPCI** In order to be eligible for PPCI, patients must meet the following criteria:

- Have symptoms characteristic of AMI and ST segment elevation on the ECG >1mm in two or more contiguous limb leads and/or >2mm in two or more contiguous chest leads OR have left bundle branch block believed to be new
- Those who have been resuscitated from cardiac arrest (whose symptoms before the arrest may be unknown) with the ECG criteria as above, also meet criteria for PPCI
- Onset of worst pain symptoms of less than 12 hours duration. Patients with a pain history of greater than 12 hours should be discussed with the on-call Cardiology Registrar in conjunction with assessment of their ECG where possible.
- The patient will ideally be conscious, coherent and able to understand their diagnosis and consent to admission for PPCI. If this is not the case, advice should be sought from the ACCU and the on-call Cardiology Registrar
- Should the patient experiencing an AMI have advanced medical conditions that will limit their anticipated life expectancy to less than 6 months, advice should be sought from the on-call Cardiology Registrar

Appendix 3: Education and Training

1. Each member of the PPCI team is responsible for working within their own professional codes of conduct in providing the best possible care to the patient.
 - 1.1. **Medical Staff**
 - 1.1.1. **Consultant Cardiologists** - All the cardiologists involved in the rota are trained in the techniques of PPCI and have been providing a 24 hour, seven day a week service since August 2007. Patient outcomes and results to date have been positive and at least comparable with national benchmarking, with results presented to local, national and regional colleagues. Audit results will continue to be presented monthly to existing and any new dedicated meetings for the PPCI service.
 - 1.1.2. **Specialist Registrars** - All registrars are appointed to Cardiology training posts by the Oxford Deanery. Their competency is assessed annually by their Training Committee. A member of the Cardiology Registrar team is resident on call 24 hours a day, seven days a week.
 - 1.1.3. **OxAMI Fellows** – Research fellows activated as part of the PPCI team undergo their own formal training through Oxford University in relation to each research study which may be undertaken.
 - 1.2. **CAS Nurses**
 - 1.2.1. All registered nursing staff within the Cardiac Angiography Suite undertake a competence based training programme for all aspects of the service. Only when this has been completed are nurses considered competent to undertake first on-call duties for the out of hour's service. Local CAS induction for all staff will include familiarisation with this policy and its application to practice. This will be facilitated by senior members of staff within the department. There is no mandatory training associated with this policy. Training sessions as required will be targeted to an individual's training needs and defined within their annual appraisal and supervision. The role of the CAS nurse will also involve admitting patients onto EPR and recording essential data onto the SOLUS database.
 - 1.3. **ACCU Nurses**
 - 1.3.1. Participating nurses from ACCU will all be Advanced Life Support/Immediate Life Support trained with relevant demonstrable and competency assessed experience in the diagnosis and management of those experiencing Acute Myocardial Infarction (AMI) and in peri-arrest situations. In addition to the ACCU core competencies of cardiac and respiratory assessment, all participating nurses will have completed a competence based training programme that prepares them for activation of the PPCI service and safe systems of working as a "runner" in the CAS. Competence based knowledge and training in the nursing management of the patient requiring temporary pacing, IABP, CPAP and inotropic therapy will also be required. An education programme for junior members of the ACCU team will ensure ongoing provision of this service.
 - 1.3.2. Local ACCU induction for all staff will include familiarisation with this policy and its application to practice. This will be facilitated by senior members of staff within the department.

1.3.3. Training sessions as required will be targeted to an individual's training needs and defined within their annual appraisal and supervision. The role of the ACCU nurse will also involve adding patients to the local 'door to balloon' spreadsheet on arrival to ACCU.

1.3.4. The policy will be available at all times on the Trust intranet.

1.4. Cardiac Physiologists

1.4.1. Qualified Clinical Physiologists (Cardiology) have undertaken specific CAS based training as part of their qualification with evidence of competence provided through an assessed portfolio, including internal verification.

1.5. Radiographers

1.5.1. All radiography staff within CAS undertake a competence based training programme. On completion of all competencies, Radiographers are signed off by the Superintendent Radiographer and become available for 'Out of Hours' service. The list is available on radiology's 'O' drive training matrix, accessible by all OUH radiographers.

1.6. Ambulance Personnel

1.6.1. The PPCI facility at the OHC will be serviced by staff from the Oxfordshire and Buckinghamshire sub-division of the South Central Ambulance Service (SCAS) NHS Trust. Additionally, any other Ambulance Trust can access this service if their patient is able to be transferred for treatment within the recognised time frame of 120 Minutes.

1.6.2. Ambulance Paramedics are registered under the Health Professions Council (HPC) and are governed by the HPC code of practice, in addition to codes of practice relating to the NHS Ambulance Service nationally. Paramedics undertake a comprehensive training programme and a process of continuing professional development including clinical refresher training on an annual basis. They commonly work in a single responder role or as a crew with an Ambulance Technician, who also undertakes a similar refresher training regime.

Appendix 4: Monitoring Compliance

- Use the following statement and mandatory table to list specifically what will be monitored to ensure that the policy is effective, including the minimum standards for compliance or non-compliance.
- Compliance with the document will be monitored in the following ways.

What is being monitored:	How is it monitored:	By who, and when:	Minimum standard	Reporting to:
Staff responsible for activation and delivery of PPCI will be adequately trained.	Local training data	The CAS Sister/Charge Nurse, the Cardiology Sister/Charge Nurse and the Cardiology/ACCU Lead Nurse and the Directorate Clinical		Directorate Clinical Governance

What is being monitored:	How is it monitored:	By who, and when:	Minimum standard	Reporting to:
		Governance will monitor		
Call to Balloon (CTB) times	Data collected from patients records (Ambulance records and hospital records)	The CAS Sister/Charge Nurse, the Cardiology Sister/Charge Nurse and the Cardiology/ACCU Lead Nurse and the Directorate Clinical Governance will monitor locally and continuously The results will be audited nationally and annually		Directorate Clinical Governance Myocardial Ischemia National Audit Project (MINAP) commissioned by the Healthcare Quality Improvement Partnership (HQIP) as one of the Clinical Outcome Review Programmes funded by NHS England
Door to Wire times	Data collected from patients records (Ambulance records and hospital records)	The CAS Sister/Charge Nurse and the Directorate Clinical Governance will monitor locally and continuously		Directorate Clinical Governance
Door to Balloon (DTB) times.	Data collected from patients records (Ambulance records and hospital records)	The CAS Sister/Charge Nurse, the Cardiology Sister/Charge Nurse and the Cardiology/ACCU Lead Nurse and the Directorate Clinical Governance will monitor locally and continuously The results will be audited nationally and annually		Directorate Clinical Governance Myocardial Ischemia National Audit Project (MINAP) commissioned by the Healthcare Quality Improvement Partnership (HQIP) as one of the Clinical Outcome Review Programmes funded by NHS England
Reporting of any events that contributed to a delay in activation of the	Trust Incident Reporting System	The CAS Sister/Charge Nurse, the Cardiology Sister/Charge		Directorate Clinical Governance

What is being monitored:	How is it monitored:	By who, and when:	Minimum standard	Reporting to:
PPCI pathway or delivery of the PPCI, to assess compliance with the policy and guide policy review		Nurse and the Cardiology/ACCU Lead Nurse and the Directorate Clinical Governance will monitor as reported		

Appendix 5 PPCI Activation Guideline

STEMI?

ST Elevation Myocardial Infarction

ST Segment Elevation >1mm in 2 or more limb leads?
ST Segment Elevation >2mm in 2 or more chest leads?
Onset of symptoms <12 hours?

Call the PPCI Hotline without
delay

Ext 21759

To activate the PPCI Team

PPCI – Primary Percutaneous Coronary Intervention

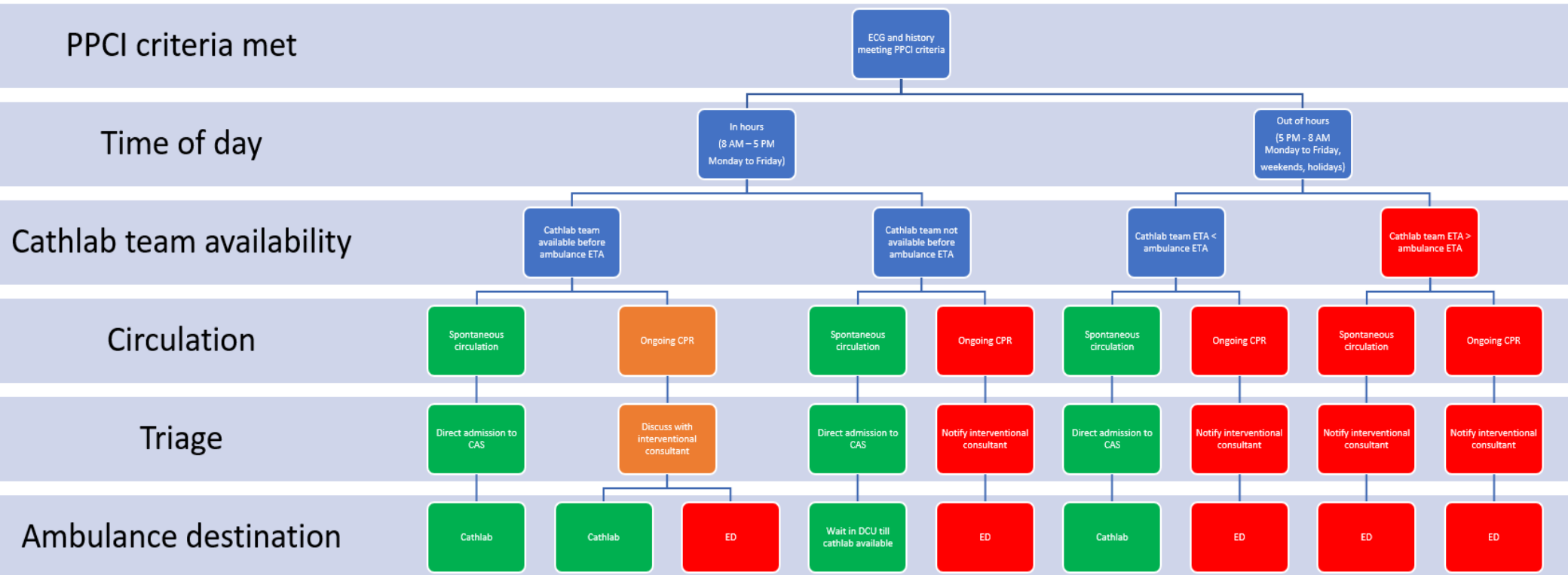
Seek urgent cardiology referral for those with:

- Left bundle branch block believed to be new in the context of acute cardiac sounding chest pain
- Those resuscitated from cardiac arrest (whose symptoms preceding the arrest may be unknown) with the ECG criteria as above

Appendix 6 PPCI Call out flow chart

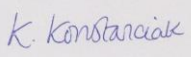
PPCI call out flow chart		
Switch Process	Core working hours	Out of hours
Emergency phone number:	4444	4444
Which hospital site?	JR main building	JR main building
Which emergency team?	PPCI team	PPCI team
Which building are you in?	Oxford Heart Centre	Oxford Heart Centre
Which floor level are you on?	Not required	Not required
Which ward/area?	Not required	Not required
State message - advise estimated time of arrival (ETA) as this will be communicated to the bleep holders.	Message: Primary PCI ETA "...." minutes	Message: Primary PCI ETA "...." minutes
Additional requirements of CCU nurse	Call <u>cath lab E</u> on 72631 to confirm Those on bleep cascade are: Cardiac bed manager, Cardiology <u>Reg</u> on call, Radiographers (both bleeps), CAS coordinator, <u>OxAMI</u> , <u>CTCCU</u> coordinator.	Then: 1. Contact on call cardiology consultant. 2. Contact 1 st on call CAS nurse 3. Contact 2 nd on CAS nurse 4. Contact on call cardiac physiologist 5. Consider contacting <u>OxAMI</u> CO registrar & radiographers will receive the fast bleep.

Appendix 7: Ambulance Triage for PPCI



Appendix 7: Equality Impact Assessment (This is a mandatory heading)

1. Information about the policy, service or function

What is being assessed?	
New Policy/Procedure ☐	New Service/Function ☐
Existing Policy/Procedure ☒	Existing Service/Function ☐
Staff member completing assessment: Katie Konstanciak	
Name of policy/service/function: Provision of a Primary Percutaneous Coronary Intervention (PPCI) Service for patients presenting with Acute Myocardial Infarction (AMI) to the Oxford Heart Centre	
Details about the policy/service/function: This policy aims to ensure the safe and timely delivery of a twenty-four hour PPCI service for those eligible patients presenting to, or referred to, the OHC with AMI.	
Review Date:	Date assessment completed: 25/03/2022
Signature of staff member completing assessment: 	Signature of staff member approving assessment:

2. Screening Stage

Who benefits from this policy, service or function? Who is the target audience? (tick all that apply)		
Patients ☒	Family/Carers ☐	Not applicable ☐
Staff ☒	Other (specify):	
Does the policy, service or function involve direct engagement with the target audience?		
Yes ☒ Continue with full equality impact assessment		
No ☐ Full equality impact assessment not required		

3. Research Stage

Notes:

If there is no impact for a particular group or characteristic, mention this in the Reasoning column and refer to evidence where applicable.

¹Race categories follow those used in the National Census by the Office for National Statistics. Consideration should be given to the specific communities within broad categories such as Bangladeshi people.

²Please select age groups which may be impacted by the policy, service or function and complete as appropriate.

³Religion or Belief covers a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus; it also covers people who do not have a faith. Consider these individually and collectively when determining impacts.

Characteristic		Positive Impact	Negative Impact	Neutral Impact	Not Enough Information	Reasoning
Sex and Gender Reassignment	Men (incl. trans men)			X		
	Women (incl. trans women)			X		
	Non-binary people			X		
Race¹	Asian or Asian British			X		
	Black or Black British			X		
	Mixed Race			X		
	White British			X		
	White Other			X		
	Other:			X		
Disability	Disabled people			X		
	Carers			X		
Age²						
				X		
Sexual Orientation				X		
Religion or Belief³				X		
Pregnancy and Maternity				X		
Marriage or Civil Partnership				X		
Other Groups /Characteristics	For example: homeless people, sex workers, rural isolation.			X		

List the sources of information used in the table below	
Using the table below, list any protected groups you will target during the consultation process, and give a summary of those consultations.	
Group	Summary of consultation
List any other individuals/groups that have been or will be consulted on this policy, service or function.	

4. Summary Stage

Outcome Measures List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.
Positive Impact List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.
Unjustifiable Adverse Effects List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.
Justifiable Adverse Effects List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

Identified Risk	Recommended Actions	Lead	Resource Implications	Review Date	Completion Date