Resuscitation Council (UK)

Quality standards for cardiopulmonary resuscitation practice and training

Introduction and overview

Resuscitation Council (UK)
5th Floor
Tavistock House North
Tavistock Square
London
WC1H 9HR

Tel: 020 7388 4678
Fax: 020 7383 0773

Website: www.resus.org.uk
email: enquiries@resus.org.uk

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Hyperlinks to other document sections or external websites are shown in blue.

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Contributors

Resuscitation Council (UK)	Resuscitation Council (UK)	AC PC PDC
Royal College of Physicians of London	Royal College of Physicians	AC
Royal College of Anaesthetists		AC
Intensive Care Society	intensive care society	AC
College of Emergency Medicine	The College of Emergency Medicine	AC
Council for Professionals as Resuscitation Officers	CPRO	AC
Faculty of Intensive Care Medicine	The Faculty of Intensive Care Medicine	AC
Paediatric Intensive Care Society		AC
Royal College of General Practitioners	RCGP Royal College of General Practitioners	PC
Royal College of Nursing	Royal College of Nursing	AC
Royal College of Paediatrics and Child Health	RCPCH Royal College of Paediatrics and Child Health	AC
Royal College of Psychiatrists		

The organisations listed on the previous page have all contributed to this Introduction and Overview document.

Contributing organisations to the Acute Care standards are indicated on the previous page with the symbol AC

Contributing organisations to the Primary Care standards are indicated on the previous page with the symbol PC

Contributing organisations to the Primary Dental Care standards are indicated on the previous page with the symbol PDC

Contributing organisations to the Community Care standards are indicated on the previous page with the symbol CC

Contributing organisations to the Mental Health standards are indicated on the previous page with the symbol MH

The Resuscitation Council (UK) Patient Advisory Group has advised on this document.

Working group members:

Jasmeet Soar (Chair), Resuscitation Council (UK)

Mick Colquhoun, Resuscitation Council (UK)

Tracey Courtnell, Resuscitation Council (UK)

Peter-Marc Fortune, Paediatric Intensive Care Society

Jamie Fulton, Resuscitation Council (UK)

David Gabbott, Royal College of Anaesthetists

Matthew Griffiths, Royal College of Nursing

Susan Hampshire, Council for Professionals as Resuscitation Officers

Fiona Jewkes, Royal College of General Practitioners

K-L Kong, Resuscitation Council (UK)

Sarah Mitchell, Resuscitation Council (UK)

Ian Maconochie, Royal College of Paediatrics and Child Health

Jerry Nolan, Resuscitation Council (UK)

Gavin Perkins, Faculty of Intensive Care Medicine

David Pitcher, Royal College of Physicians, Resuscitation Council (UK)

Steven Searle, College of Emergency Medicine

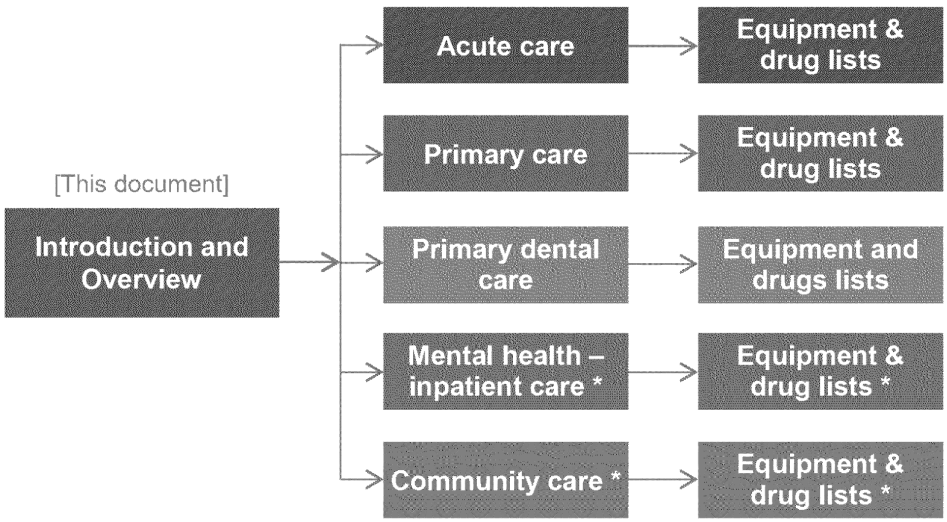
Gary Smith, Royal College of Physicians, Intensive Care Society

Richard Williams, Royal College of Psychiatrists

Contents

Other quality standards documents

A roadmap for the other documents which comprise the quality standards for cardiopulmonary resuscitation practice and training is shown below. Also included below are hyperlinks to access the other quality standards documents.



Links to the Quality Standards documents:

- **Acute care**
- **Primary care**
- **Primary dental care**
- **Mental health inpatient care ***
- **Community care ***

** Documents currently in development*

1 Introduction and scope

Healthcare organisations have an obligation to provide a high-quality resuscitation service, and to ensure that staff are trained and updated regularly and with appropriate frequency to a level of proficiency appropriate to each individual's expected role.

This document provides quality standards for cardiopulmonary resuscitation practice and training in the following settings:

1. Acute care – mainly acute hospitals
2. Primary care – general practice (including out-of-hours services)
3. Primary dental care – excluding conscious sedation for which there are existing standards
4. Community care – * *(Documents currently in development)*
5. Mental health - inpatient care – * *(Documents currently in development).*

The aim of these standards is to:

1. Improve care and outcomes for patients who are deteriorating, or suffer cardiorespiratory arrest in a healthcare setting.
2. Update existing quality standards with a particular emphasis on simplification to improve implementation.
3. Provide new standards for community hospital care and mental health inpatient care.

Whenever possible, reference will be made to existing national guidance.

These standards update and replace:

1. Cardiopulmonary Resuscitation - Standards for clinical practice and training. A joint statement from The Royal College of Anaesthetists, The Royal College of Physicians of London, the Intensive Care Society and the Resuscitation Council (UK). October 2004. Revised June 2008.
2. Cardiopulmonary Resuscitation Guidance for clinical practice and training in Primary Care. Resuscitation Council (UK). July 2001.
3. Medical Emergencies and Resuscitation - Standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice. Resuscitation Council (UK) July 2006. Revised and updated February 2012.

There are numerous types of setting where clinical care is provided. This guidance does not provide standards for every possible setting or scenario. The standards in this document can be used to help guide development of standards in clinical settings that are not included in this document. Guidance relating to other settings may be added in the future.

2 Core standards

The same core standards apply in all settings to ensure that:

1. the deteriorating patient is recognised early and there is an effective system to summon help in order to prevent cardiorespiratory arrest.
2. cardiorespiratory arrest is recognised early and cardiopulmonary resuscitation (CPR) is started immediately.
3. emergency assistance is summoned immediately, as soon as cardiorespiratory arrest is recognised, if help has not been summoned already.
4. defibrillation, if appropriate, is attempted within 3 minutes of identifying cardiorespiratory arrest.*
5. appropriate post-cardiorespiratory-arrest care is received by those who are resuscitated successfully. This includes safe transfer.
6. implementation of standards is measured continually and processes are in place to deal with any problems identified.
7. staff receive at least annual training and updates in CPR, based on their expected roles.
8. staff have an understanding of decisions relating to CPR.
9. appropriate equipment is available for resuscitation.

* *Circumstances where this standard may not be achievable are included in the relevant section.*

3 Methods

A working group was set up by the Resuscitation Council (UK). Stakeholder organisations nominated individuals to the working group. Existing standards in each area were identified and, where needed, the existing standards were updated. Updates were based on consensus from working group members.

The evidence for specific aspects of resuscitation practice comes from Resuscitation Council (UK) Guidelines 2010. The process used by the Resuscitation Council (UK) to produce the 2010 Resuscitation Guidelines was accredited by the National Institute for Health and Clinical Excellence (NICE) (http://www.resus.org.uk/pages/guide.htm).

The first draft was sent to organisations for comment and approval. The drafts and final version were also reviewed and commented on by the Resuscitation Council (UK) Patient Advisory Group.

A draft of each standard was posted on the Resuscitation Council (UK) website for at least 4 weeks. Feedback was reviewed by the working group and consensus

reached on responses to any issues raised. Final documents were approved by the working group.

4 Implementation

Where appropriate, each section contains links to implementation tools or examples of good practice. Each section also contains guidance on measures to assess adherence to standards.

Terminology:

1. The term 'MUST' has been used when the consensus is that the standard promotes normal practice and is obligatory.
2. The term 'SHOULD' has been used when the consensus is that the standard promotes normal practice.
3. The term 'RECOMMENDS' is used when the consensus is that the standard promotes best practice.

5 Supporting information

1. Care Quality Commission. http://www.cqc.org.uk
2. European Resuscitation Council Guidelines. http://www.cprguidelines.eu
3. High Quality Care For All. NHS Next Stage Review Final Report. Department of Health. June 2008.
4. International Liaison Committee on Resuscitation. http://www.ilcor.org
5. Nolan J, Soar J, Eikeland H. The chain of survival. Resuscitation. 2006 Dec;71(3):270-1.
6. The NHS Constitution for England (2012 Edition)
7. Resuscitation Council (UK). http://www.resus.org.uk
8. Resuscitation Council (UK) Guidelines. http://www.resus.org.uk/pages/guide.htm

6 APPENDIX: Conflict of interest declaration

Name	Details	COI
Jasmeet Soar (Chairman)	Consultant in Anaesthetics & Intensive Care Medicine, North Bristol NHS Trust, Southmead Hospital, Bristol BS10 5NB	Editor, Resuscitation (paid honorarium) Chair ERC ALS working group lead (unpaid) ILCOR ALS Taskforce co-chair (unpaid) National Cardiac Arrest Audit steering group (unpaid)
Mick Colquhoun	c/o Resuscitation Council (UK), 5th Floor Tavistock House North, Tavistock Sq, London WC1H 9HR	None
Tracey Courtnell	Senior Resuscitation Officer (Community and Mental Health), Oxford Health NHS Foundation Trust, Chancellors Court, 4000 John Smith Drive, Oxford Business Park, Cowley Oxford OX4 2EX	None
Peter-Marc Fortune	Consultant Paediatric Intensivist, Royal Manchester Children's Hospital, Oxford Road, Manchester M13 9WL	Trustee, Advanced Life Support Group (ALSG) Chair of ALSG PaNSTaR course Chair of ALSG Human Factors Working Group Board member of NW Simulation Education Network
Jamie Fulton	Consultant in Medicine, Derriford Hospital, Plymouth PL6 8DH	IMPACT Curriculum Committee,
David Gabbott	Consultant Anaesthetist, Gloucestershire Royal Hospital, Great Western Rd, Gloucester GL1 3NN	NCEPOD assessor (unpaid)
Matt Griffiths	Advanced Nurse Practitioner, c/o Resuscitation Council (UK), 5th Floor Tavistock House North, Tavistock Sq, London WC1H 9HR	Consultant adviser RCN Visiting Professor, Birmingham City University Consultant adviser, Cumberlege Connections
Sue Hampshire	Senior Resuscitation Officer, c/o Resuscitation Council (UK), 5th Floor Tavistock House North, Tavistock Sq, London WC1H 9HR	None

Fiona Jewkes	Clinical Author, NHS Pathways, RBDT Connecting for Health, Vantage House, 40 Aire Street, Leeds LS1 4HT	Clinical Author for NHS Pathways (full time) (paid) Teaching for military on paediatric emergency care (paid) Consultant to Viro Pharma (paid) Chair Pre-hospital Paediatric Life Support (unpaid) BASICS education subcommittee (unpaid, but honorarium for teaching on a course) Hon. Company Secretary Joint Royal Colleges Ambulance Liaison Committee (unpaid) Paediatric Lead JRCALC guidelines (unpaid) Board Member for Faculty of Pre-hospital Emergency care (unpaid) Examiner for Diploma in Immediate Medical Care Examination (honorarium)
KL Kong	Consultant Anaesthetist, City Hospital, Dudley Road, Birmingham B18 7QH	Member, Sandwell and West Birmingham NHS Trust Resuscitation Committee
Ian Maconochie	Consultant in Paediatric Emergency Medicine, St Mary's Hospital, London W2 1NY	Royal College of Paediatrics: - Officer for Clinical Standards - Registrar - Member of the Clinical Standards Committee - Member of the Intercollegiate Fever DH study (demitted) College of Emergency Medicine, Member of the Clinical Standards Committee (demitted) European Resuscitation Council, National director for EPLS- WGG Children Action Prevention Trust (demitted), Trustee Trauma Care charity, Trustee Emergency Planning Clinical Advisory Group (DH) (EPCLAG) (disbanded), Member PAID: Medical advisor to a small company dealing with major incident equipment, approx. £1800 pa before tax Medical advisor to a newly founded small company to produce media material on national guidelines (non-remunerated to date) Work as an independent medical advisor to Youth Justice Board Honoraria for EMJ, ADC and BMJ in associate editorial roles
Sarah Mitchell	Director, Resuscitation Council (UK), 5th Floor Tavistock House North, Tavistock Sq, London WC1H 9HR	None

Jerry Nolan	Consultant in Anaesthesia and Intensive Care Medicine, Royal United Bath, Combe Park, Bath BA1 3NG	Editor-in-Chief, Resuscitation (paid Honorarium) Vice Chair, European Resuscitation Council (unpaid) Chair, National Cardiac Arrest Audit Steering Group (unpaid) Council Member, Royal College of Anaesthetists (unpaid) Council Member, College of Emergency Medicine (unpaid) Board member, Intercollegiate Board for Training in pre-hospital Emergency Medicine (unpaid) Co-editor, 2015 ILCOR Consensus on CPR Science (unpaid) Partner in Circle Health (minor share holding)
Gavin Perkins	Professor of Critical Care Medicine, University of Warwick, Warwick Medical School, Coventry, CV4 7AL Heart of England NHS Foundation Trust, Birmingham, B9 5SS	Employer - University of Warwick Editor, Resuscitation Grant recipient from NIHR for studies on quality of CPR and mechanical chest compression devices Co-Director Research ICS Medical Advisor, Qualsafe Ltd Medical Advisor, RLSS (UK) (unpaid) ERC course committees
David Pitcher	Consultant Cardiologist, University Hospitals Birmingham NHS Foundation Trust. Resuscitation Council (UK), 5th Floor Tavistock House North, Tavistock Sq, London WC1H 9HR	Chairman, Resuscitation Council (UK) (unpaid) NHS Pathways Clinical Governance Group (unpaid)
Steven Searle	Consultant in Emergency Medicine, St Richards Hospital, Chichester, Sussex PO19 6SE	Member of the College of Emergency Medicine Audit & Standards Committee (unpaid) Member of the NICE Pneumonia working group (unpaid)

Gary Smith	Consultant in Intensive Care Visiting Professor at Bournemouth University	Wife is a minority shareholder in The Learning Clinic (TLC) Ltd., which is the developer of VitalPAC, a clinical software system for identifying patient deterioration and escalating care. Professor Smith is an unpaid research advisor to TLC and has received reimbursement of travel expenses from TLC for attending symposia in the UK. Co-developer of the Acute Life-Threatening Events – Recognition and Treatment (ALERT) course, which is owned and run by Portsmouth Hospitals NHS Trust (PHT). PHT receives payment for sales of the courses and course materials to other healthcare institutions. Professor Smith was an employee of PHT until 31/03/2011. Past member of Royal College of Physicians of London's National Early Warning Score Development and Implementation Group (NEWSDIG). Past member of the NICE, NPSA and DH committees that set standards for aspects of care related to prevention and response to patient deterioration. Paid external reviewer of Policy on Physiological Early Warning Score (PEWS) to Northern Ireland Northern Healthcare & Social Care Trust, 2010. Co-Director of the annual International Rapid Response Systems conference and organiser of 2013 conference in UK. Member of the Clinical Advisory Board of Cardiocity, an innovations company currently involved with patient monitoring. Co-Director of RedRisk Ltd, a company developing educational materials.
Richard Williams	Professor of Mental Health Strategy, Welsh Institute for Health and Social Care University of Glamorgan Honorary Professor Humanitarian and Conflict Response Institute, Faculty of Humanities, University of Manchester Consultant Child and Adolescent Psychiatrist, Aneurin Bevan Health Board, NHS Wales Cymru, St Cadocs Hospital, Newport NP18 3XQ	Convener Diploma in Medical Care of Catastrophes for the Society of Apothecaries of London (unpaid) Member of the Intercollegiate Board for Training in Pre-Hospital Emergency Medicine (unpaid) Presidential Lead Officer for Disaster Management for the Royal College of Psychiatrists (unpaid)