In this issue …

Chairman’s annual report

Courses subcommittees’ annual reports:
- ALS
- ILS
- EPLS and PILS
- NLS

BLS/AED Subcommittee annual report
Paediatric Committee annual report
Research Subcommittee annual report

Obituary for Peter Baskett

Decisions relating to CPR – a model leaflet for patients and update on the progress of the DNAR form

Cardiac arrest or cardiovascular collapse caused by local anaesthetic

Forthcoming events – GIC Instructor Day, ALS Instructor Day
National Cardiac Arrest Registry
Cardiothoracic ALS course
AED Signage
Emerging risks – NPSA / RC(UK)
Saving Lives – BHF magazine
Update on life support courses
As I complete my second year as Chairman, it is a pleasure to report that, unlike the rest of the Economy, the Resuscitation Council (UK) remains strong and we have yet to suffer from the impact of the ‘credit crunch’.

The RC (UK) continues to collaborate with several other agencies on cardiac arrest related projects and we have been particularly active over the last year. A revision of the national guidance on decisions relating to cardio-pulmonary resuscitation was published last year by the RC (UK), British Medical Association and Royal College of Nursing – David Pitcher co-ordinated the input from the RC (UK) and very bravely took on a live interview on national television! I would also particularly like to thank David for his efforts in facilitating the recent changes to the Constitution.

Jas Soar co-chaired with Richard Pumphrey a multidisciplinary group that developed and published new anaphylaxis guidelines that were published in January this year. These were published on-line and a summary document was published in Resuscitation in May. The on-line version has received 225,525 ‘hits’ and the guidelines have been the subject of a BMJ editorial. The RC (UK) is one of several bodies that have endorsed guidelines on oxygen administration soon to be published by the British Thoracic Society. I am encouraged that the BTS approached the Council for endorsement of these guidelines and were receptive to much, although not all, of the feedback that we provided. It is significant that we are recognised as a highly credible and authoritative body for many aspects of the treatment of critically ill patients and not necessarily just for CPR.

The number of candidates taking the Immediate Life Support Course continues to grow and we have been considering for some time how to deal with training the instructors to meet the demands of this course. We hope that the ILS instructor course, which has just been launched, will help to address these issues. Following on the footsteps of the ILS course is the paediatric ILS (PILS) course: this was launched in October 2007.

Historically, the RC (UK) has not been involved directly with basic life support courses – not least because we simply don’t have the resources to administrate the huge number of BLS courses that are already run by volunteer organisations and hundreds of first aid groups. The Council’s BLS/AED Working Group, led by Tony Handley, has addressed this issue with the recent publication of a BLS/AED manual. This will enable trainers to provide a course that follows the RC (UK) guidelines and to issue a certificate of completion of the course. This book has been very popular and over 4,000 have been sold so far.

The International Liaison Committee on Resuscitation (ILCOR) continues to meet twice each year and work continues on the 2010 review of resuscitation science, which will be accompanied by revised guidelines. Many members of the RC (UK) are contributing to this ILCOR process and the first science reviews have already been completed. We expect the 2010 Consensus on CPR Science to be published in October 2010 and hope that the RC (UK) Guidelines will appear at the same time or very soon afterwards.
Work continues with the development of electronic learning material to support the advanced life support (ALS) course. Gavin Perkins is co-ordinating the project and he is supported by Robin Davies, and also by Tom Clutton Brock who has considerable experience in the development of e-learning materials. We plan to pilot the e-ALS course in January 2009. Staying on the topic of e-learning, the Council has been collaborating with the E Learning for Health project and we have prepared two resuscitation sessions that will be used by the Royal College of Anaesthetists and hopefully the other UK medical colleges, and possibly organisations in other countries.

The 17th RC (UK) Scientific Symposium, which marked the organisation’s Silver Anniversary, took place at the Royal College of Physicians on 23 November 2007 and was attended by 320 delegates. This meeting was a great success and despite a bigger venue than had been used for our previous Symposia, we still had to turn late applications away.

At the last AGM, I was asked about what we are doing to address the problems faced by instructors when they try to obtain leave to teach on life support courses. Unfortunately, the NHS is making it increasingly difficult for all clinicians to undertake duties that are not directly concerned with meeting Trust targets. Well, we have made efforts to tackle the problem of instructor leave – in fact we have taken it directly to the top. A small group of us, representing the RC (UK) and the Advanced Life Support Group, met with Lord Darzi at the beginning of the year. He was sympathetic to our views and promised to take action. We await the results!

My American colleagues have been concerned with the topic of potential conflict of interest (COI), for several years and you will have noticed how medical journals, in particular, have tightened up on this considerably – not least because of one or two high-profile cases going through the system at the moment. I think our American colleagues have probably got it right, although I think they take it to the extreme. Today, I think it is indefensible for any guideline-setting organisation not to have a robust conflict of interest policy. For this reason, I am pleased to announce that the RC (UK) now has a conflict of interest policy which will be implemented in full very shortly.

Finally, I would like to thank Sarah Mitchell, Sara Harris, and all the RC (UK) staff – they have all made important contributions to another successful year. Thanks also to the Vice Chairman, Jas Soar, the Officers, and members of the Executive Committee, particularly the Subcommittee chairmen. As a result of the leave problems I have already mentioned, they are devoting ever increasing amounts of their own time to the work of the Council and I am very grateful for their efforts.

Jerry Nolan
Chairman,
Resuscitation Council (UK)
Introduction

The last year has seen an incredible amount of hard work on behalf of all of the Subcommittee members and also the administrative staff at Resuscitation Council (UK). The ALS Course continues to be a great success, despite the ever-present constraints upon study and professional leave for our candidates and instructors.

ALS provider course annual statistics for 2007

<table>
<thead>
<tr>
<th>Category</th>
<th>2007 Count</th>
<th>2006 Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ALS Courses</td>
<td>770</td>
<td>(697 in 2006)</td>
</tr>
<tr>
<td>Number of Recertification Courses</td>
<td>33</td>
<td>(36 in 2006)</td>
</tr>
<tr>
<td>Number of Course Centres</td>
<td>274</td>
<td></td>
</tr>
<tr>
<td>New Course Centres</td>
<td>nil</td>
<td></td>
</tr>
<tr>
<td>Number of Candidates</td>
<td>16,926</td>
<td>(16,100 in 2006)</td>
</tr>
<tr>
<td>Number of ALS Instructors</td>
<td>4,951</td>
<td></td>
</tr>
<tr>
<td>Number of Instructor Candidates (ICs)</td>
<td>1,169</td>
<td></td>
</tr>
<tr>
<td>Projected number of Courses for 2008</td>
<td>599</td>
<td>Provider / 42 Recert notified</td>
</tr>
</tbody>
</table>

Over the last year, Dr Gavin Perkins (Vice Chair ALS Subcommittee) has led a team including Robin Davies and Dr Tom Clutton-Brock with a view to developing a pilot e-ALS course. This will deliver some of the components of the traditional ALS Course in e-learning format. As a result, the face-to-face component will be reduced to one day. The work on the materials is now almost complete and the plans are to pilot this course alongside the traditional course. The original plans were to commence the pilot courses in autumn 2008 but unfortunately, due to delays in setting up the Learning Management System, we have had to postpone the first pilot courses until January 2009. I am grateful to the course centres who have agreed to participate in this pilot exercise and thank them for their patience with this delay.

A research project has been approved with the working hypothesis that the e-ALS course is no worse than the traditional course in terms of learning outcomes. If this hypothesis is proven, the aim will be to formally introduce the e-ALS course following the implementation of the 2010 guidelines. I would like to take this opportunity to thank Gavin and his team for the hard work that has gone into this project so far.

Generic instructor course (GIC)

<table>
<thead>
<tr>
<th>Category</th>
<th>2007 Count</th>
<th>2006 Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of GICs</td>
<td>65</td>
<td>(51 in 2006)</td>
</tr>
<tr>
<td>Number of candidates</td>
<td>898</td>
<td>(667 in 2006)</td>
</tr>
<tr>
<td>Number of GIC Course Centres</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>New Course Centres</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
During the last year, the second edition of the ‘blue book’ ("Pocket Guide to Teaching for Medical Instructors") has been published. This book has resulted from collaboration between the Resuscitation Council (UK) and ALSG and brings together the strengths of previous publications.

A GIC Instructor Day is scheduled for the end of September in Wolverhampton.

Thanks

The ALS Course could not function without the hard work and dedication of all of the Instructors. It is becoming increasingly difficult for them to secure time off to teach and yet they continue to do so to a high standard and I am extremely grateful for this. In addition, we have a strong cadre of Regional Representatives who also deserve credit for their hard work.

As always, I must register my grateful thanks to all members of the ALS Sub-committee. My thanks go also to all the administrative staff at Resuscitation Council (UK), and particularly to Dami Daramola, Helen Keen and Sean Russell.

Andy Lockey
Chairman ALS Course Subcommittee

ILS provides healthcare staff with the essential knowledge and skills to manage adult patients in cardiac arrest for the short time before more experienced help arrives. ILS also includes training in the ABCDE approach for the initial assessment and treatment of the sick patient. ILS has provided a standardised approach and certification process for training in these skills since 2002.

The number of candidates doing an ILS course and the number of course centres continued to grow in 2007.

**ILS Course statistics** (data from recertification courses not included)

<table>
<thead>
<tr>
<th>Year</th>
<th>No of centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>137</td>
</tr>
<tr>
<td>2003</td>
<td>160</td>
</tr>
<tr>
<td>2004</td>
<td>189</td>
</tr>
<tr>
<td>2005</td>
<td>206</td>
</tr>
<tr>
<td>2006</td>
<td>219</td>
</tr>
<tr>
<td>2007</td>
<td>233</td>
</tr>
<tr>
<td>2008</td>
<td>237</td>
</tr>
</tbody>
</table>
Work in progress

1. During 2008 all ILS centres changed to the new web-based system for course returns. This will make the process simpler.

2. The second phase of the ILS instructor course will be launched this month. This should make it easier for course centres to find instructors. Issues regarding criteria for attending an ILS instructor course and which centres can run an ILS-instructor course have been clarified. A survey of ILS course centres suggests a third are interested in running (on average) around 3-4 courses per year for 20 or so candidates. This will result in over 1000 ILS instructors trained every year. 37 course centres have subsequently expressed an interest in running the ILS instructor course.

And finally

The continuing success of ILS depends on the hard work of a large number of individuals whom I wish to thank:

- The resuscitation officers, instructors and staff at course centres across the UK.
- The ILS Subcommittee members.
- The team in the RCUK office, namely Karla Wright, Jenny Lam, Sara Harris, Bob Harris.

Dr Jasmeet Soar
Chairman, ILS course Subcommittee
EPLS and PILS Subcommittee annual report

The PILS course was developed by a working group of the EPLS Subcommittee and launched in October. Sheila Simpson was instrumental in the establishment of this one-day course which is based on the successful ILS model. The uptake of this course has exceeded our expectations with 108 centres registered to date.

Feedback from the course centres has been positive. Many centres have requested that a DVD is produced to support teaching and ensure candidates are well prepared. This is under production and will be introduced together with a recertification course in the near future.

EPLS

This maintains its high standards and number of candidates undertaking the course is consistent over the years.

With the advent of the PILS course, consideration is being given to integrating this course with the EPLS course so candidates do not undergo unnecessary repetition of common course contents, but can usefully spend their time to consolidate skills and to learn and practice more advanced skills. This may mean the development of a new course, which encompasses the PILS and EPLS material in a suitable format. Further discussion on the organisation and construction of such a course is taking place by the Subcommittee.

Data for the details of the current PILS and EPLS courses are given below.

<table>
<thead>
<tr>
<th>Number of :-</th>
<th>EPLS (2007)</th>
<th>PILS (to date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centres</td>
<td>83</td>
<td>108</td>
</tr>
<tr>
<td>Courses</td>
<td>108</td>
<td>110</td>
</tr>
<tr>
<td>Candidates passed</td>
<td>2201</td>
<td>888</td>
</tr>
<tr>
<td>Candidates failed</td>
<td>103</td>
<td>0</td>
</tr>
<tr>
<td>IPs</td>
<td>285</td>
<td>N/A</td>
</tr>
<tr>
<td>Instructors</td>
<td>587</td>
<td>N/A</td>
</tr>
</tbody>
</table>

I would like to thank the Subcommittee for their support and hard work, and the staff at the RC(UK), in particular, Karen Cooper.

Ian Maconochie
Chairman, EPLS Course Subcommittee
The NLS course is now well established in the UK and successful completion of a course is expected of all junior medical staff during the first two years of specialisation in paediatrics. During 2007 our energies were devoted to consolidating the course in the UK while preparing the launch into Europe.

Course centres

There are now 70 course centres spread through England, Scotland, Wales and Northern Ireland. There is also one course centre in Holland.

Courses held and providers trained

A total of 200 courses were held resulting in a further 3,875 NLS providers. 37% of these are doctors, 32% are midwives, 28% are nurses and the remaining 3% are made up of resuscitation officers, PAMs etc. The failure rate for candidates presenting for the course this year was 3.3%.

During 2007, 412 providers (10% of candidates) were chosen as potential instructors, 127 IPs completed the GIC course and 16 new course directors qualified bringing the total of course directors to 127.

Europe

There has been considerable interest in the NLS course from other countries in Europe. The Dutch centre mentioned above has been self-sufficient for the last 3½ years. A demonstration NLS course was held in Belgium in October 2007 which was attended by interested parties from throughout Europe. Since then UK NLS instructors and course directors have been involved in running NLS courses in Germany, Italy and Poland.

ILCOR 2010

A number of the NLS Subcommittee are involved in the neonatal subsection of the ILCOR 2010 process.

Sam Richmond
Chairman, NLS course Subcommittee
We were very pleased to welcome Kevin Dickens and Chris Smith to the Subcommittee during 2007-2008.

There were two formal meetings during the year, but members continued also to be available to answer questions on a wide range of BLS/AED topics. Those that raised important issues were circulated to committee members and a formal reply formulated, often ending up as FAQs on the website.

Two main topics dominated our meetings – the new training manual Cardiopulmonary Resuscitation and Automated External Defibrillation and the potential role of self-directed learning in basic life support.

The purpose of the training manual, which was published in November 2007, is to help facilitate the standardisation of BLS/AED training for both healthcare providers and laypeople. An important aspect is the inclusion within the manual of satisfactory completion certificates to be signed by both the instructor and the trainee. It is not intended that the Council will audit the quality of training, so the manual contains an appropriate disclaimer. Thanks are due to the members of the Editorial Board, in particular Mary Richardson and Sarah Mitchell who were responsible for the bulk of the work.

The second of the formal meetings was taken up almost exclusively by a wide-ranging discussion on the place of self-directed learning in BLS and AED usage. The topics considered were:

- Possible development of a DVD to compliment the CPR/AED manual and assist the trainer.
- Sponsorship and distribution of a DVD via a newspaper or magazine (target group).
- The need to have an affordable and accessible ‘manikin’ or simulator to enable practise of compression.
- Resources and cost.

The Subcommittee will continue to explore and investigate these ideas further, so as to be in a better position to introduce any innovation when new guidelines are published in 2010.

As always, I should like to offer very sincere thanks to the members of the Subcommittee for their time, patience, thoughtfulness, and good humour over the year.

Anthony J Handley
Chairman, BLS/AED Subcommittee
The paediatric committee has had a pleasantly quiet year. The 2005 guidelines changes are well bedded in and seem to be working well.

Members of the committee have been involved in the 2010 ILCOR process. In particular they have been part of the planning process for suggesting and refining worksheet questions. Some committee members are also involved in worksheet preparation and presentation.

<table>
<thead>
<tr>
<th>Members</th>
<th>Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob Bingham - Chair</td>
<td>Paediatric anaesthesia</td>
</tr>
<tr>
<td>Ian Maconochie</td>
<td>Paediatric emergency medicine</td>
</tr>
<tr>
<td>Fiona Jewkes</td>
<td>Ambulance service and pre-hospital care</td>
</tr>
<tr>
<td>Sam Richmond</td>
<td>Neonatology</td>
</tr>
<tr>
<td>Sheila Simpson</td>
<td>Paediatric nursing and ROs</td>
</tr>
<tr>
<td>David Zideman</td>
<td>ERC and paediatric resuscitation database</td>
</tr>
</tbody>
</table>

The core work of the committee remains to ensure that the interests of children are properly represented in Resuscitation Council initiatives and in answering the many paediatric related questions posed to our office. Members of the committee are soon to enter negotiations with the NPSA into the development of a paediatric critical incident monitoring and surveillance project, details of which should be available shortly.

Bob Bingham,
Chairman Paediatric Committee

The Resuscitation Council (UK) has always supported research into the science of resuscitation and in order to further these aims and the Research Subcommittee considers all applications for research funding. We have a yearly budget for Grants and we have previously funded a number of Fellowship awards.

This last financial year, the Research Subcommittee budget was divided such that only £50,000 was made generally available to support external Grant awards. The remaining £100,000 was earmarked internally to support and establish a National Cardiac Arrest Registry.

During 2007 - 2008 the Subcommittee has dealt with all its matters via telephone conference and electronically. We have offered advice to potential applicants but have only formally considered 3 applications during this last financial year. It is disappointing that so few requests were received over the last 12 months, which contrasts significantly with last year when 6 successful applications were awarded and over £140,000 allocated. This may have been in part due to the reduced budget generally available, but the difficult nature of undertaking good quality research may have also been a factor. Many UK based healthcare professionals do not now have the time made available to them and with increasing bureaucracy from Research Ethics Committees across the country, future resuscitation research may become increasingly difficult.
The Council continues to support and manage the national Automated External Defibrillator event database which logs the outcomes following resuscitation attempts by lay people.

Next year’s research budget will be in the region of £150,000. We are keen to support good projects and would welcome applications for funds. We are also very happy to advise prospective applicants prior to making a formal application for funds.

Finally, I would like to thank all the Research Subcommittee members for their time throughout the year, Sara Harris in particular for all her hard work and invaluable advice.

David A Gabbott
Chairman Research Subcommittee

Peter Baskett, a world leader in cardiopulmonary resuscitation and pre-hospital care, died on 18th April 2008. In the early 1970s, Peter developed advanced training for the ambulance personnel who were amongst the first paramedics in Europe. He was also responsible for introducing premixed nitrous oxide/oxygen (Entonox) into the ambulance service in the United Kingdom in 1970.

Peter was a founder member of the Community Resuscitation Advisory Committee (CRAC), which was established in 1981. In 1984, this committee became the Resuscitation Council (UK) – the first Resuscitation Council in Europe. Five years later, Peter was one of the founding members of the European Resuscitation Council (ERC) and was elected chairman (1989-94). In 2005, in recognition of his international contributions to CPR, Peter was honoured as a ‘Resuscitation Giant’ by the American Heart Association. Peter was Editor-in-Chief of the journal Resuscitation from 1997 until his death.

As a member of the International Liaison Committee on Resuscitation (ILCOR) from 1995 to 2000, Peter developed the international guidelines on airway management during resuscitation, and healthcare professionals across the world respected his expertise on this subject. In 1994, Peter published one of the first studies on the use of the laryngeal mask airway for in-hospital resuscitation. Although care of the airway was always one of his major concerns, over 100 publications attest to his interest and knowledge of all aspects of resuscitation.
Peter John Firth Baskett
(continued)

Peter remained one of the most enthusiastic and active supporters of the Resuscitation Council (UK) even after he ‘retired’. In recognition of his considerable contribution, he was made an honorary life member of the Council in 2001. Although he technically ‘retired’ from clinical practice in 1999, Peter continued to work harder than most of us in full time employment! In his retirement, he personally introduced the Advanced Life Support (ALS) course into more than 20 countries. This involved directing about two ALS courses a month for several years and was inevitably accompanied by an exhausting travelling schedule. This sustained commitment to frontline ‘hands-on’ teaching was unique for a man of Peter’s experience and stature and he was admired by healthcare professionals throughout Europe.

Peter’s numerous other contributions to CPR, trauma and disaster medicine are outlined in a Resuscitation Great article published earlier this year.² Peter is survived by his wife, Fiona, a general practitioner, son Simon and daughters Lucy, Olivia and Beatrice.

References

Decisions relating to cardiopulmonary resuscitation

Model patient information leaflet

A model patient information leaflet has been developed by the Resuscitation Council (UK), British Medical Association and Royal College of Nursing. It explains what cardiopulmonary resuscitation is and how decisions are made.

It is a general leaflet for all patients but may also be useful for relatives, friends and carers and is available on our website.
Model DNAR form

The Resuscitation Council (UK) is currently developing a model DNAR form that individual establishments may wish to adopt.

A draft DNAR form was posted on the website for consultation in January and useful comments were received. The majority of respondents welcomed the form and made positive comments about its layout. Three main areas of contrasting opinion emerged.

1. Some respondents wanted the form to make provision for patients to sign the form and others did not.
2. Some wanted the form to travel with the patient, leaving the organisation initiating the form without the original copy for medico-legal and audit trail purposes, whereas others favoured retention of the form at the point of origin and use of a transfer form.
3. Some wanted to stipulate a fixed time period for review date, whereas others wanted review to be made whenever the patient’s condition changed, when the patient or those close to them requested review or when the patient transferred to another healthcare setting.

It was a clear that we should obtain legal advice before finalising the form and this is currently taking place. Sadly, this is taking longer that anticipated. As soon as it is finalised the example form will be posted on our website and may be adapted for local use.

Introduction

Following some convincing animal studies, recent case reports describe the successful use of 20% lipid emulsion to treat cardiovascular collapse, arrhythmias and cardiac arrest caused by local anaesthetic. It has been recommended that 20% lipid emulsion should be available wherever patients receive large doses of local anaesthetic (e.g., operating rooms, labour wards, emergency department, radiology suite). The following protocol is based on others that have been published previously. This treatment is supported by only low-level evidence but in the absence of obvious significant harm it seems reasonable to follow this protocol.
Cardiac arrest or cardiovascular collapse caused by local anaesthetic (continued)

Protocol

1. If a patient develops cardiac arrest that is likely to have been caused by local anaesthetic toxicity give 20% lipid emulsion 1.5 ml kg⁻¹ (100 ml in 70 kg patient) intravenously once CPR, following advanced life support guidelines, has been started. This treatment should also be considered if a patient develops severe cardiovascular compromise (hypotension, unstable arrhythmias) that is attributable to local anaesthetic toxicity – thus potentially preventing cardiac arrest.

2. Start an infusion of 20% lipid emulsion at 0.25 ml kg⁻¹ min⁻¹ (about 20 ml min⁻¹ in 70 kg patient) and continue until a stable rhythm and adequate circulation has been restored.

3. Repeat the bolus dose at 5 min intervals until a stable rhythm and adequate circulation is restored.

Notes

- Restoration of spontaneous circulation after local anaesthetic-induced cardiac arrest may take more than 1 hour to achieve.
- Ensure that 500 – 1000 ml 20% lipid emulsion is available for the treatment of severe cardiovascular compromise or cardiac arrest associated with local anaesthetic toxicity in all clinical areas where high doses of local anaesthetics are used.
- Report all cases of suspected local anaesthetic intoxication to the National Patient Safety Agency (www.npsa.nhs.uk).
- The nearest lipid emulsion is stored……….. (for completion locally)

References


Forthcoming events

GIC Instructor Day

The next GIC Instructor day is jointly hosted by ALSG and RC(UK) on **Friday 26 September 2008** at the **University of Wolverhampton, Nursery Street, Wolverhampton**.

This day is for instructors, educators and co-ordinators who are involved with the Generic Instructor Course (GIC).

The programme includes parallel workshops on the following topics:

- Enhanced critiquing
- The realities of a VLE
- The new blue book
- Mentoring
- Using simulations as an educational tool
- Model 1 and Model 11 learning
- Continual assessment

The full programme is [on our website](http://www.alsg.org).

The registration fee for the GIC Instructor day is £45. Registration is being handled by ALSG, who will also provide travel and accommodation details when you make your booking. You can register online at [www.alsg.org/acatalog/GICAID08.html](http://www.alsg.org/acatalog/GICAID08.html)

For further details regarding registration, please contact ALSG via their website [www.alsg.org](http://www.alsg.org)

ALS Instructor Day

We will be holding this event on **Monday 8 December 2008** at the **Royal College of Physicians, 11 St Andrews Place, Regents Park, London**.

The programme is full of cutting edge topics and includes a broad range of clinical matters and instructional issues, for example – charging the defibrillator during compressions, development of the national cardiac arrest registry, and care of the acutely ill patient. The registration fee for the ALS Instructor day is **£85** and the registration form together with the full programme is [on our website](http://www.alsg.org).

It is advisable to register early as places are limited and we look forward to welcoming a large number of delegates.
The Resuscitation Council (UK) and ICNARC are pleased to announce that, following positive results from the recent feasibility study, joint, three-year, pump-prime funds from the two organisations have been allocated to establishing NCAR. NCAR will be overseen by a Steering Group of individuals with relevant expertise.

Initial work for establishing NCAR currently involves: identifying key individuals in each NHS Trust in the UK to approach for future participation in NCAR; finalising a small, minimum dataset; and establishing the infrastructure for web-based data entry and reporting.

To facilitate taking this work forward, we are now recruiting for an NCAR Coordinator to be based at ICNARC. We are keen to receive applications from all those interested - please see the advert on both organisations’ websites.

We anticipate that NCAR will be of enormous benefit to those involved and interested in outcomes following resuscitation and look forward to developing NCAR in a collaborative effort over the coming years.

Kathy Rowan  
Director  
ICNARC

Sarah Mitchell  
Director  
Resuscitation Council (UK)

The Resuscitation Council (UK) has received several enquiries about the status of the ‘Cardiothoracic Advanced Life Support (CALS)’ course. This course has been developed by Joel Dunning, a cardiothoracic surgeon from Middlesbrough.

The Resuscitation Council (UK) and the European Resuscitation Council have not been involved in its development and the course is not accredited by either Council. The topic of cardiopulmonary resuscitation following cardiac surgery is being reviewed for the 2010 Consensus on CPR Science and we expect specific guidelines to follow the publication of this document shortly after October 2010. The decision on the incorporation of this topic into the ALS course curriculum will not be made until after these guidelines are finalised.
AED signage

In 2006, the Resuscitation Council (UK) BLS/AED Subcommittee designed a standard sign to indicate the presence of an automated external defibrillator (AED). This design fulfils the requirements of the European Union as far as colour, shape, and content are concerned, and it has been accepted by the Health and Safety Executive (HSE).

It is important to have a standard sign that is easily recognised and understood in order to reduce delay in locating an AED in an emergency. We have recommended it to all AED manufacturers for use with their products within the UK.

Earlier this year, the International Liaison Committee on Resuscitation (ILCOR) announced that it had approved a universal AED sign. This is very similar to the UK version, but with three minor differences:

- There is a white cross in the top right corner
- There is an arrowhead at the bottom of the flash
- The word AED is used instead of 'defibrillator'

The BLS/AED Subcommittee has reviewed the ILCOR design. It fulfils legal requirements, but the Subcommittee considers that the UK version is better for our needs. Also, to date, we do not know to what extent Europe and the rest of the world will use the ILCOR design. The BLS/AED Subcommittee has decided, therefore, to continue to recommend the UK sign for use in this country, at least until such time as a significant number of other countries officially endorse the ILCOR version.

Anthony J Handley
Chairman, BLS/AED Subcommittee

Emerging risks – NPSA/RCUK

The Resuscitation Council (UK) continues to meet with the National Patient Safety Agency (NPSA) at regular intervals. The NPSA has a National Reporting and Learning System (NRLS) which has now logged over 2 million patient safety incidents reported by healthcare staff. Serious incidents are reviewed and where there are repeated patterns of events, or issues requiring national action, the NPSA may issue guidance.

Recently a number of 'resuscitation' based issues have emerged and the Resuscitation Council (UK) was invited to attend a meeting on 23 July 2008 to discuss some of these. Themes that were discussed related to resuscitation in Mental Health facilities and resuscitation outside hospital premises.
Emerging risks – NPSA / RCUK (continued)

Mental Health facilities

A number of patient safety issues have been reported in relation to the poor quality of resuscitation provided in Mental Health establishments. Two related topics have emerged and these are:

1. the different standards of training amongst mental healthcare staff.
2. the poor management of choking in high risk patients i.e. those with learning difficulties or suicide attempts where choking has been attempted.

It was agreed that national guidance on resuscitation in mental health and learning disability services would be helpful. The NPSA will be developing such guidance in the next few months, with input from the Resuscitation Council (UK).

Resuscitation outside hospital premises

Resuscitation attempts outside hospital premises have been an issue for many Trusts for some time. Cardiopulmonary resuscitation (CPR) may be required outside hospital but on Trust property, off Trust property but in close proximity to immediate resuscitation facilities (e.g., Accident and Emergency Dept), and/or may be required at remote sites where staff are both unfamiliar with the geography and are restricted in the time it would take to attend. In addition to this there are considerable legal issues to consider concerning liability of working off site i.e. off Trust property. In many instances there is confusion as to whom should be called to the site of such patient collapses requiring CPR, for example should it be 2222 and/or 999? Each of these options has both benefits and restrictions in terms of how quickly a response can occur and how the patient is subsequently transferred.

The NPSA had received 32 serious incidents (and one trigger incident of a reported patient death) following collapse in hospital grounds and delay in treatment due to confusion about appropriate response. The NPSA and Resuscitation Council (UK) are clearly not in a position to advise each and every Trust on this complex issue. A blanket policy is not appropriate as there are too many variables to consider. The Council therefore wishes to remind all those responsible for resuscitation services within any Trust that a local policy should be established for the circumstances of a cardiopulmonary arrest occurring outside hospital. Consideration should be given to who should be called. This will clearly be dependent upon factors such as the geography of the site, and the logistics of getting the Resuscitation Team and equipment to the correct area. In many instances it may be quicker to call 999, in other circumstances the Team should be summoned via 2222. In some case both numbers may be appropriate. The issue of CPR off Trust property should involve the Trust’s legal team in order to establish and clarify the legal issues that such an event may generate.

Other issues discussed with the NPSA include availability of opiate antagonists in drug dependency units, remote cardiac telemetry, and composition of cardiac arrest teams.

Trusts are asked to continue to report incidents (including serious near misses) to the NRLS. The nature of issues discussed at the meeting with the NPSA show the value of a national system which can identify patterns of events and underlying system weaknesses which may not be apparent from individual incidents. We will continue to work closely with the NPSA in the future.

David A. Gabbott
Executive Committee Member
The British Heart Foundation’s Saving Lives magazine is based around the ‘Chain of Survival’ concept – helping to support each link in that chain. The magazine supports collaboration across the field of community resuscitation, to develop community resuscitation capacity across the UK – this includes education and interventions in early recognition of the symptoms of acute myocardial infarction, training in emergency life support and the development of both public access and community first responder defibrillation schemes.

There are 3 issues of Saving Lives a year. For a free copy of Saving Lives or to be added to the Saving Lives circulation please send your contact details to Mavis James, Heart Save Administrator, British Heart Foundation, 14 Fitzhardinge Street, London W1H 6DH or email jamesm@bhf.org.uk

Update on the life support courses

e-Learning and ALS

Work on the e-ALS pilot programme is progressing well.

As part of the pilot phase of the e-ALS course, we are conducting a randomised controlled study comparing the e-ALS course (comprising an e-learning package and one day face to face course) with the traditional two-day, face-to-face ALS course. The evaluation of learning outcomes will be critical to the success of the initiative. After obtaining informed consent, participants seeking to enrol on an Advanced Life Support Course will be randomised to either an e-ALS course or traditional ALS course.

The e-learning ALS course will be delivered in two parts. Part 1 will be on-line e-learning and will include the lectures, demos, quizzes and tutorials. Part 2 will be the face-to-face training which will be one day and will include the practical skills, CASTeach and assessment.

A significant amount of work has been completed over the past few months developing high quality standardised learning materials and a Learning Management System (LMS) to sit behind the electronic learning. The LMS has been designed to be as intuitive as possible for both candidates and course administrators. Comprehensive testing and ongoing support will ensure that the transition to this system is as painless as possible.

Some thirty centres have volunteered to participate in this study; each of which will run two standard ALS and two e-ALS courses. By the end of 2009, almost three thousand candidates will have been randomised and completed either a standard ALS course or an e-ALS course.

The learning outcomes for these candidates will be analysed to demonstrate the comparative impact of an electronic learning ALS course.
Update to course materials

ALS Manual

With the introduction of the new anaphylaxis guidance in January 2008, and the joint statement from the BMA/RCN/RCUK ‘Decisions relating to cardiopulmonary resuscitation’, the ALS subcommittee took the opportunity to revise the 5th Edition and to amend any other areas which needed updating, for example, inclusion of information about the i-gel airway and the use of lipid emulsion for cardiac arrest caused by local anaesthetic.

The changes affect chapters 2, 4, 6, 12, 13, 15. The revised 5th Edition will be sent to course centres for their candidates on courses running in the autumn. Instructors will be able to download all the relevant changes from our website. The changes do not affect any of the answers in the multiple choice question papers.

CASTeach Assessment

With immediate effect, CASTeach must form part of the formal assessment of instructor candidates (ICs). New IC CASTeach assessment forms for teaching practices 1 and 2, and the CASTeach Matrix are available on the website. Copies were sent to all course organisers in June 2008.

Special Circumstances workshop

There is new guidance on anaphylaxis.

All these updates are on the website to download and include in your course centre packs.

Instructor Candidates on the ALS course

Please ensure that ICs with named centres attend at the correct centre to complete their teaching practice(s). We are not able to recognise teaching practices that have been completed which do not meet with their GIC recommendations. If in doubt, please check with the ALS Co-ordinators.

Instructor Recertification

We endeavour to send out reminders to instructors periodically regarding recertification so that they are current when attending to teach. Please support us by checking your certificates or by contacting the ALS Co-ordinators, who would be happy to check for you.

Course Notification Form

Thank you for your support in the use of the new notification forms. It is going well.

Can we ask that they be sent with the signature of your course director only and signed by hand? A scanned electronic signature is acceptable, not typed.
In the first six months of 2008, 28,250 candidates attended the ILS course.

Another 5,700 candidates attended the half-day recertification course during the same period.

The number of registered ILS course centres increased from 233 in 2007 to 242 in 2008.

**ILS instructor course (ILSi)**

Following a decision to develop an instructor course to train instructors specifically for the needs of the ILS course, the ILS instructor course (ILSi) was successfully piloted in a small group of course centres for two years. During the pilot phase, which ran from June 2005 until Spring 2008, 44 instructor courses were run at 9 pilot centres and the first 324 ILS instructors have received the training.

Based on the feedback from the pilot centres, changes were made to the course programme and course materials, and Phase II of the ILSi course was officially launched in June 2008. As of 1 June, all course centres accredited to run the ILS course can apply to run the ILSi course. Sixteen applications have been received in the first few weeks since the launch of the Phase II.

Any registered ILS course centres interested in running the ILS instructor course can contact the ILS Co-ordinator (karla.wright@resus.org.uk) for the application form and further information.

**Feedback**

Any feedback from instructors on the ILS, the ILS recertification course and the new ILS instructor course is helpful and much appreciated. There is a feedback facility available on our website (please follow the following path: ‘Courses’ > ‘Information for instructors’ > ‘Immediate life support instructors’).

A DVD is being developed to support teaching on the PILS course. Work is also taking place on the development of the PILS recertification course and the course materials are almost complete. The duration of the recertification course will be just 2 hours. This has been made possible because all candidates who attend this course must be sent the pre-recertification course DVD which will reiterate the ABCDE demonstration. Both the DVD and recertification course will be available in the near future.

Candidates wishing to attend a recertification courses must do so within a year of the expiry date of the PILS one-year certificate. EPLS providers may obtain a PILS certificate by attending a PILS recertification course. For further information please contact Karen Cooper at Karen.cooper@resus.org.uk
Pre-course Preparation DVD

We are developing a pre-course preparation DVD for candidates attending the GIC. Much of the feedback we have received over recent times has highlighted a need to offer candidates a better insight into what is expected of them when they attend the course. The DVD will give examples of how the practice stations are run. We hope this will benefit the candidates. In terms of how this DVD will be supplied, we plan to provide 30 copies to each GIC centre for them to keep and use on a continuous basis.

Continuous Skills Assessment

The educator group have continued to share their experiences of running the skills teach / continuous skills assessment sessions during day one of the GIC. A slightly amended day one programme and new skills station matrix and feedback form have been created to enable trials to continue. Your educator will lead you through these updates and if required, the materials are available from the GIC admin section.

GIC Organisational CD

We will soon be able to supply an updated version of the GIC organisational CD to all GIC centres that are approved by the RC (UK). The contents have undergone an overhaul and we hope you will find the update more relevant. Those GIC centres that are approved by ALSG already have access to the material via the ALSG VLE.

Dates for 2009

Along with ALSG, we will be contacting GIC centres soon to enquire about GIC dates for 2009. We will supply a form for you to complete but it would be helpful if you are running a course early next year to think about the groups and numbers you want to run with.

Let us know what you think:

If you have any comments regarding this newsletter, please contact us at enquiries@resus.org.uk