In this issue …

Chairman’s welcome

British Thoracic Society –
Guideline for emergency oxygen use in adult patients

Requirements for resuscitation training and facilities for
cardiac rehabilitation exercise programmes –
A joint statement by the Resuscitation Council (UK)
and the British Association for Cardiac Rehabilitation

Statement on the training required
to use an automated external defibrillator

Scientific Symposium 2009

Safe and effective manual defibrillation –
a statement from the ALS subcommittee

National Cardiac Arrest Audit

Air, oxygen and Apgar scores in resuscitation at birth

PILS recertification course

ALS course centre assessments

ILS course status update

e-ALS pilot course status update

Do not attempt resuscitation (DNAR) model form

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and ICs:
To ensure we can continue to
notify you about future
newsletters, please let us
know if your email address
changes.
► Online contact details
update form

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As will be clear from the contents of this newsletter, the Resuscitation Council (UK) continues to be active across all facets of cardiopulmonary resuscitation (CPR).

The Advanced Life Support (ALS) Instructor Day was held at the Royal College of Physicians on 8th December 2008. This event was particularly well attended, reflecting the combination of a first class programme and the fact that we did not hold a Scientific Symposium in 2008.

A two-day meeting of the International Liaison Committee on Resuscitation (ILCOR) was held in New Orleans in November 2008. The review of resuscitation science, which will culminate in the 2010 Consensus on CPR Science Conference in February 2010, is now well underway. During the New Orleans ILCOR meeting, many science reviews were presented and debated. The next face-to-face ILCOR meeting will be in Osaka, Japan in March 2009 but in the interim members of all the ILCOR Task Forces are participating in regular ‘webinars’. These combine telephone conferencing with web-based presentation of science reviews and enable participants from around the world to achieve consensus on conclusions and recommendations. By using this technology, it is hoped that the review of most non-controversial topics will be completed well before the conference in 2010. It is anticipated that the Consensus on CPR Science with Treatment Recommendations (2010 CoSTR) will be published on 18th October 2010. This is likely to be quickly followed by the 2010 RC(UK) resuscitation guidelines.

The recent ILCOR meeting in New Orleans was followed by the annual Resuscitation Science Symposium (ReSS) organised as a satellite component of the vast American Heart Association Scientific Sessions 2008 conference. Resuscitation researchers from around the world often chose the ReSS meeting to premiere the results of cutting edge CPR studies and the 2008 ReSS meeting was no exception. The CPR Group from Oslo, Norway presented the long-awaited results of its randomised trial of drugs versus no drugs in out-of-hospital ALS: survival to discharge was similar in the two arms of the study. The detailed results of another long awaited study, Thrombolysis in Cardiac Arrest (TROICA), were published recently.[1] Disappointingly, this randomised trial of tenecteplase versus placebo during resuscitation for out-of-hospital cardiac arrest showed no significant difference in 30-day survival between the study groups. Furthermore, there were more intracranial haemorrhages in the tenecteplase group.

After a considerable amount of work to get materials ready and some very challenging informational technology hurdles, the pilot phase of e-ALS is now well underway. This pilot is taking the form of a randomised trial that aims to determine whether or not e-ALS is equivalent to a traditional ALS course in terms of educational outcomes. An e-ALS update is included in this newsletter.
Plans for the renamed National Cardiac Arrest Audit (NCAA) are now well advanced. I am delighted to report that Edel Gallagher has been appointed as the NCAA Coordinator and she has written an update for this newsletter. The core dataset is being compiled and we will be actively recruiting centres for the project. One of the primary goals of this project is to obtain reliable data on in-hospital cardiac arrest rates across the UK. This means establishing the smallest dataset to meet this objective. Once we have achieved reliable data on cardiac arrest rates, it may be possible to broaden the dataset.

The British Thoracic Society (BTS) has recently published guidelines for emergency oxygen use in adult patients. It has been suggested that the advice given by the BTS on the use of oxygen in patients with acute coronary syndromes conflicts with recommendations made in the ALS Course manual. A statement has been made to clarify these issues - this appears in this newsletter and has been placed on the RC(UK) website.

A joint statement by the Resuscitation Council (UK) and the British Association for Cardiac Rehabilitation has been developed in response to enquiries about the facilities and level of resuscitation training required for staff supervising cardiac rehabilitation programmes. This statement was coordinated by David Pitcher and is also now on the RC(UK) website. David has also been leading on the development of a model do-not-attempt resuscitation (DNAR) form, which will soon be available for download from our website. National Health Service Trusts are welcome to adapt this form to suit their own needs and in-house style. A paediatric version is being prepared.

The duration of the pre-shock pause has been the topic of considerable debate for at least two or three years. A relatively lengthy safety check before attempted defibrillation will prolong the pre-shock and may reduce the chance of shock success. The ALS Subcommittee has written a statement to clarify its views on what we should be doing now to optimise defibrillation attempts. This statement appears in this newsletter as well as on the website. Another statement on the subject of defibrillation also appears in this newsletter. Many automated external defibrillators (AEDs) located in public places are currently accompanied by signs indicating that they should be used only by trained operators. Although AED operators should ideally be trained, it is the clear view of the RC(UK) that the use of AEDs should NOT be restricted to trained personnel. This strong message has also been given by the British Heart Foundation.

This year’s RC(UK) Scientific Symposium will be held at the Royal College of Physicians on 18th September. The programme, which includes cutting edge and controversial topics, is included in this newsletter. The last Symposium was sold out well in advance and I strongly advise you to ‘book early to avoid disappointment’.

Jerry Nolan
Chairman,
Resuscitation Council (UK)

Reference
In October 2008, the British Thoracic Society (BTS) published the “BTS guideline for emergency oxygen use in adult patients” (www.brit-thoracic.org.uk/emergencyoxygen). Along with several other organisations, the Resuscitation Council (UK) was approached by the BTS for endorsement of the first draft of this guideline. As a result of the feedback received on this document, significant amendments were made before the collaborating organisations endorsed this final guideline.

The majority of the recommendations in this guideline are consistent with the contents of the Advanced Life Support (ALS) course and manual and other RC(UK) guidelines and publications. Key is that the BTS guideline states “for critically ill patients, high concentrations of oxygen should be administered immediately”. Furthermore, in the critically ill patient or peri-arrest situation, treatment should commence with oxygen at 15 L min⁻¹ via a reservoir mask or bag-mask, and during cardiac arrest the aim should be for maximal oxygen saturation until the patient is stable. Once these patients are stable, the oxygen dose should be reduced with the aim of achieving an oxygen saturation in the range of 94-98%. In those situations where pulse oximetry is not available to monitor critically ill patients, oxygen should continue to be given via a reservoir mask until definitive treatment is available. For those patients with serious illness causing acute hypoxaemia (initial SpO₂ <85%), oxygen should also be given via a reservoir mask at a flow of 10-15 L min⁻¹. As before, once stable, the target is an oxygen saturation of 94-98%. The guideline recommends that arterial blood gas values should be checked in all of these patients. Although the guideline emphasises the need to avoid giving excessive concentrations of oxygen to patients with chronic obstructive pulmonary disease (COPD) or other risk factors for hypercapnic (Type II) respiratory failure, when critically ill, these patients should initially be given oxygen at high flow, but arterial blood gas analysis should be undertaken promptly to guide further management.

It is highly likely that future resuscitation guidelines will emphasise the need to target the oxygen saturation in all patients once a reliable pulse oximetry reading and arterial blood gas analysis can be obtained.

One recommendation in the BTS document that apparently conflicts with RC (UK) ALS guidelines is the recommendation to withhold oxygen from a patient with an acute coronary syndrome, including myocardial infarction, unless the patient is hypoxaemic: “in myocardial infarction and acute coronary syndromes, aim at an oxygen saturation of 94-98% or 88-92% if the patient is at risk of hypercapnic respiratory failure.” However, this is in the context of those patients who are not critically or seriously ill with these conditions. The ALS course focuses on the resuscitation and treatment of those patients who are critically ill (including those with acute coronary syndromes) and as described above, high concentrations of oxygen are appropriate for these patients until a reliable measure of their oxygen saturation can be obtained that confirms that they are not hypoxaemic. At this point, oxygen therapy can be targeted or stopped completely as indicated in the BTS guideline.
Although there is some low-level evidence that high oxygen concentrations may be harmful in the presence of myocardial ischaemia (and stroke), this has yet to be confirmed in prospective controlled trials.

This topic will be addressed in the 2010 International Consensus on Cardiopulmonary Resuscitation Science Conference and revised RC(UK) guidelines will be based on the recommendations that emerge from this meeting as well as those made in the BTS guideline.

Finally, the guideline contains a lot of excellent information on the physiology of oxygen, carbon dioxide and blood gases, oxygen delivery devices and pulse oximetry. If you don’t want to read all 81 pages of the main guideline, there is an executive summary.

Requirements for the management of cardiac arrest in and out of hospital:

1. Patients must receive optimal management and staff should undergo regular resuscitation training to a level appropriate for their expected clinical responsibilities and professional code of practice.

2. The precise requirements for resuscitation training, drugs and equipment at any CR programme will be determined by the risk of a cardiorespiratory arrest occurring in a member of the patient group attending that programme.

3. Each patient should undergo an individual risk assessment before entering a CR programme. The risk classification for each patient should determine the appropriate venue, staffing and resources required to allow safe and effective participation in the exercise programme. This process should be agreed locally by the CR team and venue providers.
4. The minimum standard for immediate response to cardiac arrest is that:
   - there is prompt recognition of cardiac arrest
   - cardiopulmonary resuscitation (CPR) is started immediately
   - appropriate help is summoned without delay
   - the emergency response team has clear directions to the exercise venue
   - a defibrillator is available and defibrillation is attempted for any shockable rhythm within 3 minutes of collapse.

5. All CR programmes should have a clear policy, defining the procedures to be followed in response to cardiac arrest. All staff working on the CR programme should be familiar with that policy and have a good working knowledge of how to implement the procedures.

6. Hospital-based CR programmes and other CR programmes where immediate emergency response is available should ensure a procedure that enables rapid access to a resuscitation team. The emergency team should include individuals who are trained to the level of Advanced Life Support (ALS) providers.

7. For CR programmes based outside hospitals or where there is no immediate local emergency response facility there is a need to provide a prompt response via a ‘999’ emergency protocol. The following should be in place to facilitate an optimum response:
   - prior identification of the CR venue with local emergency services
   - telephone or mobile telephone to summon a paramedic ambulance
   - automated external defibrillator (AED) available
   - easy access for ambulances and ambulance trolleys to the CR venue.

8. Irrespective of the venue, staff supervising patients during Phase III CR exercise programmes should have received training in and have maintained their competency in CPR to the level of Immediate Life Support (ILS). For a Phase IV exercise programme (following a successful period of Phase III CR exercise and confirmation that it is safe and appropriate for patients to progress), staff competency in Basic Life Support (BLS) with at least one staff member trained in the use of the AED is considered sufficient for each exercise session.

More complete guidance on appropriate facilities for and training in resuscitation can be found in “Cardiopulmonary Resuscitation - Standards for Clinical Practice and Training” and “CPR: Guidance for Clinical Practice and Training in Primary Care”.

Further advice and response to specific queries not covered by the above guidance may be obtained from enquiries@resus.org.uk or bacr@bcs.com.

Main authors:
Dr Patrick Doherty - BACR
Dr David Gabbott – RC(UK)
Dr Jerry Nolan – RC(UK)
Dr David Pitcher – RC(UK)
Dr Jasmeet Soar – RC(UK)

18 November 2008
The majority of people who survive a cardiac arrest are resuscitated from ventricular fibrillation (VF) by the administration of a defibrillatory shock. This is most likely to be successful when it is given very soon after the onset of VF; emergency service personnel are often unable to arrive soon enough to help a victim.

Automated external defibrillators (AEDs) are designed to be used by members of the public, and are very effective at guiding the operator through the process of administering the shock. They have become widely available, are safe and easy to use, and will not allow a shock to be given to a victim who does not require one.

AEDs have been used frequently by laypeople with modest training, and many reports testify to the success of this strategy. Operators without formal training have also used AEDs successfully to save lives.

While it is desirable that operators of AEDs should be trained in their use, and keep their skills up to date, circumstances can dictate that no trained operator (or a trained operator whose certificate of training has expired) is present at the site of an emergency. Under these circumstances no inhibitions should be placed on any person willing to use an AED.

It is the view of the Resuscitation Council (UK) that the use of AEDs should NOT be restricted to trained personnel. Furthermore, the Resuscitation Council (UK) considers that it is inappropriate to display notices to the effect that only trained personnel should use the devices, or to restrict their use in other ways. Such restrictions are against the interests of victims of cardiac arrest, and discourage the greater use of AEDs by members of the public who may be able to preserve life and assist victims of cardiac arrest.

This statement confirms similar advice from the British Heart Foundation.
We will be holding our Scientific Symposium meeting on **Friday 18th September** at the Royal College of Physicians, 11 St Andrews Place, Regents Park, London.

The Symposium is suitable for both healthcare and non-medical personnel and a registration form and programme is available on our website.

We hope you will be able to join us for what promises to be a great meeting.

**Call for presentation of Free Papers**

If you would like the opportunity to present a paper at the Symposium please submit your application **no later than Tuesday 14th July**. Details and application form can be downloaded from the website.

Please return your application to Sarah Mitchell at sarah.mitchell@resus.org.uk.

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The length of the pre-shock pause, the interval between stopping chest compressions and delivering a shock, is inversely proportional to the chance of successful defibrillation. Every 5 second increase in the duration of the pre-shock pause almost halves the chance of successful defibrillation, therefore it is critical to minimise the pause. The lengthy ‘top-to-toe’ safety check (e.g., “head, middle, bottom, self, oxygen away”) performed after the defibrillator has charged and before shock delivery, commonly taught and used in clinical practice, will therefore significantly diminish the chances of successful defibrillation. This statement concerning defibrillation technique provides guidance that should decrease the duration of the pre-shock pause without increasing the risk to rescuers.
Current Resuscitation Council (UK) guidance and teaching materials state that the pre-shock pause should be less than 10 seconds; we believe that it is possible to reduce this further still without endangering team members. To help achieve this and further minimise the pre-shock pause:

1. All rescuers should wear gloves during every resuscitation attempt.
2. Use self-adhesive defibrillation electrodes to deliver the shock. These should be applied whilst chest compressions are ongoing.
3. Safety issues should be addressed and planned for during chest compressions.
4. Before stopping chest compressions the team should plan what to do if the rhythm is shockable:
   a. on stopping chest compressions if the rhythm is shockable everyone should “stand clear” and remove the oxygen if appropriate,
   b. identify who will charge the defibrillator and deliver a safe shock if the rhythm is shockable,
   c. identify who will immediately resume chest compressions after the shock is delivered.
5. When the team leader asks for compressions to stop:
   a. the cardiac arrest rhythm should be confirmed as shockable and everyone should stand clear of the patient,
   b. if the rhythm is shockable the defibrillator is immediately charged whilst individuals are standing clear,
   c. during the charging process there should be a clear instruction to “stand clear” with a rapid visual safety check,
   d. the shock is delivered with minimal delay,
   e. chest compressions should restart immediately after the shock.
6. If there are delays caused by difficulties in rhythm analysis or if individuals are still in contact with the patient, chest compressions should be restarted whilst plans are made to decide what to do when compressions are next stopped.
7. A prolonged safety check during charging and before shock delivery is not necessary and is no longer recommended.
8. Consider delaying intravenous drugs until after the shock has been delivered and chest compressions restarted.
9. Rescuers must not compromise their safety.
There are very few reports of harm to rescuers during defibrillation even when the rescuer has been in contact with the patient. It is highly likely that future resuscitation guidelines will advocate that:

- chest compressions are continued during charging of a manual defibrillator
- when ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) is identified, chest compressions are continued whilst the defibrillator is charged
- shortly before the end of the chest compressions, the team leader ensures everyone is clear
- at the end of the period of chest compressions, the shock is delivered by the person who was doing chest compressions.

ALS Subcommittee
February 2009

Further reading


NCAA is a joint project between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) to establish a UK-wide database of in-hospital cardiac arrests.

Following the appointment of an NCAA Coordinator in November 2008, great progress has been made in the initial work to establish NCAA including:

- identifying relevant individuals in each NHS Trust in the UK to approach for future participation in NCAA;
- finalising a small, minimum dataset;
- identifying key individuals for inclusion in the forthcoming dataset consultation;
- establishing the infrastructure for web-based data entry and reporting.

In addition to this, key details about NCAA were released at the ALS Instructor day at the Royal College of Physicians on 8 December 2008 during a talk given by Carl Gwinnutt, for which a very positive response was received.

More recently, Prof. Kathy Rowan, Director, ICNARC, gave an NCAA progress update at the joint seminar held by the Intensive Care Society (ICS) and ICNARC on 11 February 2009 (Post-resuscitation care and NCAA). Again, this was very well received and the participants were enthusiastic in their support for the development of NCAA.

The dataset will now be sent out for consultation to all interested hospitals. If you would like to contribute to the dataset consultation process or would like your NHS Trust to register their interest in participating in NCAA, please contact NCAA on ncaa@icnarc.org

More information can be found about NCAA on www.icnarc.org

Sarah Mitchell
Director
Resuscitation Council (UK)

Kathy Rowan
Director
ICNARC

Edel Gallagher
NCAA Coordinator
ICNARC
Some eagle-eyed practitioners of newborn resuscitation have pointed out two controversial statements in the recent NICE guideline entitled “Intrapartum Care - Care of healthy women and their babies during childbirth”. These guidelines were developed by a guideline development group assembled by the National Collaborating Centre for Women’s and Children’s Health as a result of a commission from the National Institute for Health and Clinical Excellence and published in September 2007 (www.nice.org.uk/CG055). Within this 308-page document, which mainly deals with obstetric issues, there are two statements which impinge on Newborn Life Support territory and which might cause some confusion.

Unfortunately, these statements slightly conflict with the content of the NLS course manual and yet, for the reasons I outline below, there are no plans to change the content of the NLS manual or what is taught on the course. The NLS course and manual are based on UK experience and on the latest Consensus on Science reached by the International Liaison Committee on Resuscitation (ILCOR) published in 2005. ILCOR is in the process of reviewing all of the published evidence in order to update this document in 2010. The NLS course content was reviewed in the light of the 2005 publication and will be reviewed again following the 2010 publication. Any changes will be based on the consensus achieved by these international experts.

The first of these statements occurs in chapter 10, paragraph 10.2. This states that

“The Apgar score at 1 and 5 minutes should be recorded routinely for all births. If the baby is born in poor condition (the Apgar score at 1 minute is 5 or less), then the time to the onset of regular respirations should be recorded and the cord double-clamped to allow paired cord blood gases to be taken. The Apgar score should continue to be recorded until the baby’s condition is stable.”

In fact, there is no evidence to suggest that recording the Apgar score is an advantage when resuscitating newborn infants. There is also widespread agreement that the Apgar score should not be used to determine the need for resuscitation. It also has no place in determining what resuscitation steps are necessary, nor when to use them. Many hospitals in the UK do attempt to record the Apgar score at all deliveries but many have never done so. In my view, there is no reason why either of these groups of hospitals should change their current practice on this point.

The second statement occurs in chapter 16, paragraph 16.1. This states that

“Basic resuscitation of newborn babies should be initiated with air. Oxygen should be available for babies who do not respond once adequate ventilation has been established …”

There is a considerable body of literature to support the view that hyperoxia is a significant risk if exposed to 100% oxygen at birth and further that such hyperoxia has the potential to damage all tissues including the brain. Furthermore, there is some animal and human data to suggest that
resuscitation at birth can be just as effectively carried out with air as with 100% oxygen. However, though short term outcome data is accumulating, long term follow up data on the topic is much more important and yet virtually non-existent. For those wishing to brush up on the literature can I suggest a recent review of the evidence published in 2008.2

The fact remains that whether asphyxiated babies might suffer a greater or a lesser degree of lasting neurological deficit if resuscitation is started with higher concentrations of oxygen rather than air is unknown. Therefore, though it might seem reasonable to make the statement that appears in the NICE document, there is insufficient information to make it quite so categorically. Phrased in this way, there is a risk that this statement will eliminate the possibility of future research in this area.

The ILCOR consensus document from 2005 was very carefully phrased to be permissive of the use of air or supplementary oxygen for initiation of resuscitation and to avoid stepping beyond the solid ground of published evidence.1 As of January 2009 there have been no further publications to suggest it needs changing. Here is what it said:

“There is currently insufficient evidence to specify the concentration of oxygen to be used at the initiation of resuscitation. After initial steps at birth, if respiratory efforts are absent or inadequate, lung inflation/ventilation should be the priority. Once adequate ventilation is established, if the heart rate remains low, there is no evidence to support or refute a change in the oxygen concentration that was initiated. Rather, the priority should be to support cardiac output with chest compressions and coordinated ventilations. Supplementary oxygen should be considered for babies with persistent central cyanosis.”

Sam Richmond
Chairman, Newborn Life Support Subcommittee
February 2009

References

The launch of the Paediatric Immediate Life Support (PILS) course in October 2007 was very successful with 793 courses held during 2008 and over 8,000 candidates have gained a PILS certificate.

The PILS recertification course will be available in March 2009. Current PILS course centres will be able to access the course material on our website ending the need for a course CD.

Centres must send the candidates the recertification DVD, showing the ABCDE demonstration, in advance of the course. This pre-course instruction has enabled a two-hour course programme to be developed.

PILS recertification courses must be taken within one year of the expiry date of the PILS certificate. EPLS providers who have a current EPLS certificate may obtain PILS certification by attending a PILS recertification course. Certificates will be issued in the same way as for the PILS course.

ALS course centres accredited by the Resuscitation Council (UK) must be reassessed every four years. To remind centres, the ALS co-ordinators write to those due for reassessment a year ahead of this date and inform them that the onus is on the centre to arrange this with their Regional Representative. They are urged to give their Regional Representative all their prospective course dates for the next 12 months so they should be able to find a suitable time for reassessment.

With advanced notification their Regional Representative should be able to prioritise the centres they are required to assess. If they are unable to attend they will inform the Council and an extension can be applied. Centres that have not been reassessed, and whose Regional Representative has not asked the Council for an extension, will need to submit a new application to the ALS Subcommittee in order to remain an accredited centre.

Please don’t delay arranging reassessment of your centre and contact the ALS course co-ordinators (ALS@resus.org.uk) if you are experiencing difficulties in doing so.
1. Growth of the ILS provider course steadied in 2008 whereas the numbers doing the ILS recertification course doubled.

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* Still receiving course returns for 2008

2. The ILS subcommittee decided to keep the course centre registration fee at £500 and manual costs at their current level for 2009/10. The registration fee has remained unchanged since the launch of the course in 2002. The Resuscitation Council (UK) is investing in the development of an updated version of the ILS course. The updated course will be launched after the release of new cardiopulmonary resuscitation guidelines in 2010. The cost of registration and manuals will be reviewed with the launch of the new course.

3. The ILS instructor course is now in its fourth year (this includes the pilot period) and growing steadily. To recognise the important role of ILS instructors we have created a position for an ILS instructor on the ILS subcommittee.

4. It is my hope that at some stage in the near future we will update the ILS faculty regulations so that all instructors on the ILS course have completed either the Generic Instructor Course (GIC) or the ILS instructor course. I recognise that under the existing regulations there are a large number of ALS providers who have not done the GIC or ILS instructor course but provide a high level of teaching on ILS courses. ALS providers teaching on the ILS course should be encouraged to do an ILS instructor course.
5. The current requirements to be a candidate on an ILS instructor course will be changed so that ALS providers will only have to observe, instruct, or be a candidate on one ILS course in the 12-month period before attending the ILS instructor course.

6. Further information about the ILS courses and regulations are available from the Council website or by contacting the ILS coordinator Karla Wright on ILSadmin@resus.org.uk

Dr Jasmeet Soar  
Chair ILS Subcommittee

The e-ALS evaluation study is progressing well. 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. A step-by-step guide to the LMS has been written and distributed to all participating centres and each course centre has been visited by either Robin Davies or Jenny Lam to 'walk-through' the administration process.

Some twenty five centres have enrolled in the 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.

The e-learning ALS course is delivered in two parts.

- **Part 1** is on-line e-learning and includes the lectures, demos, quizzes & tutorials.
- **Part 2** is the face-to-face training which is one day and includes the practical skills CASTeach and assessment.
The first study course was run in early January and since then almost 150 candidates have participated in the study. These candidates were randomised between each arm: the standard ALS course and the e-ALS course. Congratulations to Bristol Royal Infirmary, St Georges, Royal Group of Hospitals Belfast and University College Hospitals who ran the first courses in January and many thanks for your hard work in making these courses happen.

There is still an opportunity to participate in this study. Interested course centres should contact either Jenny Lam or Robin Davies for details:

jenny.lam@resus.org.uk
robin.davies@resus.org.uk

We are very close to publishing the model DNAR form. This has taken some time because we took and incorporated detailed legal advice so that users of the form can be confident that it complies with current laws. Differences in the law relating to capacity in England and Wales, in Scotland, and in Northern Ireland, and the different laws that apply to children did not allow us to develop a single model form for universal use. However the basic principle of a single design with a similar appearance, similar if not identical content and similar if not identical layout will apply.

In the first instance we will publish a form for adults in England and Wales and this will be on the website in the next few weeks. A paediatric form will follow soon afterwards, and we will make minor adjustments so they will be suitable for Scotland and Northern Ireland.

Whilst identifying minimum requirements for good practice in recording DNAR decisions, the Resuscitation Council (UK) recognises that there will be some minor variation in the documentation requirements according to local circumstances. When published, the model DNAR forms may be adapted to meet local needs by individual healthcare organisations.