

Quality Standards: Primary care

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Published November 2013; last updated May 2020.

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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 to a level of proficiency appropriate to each individual's expected role.

In this document, primary care refers to the services provided by General Practitioners (GPs) and their practices as well as walk-in centres and out-of-hours service providers. These quality standards also apply to all other healthcare professionals who contribute to the delivery of primary care services. Separate quality standards for cardiopulmonary resuscitation practice and training in primary dental care are available.

Each section of this document contains the quality standards and supporting information and, where appropriate, supporting tools for each specific aspect of cardiopulmonary resuscitation in primary care.

The core standards for the provision of cardiopulmonary resuscitation across all healthcare settings are described in the [Introduction and overview page](#).

Alongside the quality standards, there is a primary care equipment and drug list. Please refer to that by clicking [here](#).

1. Background

Dealing with a cardiorespiratory arrest is a rare event for the individual primary care clinician. The circumstances and skills available to assist at such a time may vary widely, as may the equipment available. However, excellent results of resuscitation by GPs have been reported when defibrillation is carried out promptly, with survival rates exceeding 50% under favourable circumstances.

Since the publication of “Cardiopulmonary Resuscitation: Guidance for clinical practice and training in Primary Care” in 2001, the delivery of primary care in the UK has changed. The provision of primary care “in hours” and “out of hours” is now clearly demarcated. The patients have very different characteristics and are attended by professionals with varying skill sets. Doctors working with a higher-risk patient caseload, or GPs with an extended role in Urgent and Emergency Care, may have more skills in resuscitation than those working purely in daytime practice or who have other special interests. Individual doctors’ skill sets are also dictated by factors such as working in remote and rural areas or responding to requests for assistance from the ambulance service. Even the equipment required by a clinician on call for emergencies from a surgery will differ from that needed for routine home visits.

These guidelines do not define the skill sets or equipment required for each area of practice. They aim to provide standards that can be tailored to the needs of the individual practitioner or healthcare organisation and allow decisions to be made about the skill sets and equipment that are required for the patients under their care.

Supporting information

1. Resuscitation Council UK. Cardiopulmonary Resuscitation Guidance for clinical practice and training in Primary Care. 2001.
2. Royal College of General Practitioners. Guidance and competences for the provision of services using practitioners with special interests (PWSIs) - Urgent & Emergency care. 2008.
3. Colquhoun MC. Resuscitation by primary care doctors. Resuscitation 2006; 70: 229-237

2. Resuscitation Officers

Standards

All providers of primary care should have ready access to advice about resuscitation practice and training. This is best led by a dedicated, adequately trained Resuscitation Officer (RO) whose prime responsibility is for the coordination of all matters pertaining to resuscitation including training, audit and overseeing equipment. However, this may be difficult to organise in some primary care settings and some or all of the responsibilities could be delegated to providers outside the NHS or other providers such as the ambulance service. If a dedicated RO post is not commissioned, the responsibilities for the role should be undertaken by people or organisations of at least an equal level of training and experience in resuscitation, and their expected roles must be clearly defined. An RO in the community might be expected also to cover other healthcare provision outside acute hospitals such as clinics or community hospitals.

1. Every primary care organisation should have access to guidance and training in resuscitation.
2. As a guide, in hospitals one RO is required for every 750 clinical members of staff (See our [Acute Care Quality Standards](#) for further information).
3. Depending on geography and numbers needing training more than one RO (or people undertaking the duties of an RO) may be required in some places, or adjacent commissioners may consider sharing a post in others.
4. An RO (or people undertaking the duties of an RO) should be mobile, with a commitment to visit practices and urgent-care facilities to provide training and to advise on equipment.
5. Because of geography, the RO (or people undertaking the duties of an RO) for an area will require a local, named resuscitation lead in smaller organisations such as some General Practices. This person should be accountable for adherence to quality standards within their organisation and should ensure that basic tasks such as checking equipment are done routinely.
6. ROs (or people undertaking the duties of an RO) should be adequately trained and credible. At least one such clinical trainer should be an Advanced Life Support (ALS) provider (or equivalent) at a minimum and preferably an ALS Instructor or holder of another qualification in teaching/training, so that they can support and train clinicians with extended skill sets and those caring for high-risk patients.
7. The accommodation required for resuscitation training will vary according to local arrangements. An RO (or people undertaking the duties of an RO) must have an office base with computer facilities, internet access, a telephone

and secure filing for confidential documents. There must be adequate storage space for training equipment. The venues where training is delivered must have adequate space for training using a manikin and appropriate electronic teaching aids should also be available.

8. An RO (or people undertaking the duties of an RO) should have adequate administrative support.
9. Equipment for training will vary according to local needs. Adult, paediatric and newborn manikins should be available as should a training AED, ECG monitor and rhythm simulator. Airway management manikins may be required in some settings or for some groups of professionals. Equipment should be portable so that it can be taken to training venues. To ensure that training is of maximum relevance, whenever possible equipment (especially defibrillators) used in training should be the same model as that used in actual clinical practice.
10. Adequate financial provision should be made for staffing, equipment and accommodation for such resuscitation training when contracts are being negotiated.
11. An RO (or people undertaking the duties of an RO) has a responsibility to maintain his/her own education in resuscitation. In order to achieve this, teaching on resuscitation courses outside their own organisation is recommended. In addition, regular attendance at professional meetings must be supported with a budget for study expenses. They should consider clinical attachments in acute settings, in particular to provide opportunities for clinical involvement in resuscitation attempts, in order to maintain clinical credibility.

Supporting information

1. Resuscitation Council UK. <http://resus.org.uk>
2. Scottish Resuscitation Group. <http://www.srg.scot.nhs.uk/>

3. Training of staff

Standards

1. All staff in a primary care organisation, including non-clinical staff, should undergo regular training in resuscitation of both adults and children to the level appropriate to their role.

2. Staff should undergo such training at induction and at appropriately frequent, regular intervals thereafter to maintain knowledge and skills.
3. According to Resuscitation Council UK guidelines, training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation (CPR). Training and facilities must ensure that, when cardiorespiratory arrest occurs, as a minimum all clinical staff can:
 - recognise cardiorespiratory arrest,
 - summon help,
 - start CPR,
 - attempt defibrillation (if appropriate) with an automated external defibrillator (AED) with the minimum of delay, whenever possible within 3 minutes of collapse.
4. Clinical staff should have at least annual updates.
5. Training and updates that include an assessment are recommended for clinical staff.
6. Non-clinical staff generally should have annual updates also. However, a local risk assessment may be undertaken to assess the likelihood of them encountering a patient requiring resuscitation (for example a driver for an out-of-hours doctor's car may be required to assist at a cardiorespiratory arrest more frequently than a secretary in some daytime General Practices).
7. As a minimum, non-clinical staff must be trained to:
 - recognise cardiorespiratory arrest,
 - summon help,
 - start CPR using chest compressions.
8. For all staff, various methods to acquire, maintain and assess resuscitation skills and knowledge can be used for updates (e.g. life support courses, manikin/simulation training, mock-drills, 'rolling refreshers', e-learning, video-based training/self-instruction). The choice should be determined locally. For example, training materials such as [Lifesaver](#) developed by Resuscitation Council UK, or very brief videos aimed at lay people may be appropriate for non-clinical staff. Hands-on training using simulation and including assessment is recommended for clinical staff.
9. A system must be in place for identifying any resuscitation equipment that requires special training, and for ensuring that such training takes place.
10. The RO or resuscitation lead should organise and co-ordinate resuscitation training for staff. However, in order to achieve training targets, the RO may need to delegate some aspects of training.
11. All primary care providers should make provision for staff to have sufficient time to train in resuscitation skills as part of their employment.

12. Specific training for cardiorespiratory arrests in special circumstances (e.g. resuscitation of children or the newborn) should be provided for medical, nursing and other clinical staff where appropriate.
13. All training must be recorded (e.g. in an organisation's training database).

Supporting information and tools

Supporting information

1. Resuscitation Guidelines 2015, Resuscitation Council UK.
2. Quality and Outcomes Framework 2012-2013 Guidance for PCOs and practices March 2012. BMA and NHS Employers. https://pcc-cic.org.uk/sites/default/files/articles/attachments/qof_vol4_2012.pdf

Supporting tools

Lifesaver. An interactive film by Martin Percy with Resuscitation Council UK. 2013. <http://www.life-saver.org.uk/>

4. The team approach to resuscitation

1. Each practice should plan for the need to attempt resuscitation. Staff should have an understanding of what role they would be expected to undertake in those circumstances.
2. In primary care the availability at any one time of particular resuscitation skills and the numbers of people available to assist may vary. This should be borne in mind when planning the response to a collapsed patient and team members must be prepared to be flexible about their role within the boundaries of their own skill level.
3. All those trained to participate in resuscitation should know where essential drugs and equipment can be accessed immediately.

5. Resuscitation equipment

Standards

Click [here](#) to view the equipment and drug list for cardiopulmonary resuscitation in Primary Care.

6. Decisions relating to cardiopulmonary resuscitation

Standards

1. Healthcare professionals must be familiar with and follow published guidance, including in particular '[Decisions relating to Cardiopulmonary Resuscitation](#)', a joint statement by the British Medical Association, Resuscitation Council UK, and the Royal College of Nursing and the General Medical Council's current guidance on 'Treatment and care towards the end of life: good practice in decision making'. The detailed guidance in the Joint Statement should be used as the main source of reference to guide clinical practice.
2. Healthcare professionals must be familiar with and must comply with the law as it applies to decisions about CPR. There are some differences in the law among countries of the United Kingdom. Healthcare provider organisations must ensure that their staff receive appropriate information and training regarding these laws.
3. It is essential to identify:
 - patients for whom cardiorespiratory arrest is an expected part of the process of dying and in whom CPR is inappropriate,
 - patients who do not wish to receive CPR.
4. It is important to identify:
 - patients at risk of dying for whom advance care planning, including decisions about CPR, may avoid inappropriate treatment, including inappropriate resuscitation attempts.

The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) 2013 identified a number of pitfalls for GPs regarding do-not-attempt-CPR (DNACPR) decisions:

- Incomplete documentation, especially unclear recording of the reason for not attempting CPR.
- "Blanket" policies concerning DNACPR in some care homes.
- Premature decisions not to attempt CPR.

- Failures to inform family and/or carers of decisions.

Supporting information and tools

Supporting information

1. [Guidance from the British Medical Association, Resuscitation Council UK, and the Royal College of Nursing](#). 2016.
2. Recommended standards for recording decisions about cardiopulmonary resuscitation. Resuscitation Council UK. Revised 2015.
3. Treatment and care towards the end of life: decision making, General Medical Council. http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp
4. The Confidential Inquiry into premature deaths of people with learning difficulties (CIPOLD) 2013. <http://www.bris.ac.uk/cipold/fullfinalreport.pdf>
5. Adults with incapacity (Scotland) Act 2000 Part 5 Code of Practice. <https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorized-carry-out-medical-treatment-research-under-part-5-act/>
6. Mental Capacity Act 2005 (England and Wales). <http://www.legislation.gov.uk/ukpga/2005/9/contents>

Supporting tools

1. Resuscitation Council UK has provided model DNACPR forms for use in adults and children respectively.
2. Scotland has a single DNACPR policy. For more information including supporting tools see: <http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/Living-Dying-Well/DNACPR>
3. [Recommended Summary Plan for Emergency Care and Treatment](#).

7. Audit and reporting

The audit and reporting of resuscitation attempts in primary care presents some logistical challenges due to the relative rarity of such events in any one practice. Nevertheless, for this very reason, it is important to capture as much information as possible to allow review of the response and improve patient outcome in

subsequent cases.

Standards

1. Audit should always include a full 'debriefing' of staff after any cardiorespiratory arrest. This allows them to reflect on the treatment given and permits discussion of whether anything might have been done differently. When appropriate, a root cause analysis should be undertaken and the action plan implemented. This may be done locally as a practice 'significant event' or by studying all the events in the locality, collated by the lead for resuscitation.
2. Patient safety incidents (any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS-funded healthcare) should be reported to the National Reporting Learning System.
3. Audit of DNACPR policies is mandatory (Health Services Circular 2000/028).

Supporting information

1. National reporting learning system: <http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/healthcare-staff-reporting/>
2. NHS Executive. Health Services Circular 2000/028 - Resuscitation Policy http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004244

8. Research

Despite significant advances in recent years, there remains substantial scope for research to improve best practice in resuscitation science, training and clinical practice. Research to further the evidence base concerning resuscitation in primary medical care should be encouraged. Research is a core activity of the NHS [NHS Constitution Key Principle 3] and should be supported whenever possible.

Standards

1. Research must be conducted in accordance with the NHS Research Governance Framework. Research involving human participants, their

organs, tissue or data require NHS Research and Development approval. Such research may also require approval from a Research Ethics Committee. If in doubt advice should be sought from the local Research and Development Office in the first instance or NHS Research Ethics Advice Service.

2. Research involving patients who lack capacity must also comply with relevant legislation (e.g. UK Medicines for Human Use [Clinical Trials] Regulations 2004; Mental Capacity Act 2005 [England and Wales]; Adults with Incapacity [Scotland] Act 2000).

Supporting information

1. National Research Ethics Service. <https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/research-ethics-service/>
2. National Research Ethics Service Does my project require review by a Research Ethics Committee? <https://www.hra.nhs.uk/approvals-amendments/>
3. NHS Constitution. <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

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