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This year we are all looking forward to Guidelines 2010. The International Liaison Committee for Resuscitation (ILCOR) will publish the Consensus on Science and Treatment Recommendations (CoSTR) on 18 October 2010. The European Resuscitation Council Guidelines based on the ILCOR CoSTR will be published at the same time. We hope to publish the Resuscitation Council (UK) guidelines shortly after this. We will make every effort to ensure that we post updates on the process on this website and in our newsletters.

The ILCOR guidelines process is still ongoing and to find out more you can visit the ILCOR website (www.ilcor.org). Several individuals have asked me if I know the new guidelines already. Even though I have attended all the ILCOR meetings as a task force co-chair, I must admit I still do not know what the new guidelines will be as the process of reviewing the science is still ongoing. I personally am hoping the areas in the current guidelines I struggle with will be resolved – I do hope we can make several areas easier to remember and implement during cardiac arrest such as when to give drugs during ALS.

Once the guidelines are available, there are a number of major pieces of work that have to be completed in order to have new course materials. We have therefore put together a Guidelines 2010 project team led by Jerry Nolan. The process for courses over the transition period is covered elsewhere in this newsletter. The first opportunity to hear about the new guidelines and find out more about the courses from the course chairs will be our 2010 Symposium on 18 November 2010. The Guidelines 2005 Symposium was sold out well in advance so I strongly advise you to 'book early to avoid disappointment'.

2009 was a busy year and the Resuscitation Council (UK) continues to spread its influence in a number of areas as can be seen from the wide range of topics covered in this newsletter. This includes working with NICE as stakeholders, the NHS Litigation Authority about CNST standards, and the Royal College of Anaesthetists on its continuing professional development matrix and training syllabus. We have also collaborated with the National Patients Safety Agency (NPSA) on several projects. David Gabbott has worked with the NPSA to produce a report on incidents in mental health settings. We are currently reviewing all critical incidents related to resuscitation that have been reported to the NPSA's national reporting and learning system (NRLS). This includes adverse incidents reported in most trusts in England. I am hoping the information gleaned from the reports will help us to make recommendations for improving resuscitation practice and where possible we can incorporate the key issues in to our course materials.
As a gadget person I am also pleased to announce that the Resuscitation Council (UK) has launched an iPhone ‘app’ which enables rapid access to the latest resuscitation guidelines and updates. It’s also free to download. Technology permitting, we will try to make the iResus ‘app’ available on other smart phones. The e-ALS study also continues and I thank all those centres involved in recruiting candidates. We have also managed to persuade the Australian Resuscitation Council to join the e-ALS project. The experience of the pilot phase and results of the trial comparing the current ALS course with the e-ALS will help with decision making regarding how the Resuscitation Council (UK) delivers its courses in the future.

The National Cardiac Arrest Audit (NCAA) is now up and running and has already started gathering data. If your hospital has not yet joined NCAA, I strongly encourage you to do so. Analysis of good quality local and national cardiac arrest data will help us all identify areas where we can improve the care of patients who need resuscitation.

Jas Soar
Chairman,
Resuscitation Council (UK)
Resuscitation Council (UK) life support courses

The Resuscitation Council (UK) is not imposing a moratorium on its courses; it is in the best interests of healthcare staff and patients that centres continue providing training right up until the new material is available. This strategy worked well in 2005. The Council is liaising with the National Patient Safety Agency with the view to issuing a rapid response report to optimise implementation.

The relevant course subcommittees will be able to agree the final content of the new courses only once the ERC and Resuscitation Council (UK) guidelines have been finalized. Because of the vast amount of material that will require changing, the Guidelines project team has opted to stage the introduction of these new courses. Once the new material has been prepared, time will be needed for printing and for distribution to course centres so that they receive the material at least 4-6 weeks before the date of a course. As yet we are unable to give a precise dates for when the new material will be ready for all the courses. We are aiming that the first of each of the new courses can be held as follows:

- **ALS and ILS:** January 2011
- **EPLS and PILS:** May 2011
- **NLS:** late Spring 2011

Following the publication of the new guidelines the Resuscitation Council (UK) will hold the Scientific Symposium on **Thursday 18 November 2010** at the National Motorcycle Museum in Solihull.

At this meeting the new guidelines and the science will be presented. The full programme is available on our website’s forthcoming events page. Although this is a bigger venue to accommodate more delegates we advise that you register early to avoid disappointment.

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 31st August. Details and an application form can be downloaded here. Please return your application to Sara Harris at sara.harris@resus.org.uk
Emergency use of buccal midazolam in dental practice

The RC(UK) has recently received a number of enquiries regarding the use of midazolam for emergency seizure control in dental practice. The following statement should clarify any concerns or queries:

Prolonged seizures are dangerous and may cause severe long lasting cerebral damage to adults and children alike. In the event of a seizure occurring in a dental practice setting the guidance published by the Resuscitation Council (UK) ‘Medical Emergencies and Resuscitation: Standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice’ should be followed. If the patient continues to fit after an ambulance has been called then the RC(UK) guidance suggests the administration of buccal midazolam to assist in terminating the seizure. The dose is 10mg for adults and an appropriately reduced dose for children.

The evidence for using midazolam in this manner and for this indication is strong. Despite this being an ‘unlicensed’ use of the drug, buccal midazolam for prolonged seizure control is recommended in the British National Formulary, by the Advanced Paediatric Life Support course, the Royal College of Paediatrics and Child Health and numerous other high profile institutions throughout the UK, e.g. Great Ormond Street Hospital for Children. Paediatricians throughout the country prescribe this drug for parents of children who may have a seizure at home and all the National Epilepsy organisations recommend its use in this situation.

Preparations of midazolam have changed recently in an effort to standardize and reduce overdose concerns. Current formulations include midazolam solution for injection 1mg/ml, 2mg/ml and 5mg/ml. The 2mg/ml and 5mg/ml solutions are now largely limited to general anaesthesia and intensive care settings. An unlicensed ‘special order’ preparation of midazolam buccal liquid 10mg/ml is available for use in emergency settings for seizure control (‘Epistatus’). Most recently the Scottish Dental Clinical Effectiveness Programme (SDCEP) ‘Drug Prescribing for Dentistry’, November 2009 Update, has removed ‘midazolam buccal liquid’ from its list of available drugs. This is the 10mg/ml ‘special order’ preparation. It has not removed the use of midazolam however, but has replaced the ‘special order’ preparation with ‘midazolam injection solution’ which is 2mg/ml or 5mg/ml. Use of midazolam for uncontrolled seizures is still recommended by the SDCEP.

Other concerns regarding midazolam have centred around the drug’s reclassification as a ‘Schedule 3’ Controlled Drug. Such reclassification requires certain legal processes. This includes written prescription requirements. However, the law for this Schedule 3 drug does NOT require safe custody i.e. locked cupboard, nor the need to keep a midazolam controlled drug register. Some institutions are encouraging such practices as part of their own Health and Safety protocols but there is no legal obligation to do so.
Similarly, concerns have been raised about acquiring stocks of midazolam for use in the emergency setting of seizure control. Those dental practitioners who perform ‘conscious sedation’ using midazolam injection solution will of course have regular stocks of the drug and can use the intravenous preparation via the buccal route (as recommended by the SDCEP above). Those dental practitioners who do not use midazolam regularly are still permitted to requisition the Schedule 3 Drug under the conditions laid out by the Royal Pharmaceutical Society of Great Britain Guidance ‘Medicines, Ethics and Practice: a guide for pharmacists and pharmacy technicians: Section 1.2.14’.

David A Gabbott and Alexander Crighton
Chairmen of the Project Group:
Resuscitation Council (UK) ‘Medical Emergencies and Resuscitation: Standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice’

Course centre recruitment
The UK base of e-ALS course centres continues to expand, as the last few months have seen Colchester General Hospital, Maidstone Hospital, Staffordshire General Hospital, University Hospital of North Durham all coming on board.

Due to the success and commitment of participating centres in recruiting candidates for the study (see below) we are no longer recruiting new centres.

Candidate recruitment
Thanks to all the hard work by the course centres, the project is on target for candidate recruitment. We need 2754 candidates recruited by October 2010. The graph overleaf shows the target recruitment and actual recruitment as at the beginning of December 2009.
Trial Steering Committee

The role of a Trial Steering Committee (TSC) is to provide overall supervision of the trial and ensure that it is being conducted in accordance with the principles of good clinical practice paying particular heed to safeguarding interests of patients and learners. The TSC agrees the trial protocol and any protocol amendments and provides advice to the investigators on all aspects of the trial. Decisions about continuation or termination of the trial or substantial amendments to the protocol are also the responsibility of the TSC.

The e-ALS TSC is chaired by Prof. Ed Peile (Professor of Medical Education at University of Warwick) and met most recently in January 2010. The Committee is pleased with the progress of the study thus far and has agreed that recruitment of candidates should continue.

Once the Trial is over will the e-ALS course replace the traditional ALS course?

The Council has no intention of replacing the traditional 2-day face-to-face course with the e-ALS course. Once the trial is completed, the ALS Subcommittee will review the results to establish if and how e-learning fits into the portfolio of courses offered by the Council.

If you have any questions on e-ALS please contact:

Robin Davies, Lead RO  (robin.davies@resus.org.uk)
Jenny Lam, e-ALS Coordinator  (jenny.lam@resus.org.uk)
This advisory document is a revision of previous guidance published by the Resuscitation Council (UK) in 2001.

The updated document (on our website) provides realistic principles for dealing with manual handling situations which have been scored using Rapid Entire Body Assessment (REBA). REBA is a tool designed to assess postures for risk. The document also includes a section on bariatric patients.

This document was first published by the RC(UK) in August 2000 and is currently being revised to include the Mental Capacity Act and more information about the responsibility to provide an AED. We hope it will be available in the next few months.

Cardiac rehabilitation programmes –

Supplementary statement on AEDs and exercise (Sept 09)

This supplementary statement clarifies aspects of the recommendations made in the joint statement on resuscitation training and facilities (BACR and the Resuscitation Council (UK), November 2008). The drive for the original statement came from inconsistencies in the management of cardiac patients taking part in community-based exercise programmes. This supplementary statement addresses issues raised by cardiac rehabilitation staff seeking clarification on training and equipment in phase IV programmes.

View supplementary statement
The Resuscitation Council (UK) is delighted to announce the launch of its application for the iPhone – iResus.

It is FREE to download and is available on the App Store at iTunes. Please see the information page on our website for details of how to obtain further information from the Apple website.

This application provides rapid access to the latest resuscitation guidelines algorithms. When these are updated, they will be automatically pushed to the iResus application so you will always have up-to-date guidance. Some sample screenshots are shown below. The anaphylaxis algorithm and paediatric arrhythmias algorithm will be added shortly.

Currently it is in the top ten best selling medical apps and we welcome your feedback. We would like to see this guidance in the pockets of all doctors and healthcare professionals.

The application currently runs on the Apple iPhone but we are planning to make it available on other platforms including the Symbian, RIM (Blackberry OS), Windows Mobile, and Java ME in the future.
NCAA is a joint initiative between Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) to establish an audit of in-hospital cardiac arrests with a view to improving resuscitation care and patient outcomes.

Since releasing the NCAA Recruitment Pack in September 2009 to hospitals that had expressed an interest in NCAA, the first data were entered onto the NCAA secure web-based system just a month later, in October 2009.

Recruitment of acute hospitals in England and Wales to this ongoing audit continues apace! If you have not already received the NCAA Recruitment Pack (which includes details such as the initial dataset, subscription fee, local resources needed to participate and how your hospital can sign up), please email the NCAA Team on ncaa@icnarc.org.

Once you have digested all the information within the NCAA Recruitment Pack, the Chair of the Resuscitation Committee at your hospital must request the NCAA Joining Pack from us (which contains the NCAA Participating Hospitals Agreement and NCAA Contacts Form). Once these forms have been returned to the NCAA Team, your hospital can begin collecting and entering data within a few days.

The initial scope of NCAA data collection is ‘all individuals (excluding neonates) receiving chest compressions and/or defibrillation from the hospital based resuscitation team (or equivalent)’ i.e. the team that responds to internal crash call telephone calls (2222) at your hospital. Data must be collected for all team visits made by the resuscitation team (or equivalent) based at your hospital, where chest compressions and/or defibrillation have been administered (adult or paediatric). Cardiac arrests not attended by the resuscitation team are not counted.

Is your hospital keen to get assistance with funding for the NCAA subscription fee? Try approaching your Strategic Health Authority (SHA) to see if they can help as part of their commitment to the Patient Safety First Campaign. One SHA has already funded all of their hospitals to participate in NCAA as part of the ‘Deterioration’ arm of the campaign.

To request the NCAA Recruitment Pack or if you are the Chair of the Resuscitation Committee at your hospital and you would like to request the NCAA Joining Pack, please email ncaa@icnarc.org.

Sarah Mitchell
Director
Resuscitation Council (UK)

Kathy Rowan
Director
ICNARC

Edel Gallagher
NCAA Coordinator
ICNARC
The ALSG and RC(UK) Educator and GIC working group have undertaken a review of the GIC programme. Their aim is to ensure that the course is contemporary and remains fit for purpose for the range of Provider courses that the GIC serves.

A pilot programme has been devised that is being trialled from mid January until 23 April. New content has been developed which includes how to give structured feedback and the role of the mentor, and the language has been contemporised to reflect the current literature, for example the replacement of ‘scenario teaching’ with ‘simulation teaching’. Only those centres running a course within the pilot period are being sent the new materials.

One of the main changes is in the way we will be teaching the candidates to structure their feedback to candidates. All Provider course directors have been sent a “Debrief as a Learning Conversation” document that gives details of the new approach. This document is also available on our website and we ask course directors and faculty to be supportive to those candidates who have completed the pilot programme, as they will be using this new approach when they undertake their Instructor candidacy.

The Educator group are mindful of the impact of these changes and look forward to receiving feedback from candidates and faculty on the pilot courses.

If you have any queries then please e-mail GIC@resus.org.uk