NHS
National Patient Safety Agency

Rapid Response Report

NPSA/2008/RRR010

From reporting to learning 26 November 2008

Resuscitation in mental health and learning disability settings

Mental health (MH) and learning disability (LD) patients can be vulnerable to cardiac or respiratory arrest through coexisting physical illness, self-harm, and the effects of medication, including rapid tranquilisation. They are also vulnerable to choking, through dysphagia associated with illnesses like dementia, food bolting, pica, or through intoxication, substance abuse or intentional self-harm. Existing guidance from the Resuscitation Council (UK)[1] requires that all healthcare settings offer Basic Life Support (BLS) and, in addition to BLS, any unit where a cardiac arrest might be expected at least once in every five years has access to Automated External Defibrillators (AEDs). NICE guidance[2] requires that any setting where rapid tranquilisation, physical intervention, or seclusion is used must have access to staff trained to immediate life support (ILS) standards and to appropriate ILS medication and equipment including AEDs. This is likely to mean (as a minimum) access for all admission units and forensic units.

Following a trigger incident in April 2008 of a failed resuscitation attempt, a search of NPSA data revealed 599 reports of at least moderate harm related to choking or cardiac or respiratory arrest in MH & LD settings that demonstrated wide variations in standards of resuscitation. Twenty-six of these incidents described significant lack of staff knowledge or skills (e.g. in identifying cardiac arrest) or of equipment availability (from basic mask-to-mouth devices to AEDs). In addition we found three reports of patient deaths after choking on food, and another 22 moderate or severe harm reports of patients choking, where staff did not always seem to have skills to deliver effective first aid.

For IMMEDIATE ACTION by Medical & Nurse Directors providing MH or LD inpatient care (NHS & independent sector). DATE FOR ACTION COMPLETE is 20 MAY 2009

Local organisations should ensure that:

1. Their rolling programme of basic life support (BLS) training for all staff is based on Resuscitation Council (UK) standards[1] that include the management of choking.
2. All patient areas have immediate access to appropriate BLS equipment (e.g. self-inflating bag-mask devices, or mouth-to-mask devices).
3. All patient areas where a cardiac arrest might be expected at least once every five years should have access to Automated External Defibrillators (AEDs) within three minutes.
4. All units where rapid tranquilisation, physical intervention, or seclusion may be used have access to staff trained in immediate life support (ILS) and to all equipment specified in NICE Guideline 25 (including AEDs).[2]
5. Wherever feasible, their training includes regular practices or drills in addition to classroom teaching.
6. A leadership role for resuscitation issues is identified (including within organisations whose resuscitation training is contracted out) and levels of attendance at life support training are routinely audited, reported to a senior level of the organisation, and any lapses acted on.

The NPSA has informed:
NHS organisations, the independent sector, commissioners, regulators and relevant professional bodies.

Information to support implementation
A *Supporting Information* document with more information on our findings, links to resources, compliance checklist, and an **'ask the experts' web discussion board** is available at www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr or contact Ben Thomas, Head of Mental Health and Learning Disabilities, rrr@npsa.nhs.uk tel: 020 7927 9890.

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[1] Resuscitation Council (UK) *Resuscitation guidelines. 2005.* www.resus.org.uk
[2] NICE Clinical Guideline 25. *The short-term management of disturbed/violent behaviour.* February 2005. www.nice.org.uk

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