Defibrillators in public places: the introduction of a national scheme for public access defibrillation in England

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Abstract

Objective: To implement a government-led project—the ‘Defibrillators in Public Places’ Initiative—to deploy Automated External Defibrillators (AEDs) in public places. Background: A Defibrillator Advisory Committee (DAC) was formed to assist the government with the implementation of the project. Its particular tasks were to: recommend criteria for the selection, training and assessment of those individuals likely to use the devices; procure the equipment necessary for the implementation of the project; procure the training services required for the implementation of the project; ensure the AEDs are sited where they are most likely to be of benefit; establish a mechanism to audit the use of this equipment and the outcome of this initiative. To co-ordinate this project a National Project Manager was appointed. Consultation with Ambulance Services NHS Trusts established the places where cardiac arrest occurred under circumstance where the availability of a defibrillator might be most likely to be effective. Defibrillators were procured under the direction of the NHS Purchasing and Supply Agency in conjunction with medical advisors. Devices that were reliable, safe, simple in operation and with good data retrieval systems were selected. Training contracts were awarded under the direction of the NHS Purchasing and Supply Agency in conjunction with medical and educational advisors. Organisations with accredited training experience and possessing the appropriate administrative and data handling abilities were selected. The ability to undertake training in an area concordant with current NHS regions was an essential requirement. In the first stage of implementation, pilot trials were successfully established at sites where persons were willing to be trained in the use of automated defibrillators. Arrangements for national progress of the project were made on the basis of the experience gained at pilot sites. A robust system for monitoring the outcome of the project has been established in partnership with the Resuscitation Council UK. The long-term success of this innovative project requires: Continuing central administrative support in the short to medium term. Central audit and data collection. The results of this project should contribute to national databases being established by the Resuscitation Council UK. Continuing adequate funding. The recognition that the provision of defibrillation to the victims of cardiac arrest is a key feature of the NHS. © 2002 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Defibrillators; Public places; National scheme; England

1. Introduction

In July 1999 the government of the United Kingdom (UK) published a statement of government policy (known as a white paper in the UK) entitled ‘Saving Lives—Our Healthier Nation’ which contained ambitious plans to prevent premature death or avoidable ill health from coronary heart disease [1]. Mortality from this condition in the UK is among the highest in the world [2], the majority of deaths occurring after sudden cardiac arrest outside hospital [3]. So that the victims of sudden arrhythmic death might have a greater opportunity of resuscitation, it was proposed that automated external defibrillators be placed in busy public places throughout England for use by lay personnel. This proposal was the first government-led national public access defibrillation project of its kind.
Implicit in this policy was the recognition of the frequency of ventricular fibrillation in these circumstances [4,5], and the effectiveness of prompt defibrillation [6,7]. The rate of successful resuscitation for those collapsing outside hospital in England compares poorly with that reported from some other countries. The rate in neighbouring Scotland is three times higher than in England [8] and even higher rates have been reported from other countries [9,10]. The effectiveness of defibrillation performed by rescuers with minimal training using an AED is well established [11–13] and the concept of public access defibrillation has been widely endorsed by authoritative bodies including the International Liaison Committee On Resuscitation [14,15], the European Resuscitation Council [16] and the American Heart Association [17]. Early reports from established public access defibrillation programmes testify to the effectiveness of this policy [18–20].

The government initially allocated two million pounds ($2.78 million, 3.25 million Euro) to be invested in a project designed to save lives that would otherwise be lost following a cardiac arrest in the community. Approximately half the money was allocated to purchase AEDs, with the remainder used to train potential first responders in their use. It was the wish of the government that the project be implemented as quickly as possible.

The project became known as the ‘Defibrillators in Public Places Initiative’ and in this paper we describe how the policy was implemented on a national basis. Important procedural processes are required by such a government-led scheme, particularly when the country concerned is a member of the European Union (EU). Many problems will be common to other countries and also apply to less ambitious projects that aim to introduce public access or first responder defibrillation. This record may therefore be helpful to others who have the task of implementing similar projects.

2. Implementation of the project: formation of an administrative structure

Once the plan had been announced as an item of government policy, implementation became the responsibility of civil servants at the Department of Health (DoH) which is responsible for the administration of the British National Health Service (NHS).

The precise requirements specified by the government were:

- to introduce AEDs into the public places where they were most likely to be used, such as airports, stations, and other places where the public congregate in large numbers and where cardiac arrest occurs frequently;
- to deploy AEDs in an equitable fashion to all areas of the country;
- to ensure that these AEDs are accessible to people from all walks of life so that a potential inequality in health service provision is avoided;
- to deploy AEDs and provide training for potential users within the specified budget;
- to ensure the co-operation of other agencies involved in this field, particularly the statutory ambulance service and the voluntary organisations such as St. John Ambulance and the British Red Cross.

The civil servants at the DoH responsible for the project set up a defibrillator advisory committee to advise on the detailed implementation of these policies. In theory, the role of this committee was to advise the DoH, but in practice it assumed responsibility for co-ordinating the introduction of the project.

The defibrillator advisory committee was asked to advise the DoH specifically on:

- the selection, training, and assessment of individuals who may use defibrillators;
- the procurement and maintenance of equipment;
- liaison with the statutory ambulance service to ensure that defibrillators were placed at sites where they are most likely to be of benefit and to ensure their close involvement with resuscitation attempts;
- the audit of the use of the defibrillators provided by this project.

The chairman of the committee was a lay person with knowledge of business administration and the ambulance service. The other members included:

- medical experts in the field of resuscitation and the ambulance service.
- the national director for heart disease (a consultant cardiologist);
- experts in accident and emergency medicine;
- medical advisors to leading medical charities and the voluntary aid societies;
- senior members of the ambulance service;
- a senior member of the British Transport Police;
- a hospital resuscitation officer;
- a representative of a patients association.

There were originally 14 members of the committee. Representatives from the DoH also attended meetings. The need to appoint a full time National Project Manager for the project was recognised at the outset. This person, to be based at the DoH for day to day administration of the initiative, was required to have:

- expert knowledge in the field of resuscitation medicine;
- proven ability to teach resuscitation techniques, particularly to lay persons;
- administrative abilities and knowledge of the administration of the NHS;
knowledge of the ambulance service in the UK;
• ability to work with the voluntary aid societies and other involved organisations.

A potential problem was that the post was seen initially as short term lasting for 1–2 years, and the most suitable persons would be unlikely to leave an established career post for this role. In the event, a senior nurse with extensive experience of resuscitation and its training was appointed (S.D.). At the time she was a national co-ordinator for Heartstart UK (an initiative co-ordinated by the British Heart Foundation that aims to educate the lay public throughout the UK in basic life support skills). She joined the DoH on secondment from the British Heart Foundation for this task.

3. The first phase of implementation

The defibrillator advisory committee identified the following matters as of immediate priority:
• to define the legal status of lay persons who attempt resuscitation and use an AED;
• to purchase defibrillators;
• to identify pilot sites for the initial implementation of the project;
• to arrange training at the sites and deploy AEDs.

3.1. The legal status of those using the equipment

In the UK there are no Good Samaritan or similar laws to protect members of the public who go to the aid of another person. Similarly there is no general legal requirement or obligation for a lay person to go to the aid of another. Concerns had been expressed about the potential legal liability of lay persons who did attempt to resuscitate another person. For this reason, formal legal advice was obtained from the legal department at the DoH.

In the UK there are no statutory laws (i.e. those made by parliament) relating to resuscitation. Legal liability might arise in common law (that has been formulated over the centuries from precedents gained in court) on the grounds that the actions of a rescuer constituted trespass against the victim (i.e. assault, or more correctly, battery). The legal advice was reassuring, provided the rescuer acted in the best interests of the victim, in a reasonable fashion, and in a similar way to other lay persons of equivalent training and experience.

A claim for negligence was also considered possible grounds for the institution of legal proceedings if a duty of care towards a victim was breached. This would only arise, however, if it could be shown that the negligent actions of the rescuer caused an injury that would not otherwise have occurred, or left the casualty in a worse state than if they had not intervened. In the circumstances under consideration, the victim would certainly die and so the risk of incurring such liability was thought to be extremely small. The simplicity and reliability of modern AEDs was a major factor in reaching both these conclusions and the ultimate decision that lay persons would be justified in using an AED when no more qualified person was available. The importance of adequate training and practising in accordance with the guidelines of authoritative bodies in the field (in England the Resuscitation Council (UK)) was emphasised.

This was an important conclusion, because had it been necessary for parliament to introduce legislation to protect rescuers from litigation, the implementation of the project would have been delayed.

3.2. Procurement of defibrillators

The purchasing of equipment for use in the health service in the UK is governed by strict regulations and is undertaken under the direction of a specialised department, the NHS Purchasing and Supply Agency (PASA). In view of the size of the contract in this project (approximately £1 million), the procurement process was also governed by EU procurement regulations. In the first stage it was necessary to invite suppliers to express an interest in the supply of defibrillators for this initiative. Accordingly, an advertisement was placed in the official Journal of the European Communities (OJEC) inviting this.

A detailed specification of the AEDs for the initiative was defined, the essential points being that:
• the AEDs should comply with the requirements of the EU Medical Devices Directive and be suitable for use by persons with minimal training;
• the AEDs should be reliable, portable, require minimal maintenance and have prolonged battery life;
• training in the use of the AED should be straightforward;
• the AEDs should incorporate technology that regularly checks the device’s state of readiness and provides visual indication if servicing or a change of battery is required;
• to ensure simplicity of operation the AED should have no more than three (and preferably two) controls. It should provide clear instruction to the operator with both visual and voice prompts. ECG monitoring screens were not required;
• suppliers had to be able to provide reliable maintenance and servicing arrangements;
• the AED had to be able to store data from the resuscitation attempt in a format that was easily accessible for analysis;
the rhythm analysis algorithms had to offer high sensitivity and specificity;
• the AED should administer biphasic shocks of equivalent efficacy to those recommended for monophasic shocks;
• to avoid the necessity to use high-energy shocks during training, versions of the AEDs that used low energy shocks had to be available for training purposes;
• the price of consumables such as electrodes had to be included in the initial purchase cost.

A subcommittee of the defibrillator advisory committee was formed to co-ordinate the procurement of AEDs. Known as the procurement panel, it comprised two members from PASA, a representative from the DoH, the National Project Manager, and a member of the Resuscitation Council (UK). The requirements expected of manufacturers submitting a formal offer were formally defined. These included (in addition to the specification outlined above) precise details about:
• delivery arrangements;
• installation procedures;
• supply and replacement of consumables;
• support services and maintenance;
• data handling and retrieval.

An expression of interest to supply AEDs had been received from nine companies all of whom were invited to submit formal offers for a contract to supply AEDs. Following the receipt of offers, six companies presented the details of their offer to the procurement panel at a meeting held at the DoH. The members of the PASA asked each company detailed questions about the financial, business, and practical issues relating to the supply of their AED. The medical members of the panel clarified matters relating to the use of the machines and training in their use. Contracts to supply AEDs were subsequently issued to two companies. By purchasing machines in bulk the cost per machine was considerably reduced, so that more machines were ultimately procured.

The involvement of the PASA had been an essential part of achieving this highly desirable outcome. All 692 AEDs purchased were delivered into an NHS managed warehouse before the date specified in the contract.

3.3. Pilot sites

The defibrillator advisory committee considered that the best way to begin the implementation of the project was to install the first AEDs at designated pilot sites. These would be monitored closely and the experience gained could subsequently be applied during the wider implementation of the initiative. To identify the most appropriate locations for pilot sites all ambulance services in England were asked by the DoH to supply data about the public places where heart attacks and cardiac arrest occurred most commonly in the areas they served. Further data was then obtained about the number of persons passing through these sites (from the body responsible for their administration) and about the availability of individuals able to be trained in resuscitation and the use of the AED at these sites.

It was believed that the most effective providers would be those already trained in first aid (there is a statutory requirement of employers in the UK to provide persons trained in first aid in the workplace): as they should acquire the necessary skills more readily than untrained staff or members of the lay public. The continuity of cover available from such staff was an additional consideration.

Finally there had to be suitable places where defibrillators could be installed at each site and suitable areas for training.

The data supplied by ambulance services indicated that the public places where cardiac arrest most frequently occurred were transport facilities, particularly busy railway and coach stations, airports, and certain London underground (subway) stations. Some large shopping complexes were also identified. The pilot sites ultimately chosen comprised seven railway stations, Heathrow Airport terminal four, one London underground station, and one shopping complex.

Negotiations took place between the national project manager and the management and staff at each site to explain the nature of the initiative and the implications for all concerned. The size of each site was the principal consideration in determining the number of defibrillators installed at each one. The principal concern was that an AED could be available to a collapsed victim within 2 min. Similarly the number of staff trained at each site was related to the area of the site and number of defibrillators. Account was taken of continuity of cover and the need to train sufficient staff so that cover can be available whilst the public are on the premises (usually 24 h per day).

A detailed training syllabus that covered revision in basic life support and instruction in the use of the AED was defined and training organisations (the ambulance service or the voluntary aid societies) were commissioned by the DoH to provide training for the potential operators of the defibrillators at the pilot sites. Training was provided at no cost to employers who in return were expected to release their staff from their normal duties for the duration of the training course without cost to the DoH. An integral part of the training was the staging of scenarios with manikins and evaluation of these exercises before each site was in a position to respond with an AED.

Careful assessment of the training process took place so those potential problems could be identified at an early stage and rectified before the later stages of the project. No significant problems were identified and the
training syllabus subsequently became the detailed training programme specified for the formal procurement of training services during the national implementation of the project.

Close liaison with the local ambulance service was the rule to ensure appropriate awareness of the project.

Some personnel at the pilot sites initially expressed apprehension when asked about being trained in the use of the AED, but after explanation their concerns disappeared and all proved very receptive and keen to learn. Staff with different levels of expertise in first aid volunteered for training, and in practice training was not restricted to those with previous first aid experience.

Defibrillators were placed in strategic positions in purpose-built cabinets that incorporated an alarm which was activated automatically when the door was opened to remove a defibrillator. At some sites it was possible to link the alarm to a central control room at the site so that the emergency medical services could be activated with the minimum of delay, and further help provided in a co-ordinated fashion.

3.4. Experience at pilot sites

The initial experience gained at the pilot sites did not suggest the need to make any significant modifications to the process during the nationwide implementation of the project.

4. Second phase: national implementation of the project

The key stages in the national implementation of the project were identified as

- identifying further sites for the project;
- arranging training for personnel at these sites;
- providing a continuing source of medical expertise and advice for the project;
- audit of the use of the defibrillators.

4.1. Further sites

A further 62 sites spread throughout the country were subsequently identified using a process similar to that employed previously. There was a clear bias towards large cities and the most densely populated areas. Once again it was transport facilities that were identified: 26 mainline railway stations, 15 airports, 10 London underground stations, four seaports, and seven major bus stations.

4.2. The procurement of training services

A formal procurement process to purchase training services was undertaken in an analogous fashion to that used in the procurement of defibrillators. A procurement panel was established to oversee this process. Membership comprised a member of PASA, an official from the DoH, an expert in medical education, the National Project Manager and a member of the Resuscitation Council (UK).

It was agreed that commercial contracts to supply training would be placed with providers of training services in accordance with the EU Public Procurement Regulations. The main details of the contracts included the following provisions:

- to undertake training in BLS and the use of the AED in adult victims of cardiopulmonary arrest in classes lasting approximately 4 h. Class content was to be in accordance with the detailed training specification already defined. This had been agreed as acceptable to the voluntary aid societies and to the Resuscitation Council (UK);
- to require contractors to provide all necessary trainers and training materials for the classes. This included the use of the pocket mask in BLS. The provision of documentation and compliance with an incident reporting procedure was required. Other post-event procedures were also to be covered;
- to assess class delegates for competency at the end of the class and arrange further training for those requiring it;
- to offer contracts for an initial period of 2 years with the possibility of an extension for a further 2 years;
- to undertake initial training and arrange 6 monthly refresher courses for those already trained. The initial training course is the most intensive when a new site is established, but continues as new staff willing to be trained are recruited;
- to simplify the long-term administration of the project it was decided that training providers would undertake training in a geographical area identical to the boundaries of the eight NHS regions;
- to arrange that each contractor would be totally responsible for the training in at least one region.

An advertisement was placed in the Health Service Journal inviting expressions of interest in competing for these contracts. A total of 37 such expressions were received by the closing date contained in the advertisement. The procurement panel considered the 37 expressions of interest at a formal short-listing process. The criteria for receiving an invitation to submit offers for a contract were evidence of:

- ability of the training organisation and its trainers to deliver the proposed course;
- experience of training lay persons in the techniques of BLS and the use of the AED;
- a clear plan for the delivery of the training;
- ability to provide a continuing service at the regional level defined;
- ability to submit a commercially competitive offer;
ability to maintain electronic training records;
- a system for monitoring the quality and effectiveness of training classes;
- compliance with procurement regulations;
- financial stability of the training organisation.

Of the 37 expressions of interest, 11 were rejected because they did not meet one or more of these criteria. The remaining 26 were invited to submit formal offers for the contracts. These came from 12 Ambulance services, 11 commercial training organisations, two voluntary aid societies, and one NHS hospital resuscitation training department. Twenty-one formal offers were subsequently received and the procurement panel assessed each against objective scoring criteria based on the points mentioned above.

Eleven offers did not meet these criteria and were rejected; the remaining 10 suppliers attended the DoH to present their offers formally to the procurement panel. Detailed questioning by members of the panel in their areas of expertise followed each presentation. Each member of the committee assessed the offer independently against the criteria defined above. The scores of each member of the panel were independently audited to ensure consistency. Three potential suppliers were eliminated at this stage.

The PASA procurement representative and the National Project Manager subsequently undertook a visit to the headquarters of the seven remaining organisations to verify the information contained in the tender documents. The committee subsequently met to review the results of these visits and to recommend the award of contracts in each of the eight regions. In summary, training contracts for five NHS regions were awarded to ambulance service training departments, St John Ambulance was awarded contracts for two regions, and the British Red Cross was awarded a contract for one region.

4.3. Continuing medical advice and audit

While the defibrillator advisory committee had been established with the short-term aim of introducing this initiative, it had become apparent that there was a longer-term requirement for a source of medical expertise in the field of resuscitation and defibrillation. Accordingly a clinical reference group was established to:
- provide medical overview and control for the initiative;
- assess the effectiveness of the training in the light of the performance at actual resuscitation attempts;
- review and audit all resuscitation attempts;
- prepare an annual report;
- provide continuing advice to the National Project Manager and the DoH;
- implement effective systems of clinical governance.

Medical membership consisted of two past chairmen, the current secretary of the Resuscitation Council (UK) and the national heart director (i.e. three consultant cardiologists and one general practitioner). Other members comprised the National Project Manager, a senior ambulance representative and a civil servant from the DoH.

To assist the process of audit a system of direct reporting to the DoH of all incidences of defibrillator usage had been established; this was often complimentary to established reporting systems already in use at the sites. The procedure entailed the immediate reporting that an event had occurred and the replacement of the memory module in the defibrillator with a new one. The memory card was downloaded and copies of the event were distributed to two medical members of the group. The memory card was kept for future reference so that the ECG could be further analysed, and the performance of the defibrillator assessed.

A reporting form for each event was devised based on the Utstein criteria and adopted by the Resuscitation Council (UK) for use with all AEDs used by first responders. The voluntary aid societies have agreed to add their results to what will become a national database monitored by the Resuscitation Council (UK). It is hoped ultimately to supply a copy of the form with each set of defibrillator electrodes.

The process of audit is considered essential because only by examining carefully the outcome of establishing a national scheme for first responder defibrillation can its effectiveness and safety be assessed. It is only from the lessons learnt through audit that the most effective use of resources can be guaranteed and improvements to the system can be made.

5. Long-term management strategies

The establishment of the first wave of sites at which defibrillators have been installed and personnel trained in their use marks the end of the initial stage of the establishment of a national programme to establish first responder defibrillation. The programme is still at an early stage of development and it is hoped that the government will retain a long-term commitment to it so that more defibrillators are made available and training is undertaken on a long-term basis.

During the initial stages of the project’s implementation there have been many advantages in having the management function in one central location—the Department of Health in London. Very tight control on the development of the project has been exercised, and consistency throughout the project has been relatively easy to achieve. Leadership has been seen to come from a high level thereby helping to convince people of the high profile of the project. The involvement of key
medical and other experts in the field of resuscitation has also helped this process and their easy accessibility for expert advice during the first project of its kind has been indispensable. From an operational perspective, the access to senior civil servants for advice about administrative matters and the close proximity to the sources of funding that the DoH provides has also proved invaluable. The DoH may not be the best place for the longer-term administration of the project however because operational activities such as this are not a key part of DoH work. The success of the project to this stage has been highly dependent on a few individuals, all experts in their own fields, who have been recruited to help start the project. The options for the continued management of the initiative are not finally decided at the present time. One long-term management option would be to devolve responsibility for the initiative to ambulance service trusts. The advantages of this strategy include:

- considerable existing experience in the field of resuscitation; co-ordination with the existing first responder schemes that they already administer. Although in their early stages at present these will expand in the future.
- an established training infrastructure already exists;
- co-ordination of response to cardiac arrest calls;
- liaison with the DoH already established;
- a source for continuing funding;
- continuing access to the NHS Purchasing and Supply Agency to maintain the considerable advantages of central procurement;
- no requirement for new legislation.

6. Conclusions

- A government policy to introduce public access defibrillation to one country within the United Kingdom was successfully implemented.
- The implementation of the project was heavily dependent on the input of medical experts in the field of resuscitation working in cooperation with civil servants at the Department of Health, the central co-ordinating organisation for the British National Health Service. This was co-ordinated from the DoH main headquarters in London.
- Experts in the procurement of medical equipment and training played a crucial role during the procurement of defibrillators and training services.
- An administrative infrastructure that included representation from a wide range of organisations with an interest in resuscitation proved an effective method of obtaining advice about the implementation of the project.
- A separate smaller committee consisting of experts in the field of resuscitation medicine proved effective in planning the detail behind the implementation of the project and the audit of its outcome.
- Routine data held by the ambulance service was capable of identifying public places where cardiac arrest most frequently occurred. Transport facilities, particularly airports and major railway stations, were the most frequently identified sites.
- The presence of staff willing to be trained in the use of AEDs at the places where AEDs were installed was a crucial requirement in the selection of sites. Agreement and commitment by senior managers at each site were also essential requirements.
- Initial implementation at a limited number of pilot sites proved an effective way of gaining experience and identifying potential problems before the national implementation of the initiative.
- Close liaison with the ambulance service serving the area where defibrillators were placed was essential.
- The legal status of those attempting resuscitation and using an AED required definition at the outset.
- Once the project had been initiated and was running successfully, further implementation could be devolved to a regional level.

References


Português Abstract and Keywords

Objetivo: Implementar um projeto governamental nacional —a iniciativa ‘Defibrillators in Public Places’— para dispor Desfibrilhadores Automáticos Externos (DAEs) em locais públicos. Antecedentes: Para apoiar o governo na implementação do projeto foi formada uma “Comissão de Aconselhamento para a Desfibrilação”. As suas tarefas particulares eram: recomendar critérios de seleção, treino e avaliação dos indivíduos com probabilidade de usar os aparelhos; identificar o equipamento necessário para a implementação do projecto; identificar os serviços de formação necessários para a implementação do projecto; garantir que os DAE eram colocados nos locais onde seria mais provável virem a ser úteis; estabelecer um mecanismo para auditar o uso deste equipamento e o resultado desta iniciativa. Para coordenar este projecto foi nomeado um “Coordenador Nacional do Projecto”. Estabeleceram os locais onde era maior a probabilidade de eficácia da disponibilidade de desfibrilhadores em caso de paragem cardíaca, em colaboração com agências de ambulâncias do Serviço Nacional de Saúde (NHS). Os desfibrilhadores foram reunidos sob a direcção da Agência de Procura e Aquisição do NHS em conjunto com conselheiros médicos. Foram seleccionados os equipamentos fláveis, seguros, fáceis de operar e com bons sistemas de registo de dados. Estabeleceram-se contratos de formação sob a direcção da Agência de Procura e Aquisição do NHS em colaboração com conselheiros médicos e educativos. Seleccionaram-se organizações com experiência de treino e acreditada e possuindo capacidades de manuseamento de dados e de funções administrativas. A capacidade para realizar treino numa área concordante com as regiões actuais do NHS foi uma exigência essencial. Neste estádio de implementação, foram estabelecidos com sucesso locais piloto nas áreas onde existiam pessoas com desejo de serem treinadas no uso de desfibrilhadores automáticos. Com base na experiência obtida nos locais piloto, foram criadas as condições para o alargamento nacional da iniciativa. Um sistema forte de monitorização do resultado do projecto foi estabelecido em cooperação com o “Resuscitation Council UK”. O sucesso a longo prazo deste projecto inovador requer: suporte administrativo central continuado, no curto e médio prazo; auditoria e recolha de dados centralizados, devendo os resultados deste projecto contribuírem para o estabelecimento de bases de dados nacionais pelo o “Resuscitation Council UK”; financiamento contínuo adequado; e o reconhecimento de que disponibilizar a desfibrilação para vítimas de paragem cardíaca é um aspecto essencial da missão do NHS.

Palavras chave: Desfibrilhadores; Lugares públicos; Esquema Nacional; Inglaterra

Spanish Abstract and Keywords

Objetivo: implementar un proyecto gubernamental para desplegar desfibriladores automáticos externos(AED) en lugares públicos. Antecedentes: Se formó un comité consultor para apoyar al gobierno en la implementación del proyecto: sus tareas particulares fueron: recomendar criterios para la selección, entrenamiento y evaluación de aquellos individuos que podrían usar estos equipos; procurar el equipamiento necesario para la implementación del proyecto; procurar los servicios de entrenamiento requeridos para la implementación del proyecto; asegurar que los AED están ubicados en lugares donde tengan la mayor probabilidad de ser beneficiosos; establecer un mecanismo para revisar el uso de los equipos y el resultado de esta iniciativa. Para coordinar este proyecto se designó un gerente Nacional de Proyecto. Se consultó con el servicio de ambulancias del Servicio Nacional de Salud y se establecieron los lugares donde había una mayor ocurrencia de paro cardíaco y donde la disponibilidad de desfibriladores pudiera ser posiblemente efectiva. Los desfibriladores fueron procurados bajo la dirección de la agencia de abastecimientos del servicio nacional de salud, en conjunto con consultores médicos. Se seleccionaron los equipos que eran confiables, seguros, simples de operar con buenos sistemas de recuperación de datos. Los contratos de entrenamiento fueron entregados bajo la dirección la agencia de abastecimiento en conjunto con consultores médicos y educacionales. Se seleccionaron organizaciones con experiencia acreditada en entrenamiento y que poseían apropiadas habilidades administrativas y de manejo de datos. La habilidad para realizar entrenamiento en un área concordante con las actuales regiones del Servicio nacional de salud fue un requisito esencial. En la primera etapa de implementación se establecieron exitosamente sitios piloto donde las personas deseaban ser entrenadas en el uso de desfibriladores automáticos. Sobre la base de la experiencia ganada en los sitios piloto se hicieron los arreglos para el desarrollo nacional de la iniciativa. Se ha establecido un sólido sistema de monitoreo de los resultados con ayuda
del Consejo de Resucitación del Reino Unido. Un éxito a largo plazo en este proyecto innovador requiere: Apoyo administrativo central en el corto y mediano plazo. Revisión y colección de datos centralizada. Los resultados de este proyecto deberían contribuir a la base de datos nacionales que está siendo establecida por el Consejo de Resucitación. Continuidad en un financiamiento adecuado. El reconocimiento que la provisión de desfibrilación a víctimas de paro cardíaco es un aspecto clave de la provisión de servicios del Servicio Nacional de Salud.

Palabras clave: Desfibriladores, Acceso publico; Esquema nacional; Inglaterra