



# Time Matters

A review of the quality of care provided to patients aged 16 years and over who were admitted to hospital following an out-of-hospital cardiac arrest

## Executive summary

### Method

Data were collected to review the clinical care delivered to patients from the time of an OHCA to discharge from hospital or death. Only patients with a sustained return of spontaneous circulation (ROSC) for at least 20 minutes, were included. Review of the clinical pathway included the community and emergency service response, hospital admission, and inpatient care, in particular cardiac and critical care services. Data were also collected to assess organisational aspects of care within acute hospitals.

### Key messages

The five key messages here, agreed as the primary focus for action, have been derived from the report's recommendations.

#### **1. Bystander Cardiopulmonary Resuscitation (CPR)**

Ongoing strategies are needed at a population level to ensure that people who sustain an OHCA are treated rapidly with high quality resuscitation, including defibrillation, through a co-ordinated network of accessible and identifiable public access devices.

#### **2. Advance treatment plans**

When advance treatment plans are in place, they should be documented using a standard process (such as the ReSPECT form) to ensure that people receive treatments based on what matters to them and what is realistic. Effective communication

between all parts of the healthcare system, including, primary care, community services, ambulance services and acute hospitals is then needed to ensure that appropriate decisions are made, irrespective of time or location.

#### **3. Prediction of survival**

No single factor is accurate enough for clinical decision-making at the time of admission to hospital following an OHCA. Time is needed to ensure an accurate assessment of prognosis can be made. Neurological prognosis is particularly difficult to assess, and this should be delayed for at least 72 hours after return of spontaneous circulation.

#### **4. Targeted temperature management**

Elevated temperature is common following an OHCA and is associated with a worse prognosis, but this can be improved by accurate, active temperature control. The current approach in clinical practice appears to be inconsistent and a more active approach is needed.

#### **5. Rehabilitation**

Physical, neurological, cardiac and emotional impairment following an OHCA can all affect quality of survival, and patients benefit from targeted rehabilitation and support. In some areas of the UK there is no provision of these services. These gaps should be closed by local clinical teams and commissioners working together.

