Acacium Group Resuscitation Policy

Policy Reference | CLIN 19

Version | V5.1

Policy Name	Resuscitation Policy
Purpose of Document	The purpose of this document is to inform all workers of their responsibilities and the standards required in regard to the management of resuscitation, ensuring compliance with national policies, Acacium Group policies and SOPs.
Target Audience	All workers with clinical responsibilities.
Version	V5.1
Author	Karen Matthews-Shard
Date of Approval	February 2012
Published Date	February 2012
Lead Director	Karen Matthews-Shard
Review Frequency	Annually
Last Reviewed	March 2024
Next Review Date	March 2025
Risk and Resource Implications	Resource implications: Training. Risks: Lack of skills to respond to cardiac arrest. Contract COVID-19
Associated Strategies and SOPs	See page 16
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
Draft v 1	Nov 2011	First draft	K. Matthews-Shard
Final	Nov 2011	Includes K. Matthews-Shard and S. James, KNF changes	K. Matthews-Shard
V1	Sept 2013	Yearly update	KNF/KMS
V2	Sept 2014	Yearly review/Welsh legislation added	KNF/KMS
V2	Feb 2015	Yearly review	SJ/KNF
V2	Aug 2016	Annual review	VM/KNF
V2	Oct 2016	Update with new legislation	KNF/SJ
V2	Jan 2017	Implementation of new policy template	KNF/VM
V2	Aug 2017	Annual review	KNF/VM
V2	Nov 2017	Updated to include new TCS bio brand description page	LB/MS
V2.1	May 2018	Updated CSSIW to CIW	LW
V2.2	Aug 2018	Annual review with update from Resuscitation Council UK 2018 guidelines for managing Cardiorespiratory Arrest	KMS/SJ
V2.3	Apr 2019	Implementation of new Policy template	CCR/KG
V2.4	Aug 2019	Annual Review	Clinical Advisory Group
V2.5	Mar 2020	COVID-19 measures added	DL/KMS
V2.6	July 2020	Review date changed to March 2021 as COVID-19 Measures still in place	KG
V2.7	Oct 2020	Update re Rebrand	CCR/CC
V2.8	Jan 2021	Yearly Review	Clinical Advisory Group

V2.9	Jan 2021	Update re Rebrand 2	CC
V2.10	Apr 2021	Added CHS brand	CC
V3	March 2022	Annual Review and update	Clinical Advisory Group
V3.1	June 2022	Review	AM
V4	Mar 2023	Reviewed and updated	Clinical Advisory Group
V5	Jan 2025	Rebrand	Clinical Advisory Group
V5.1	Mar 2024	Reviewed and updated	Clinical Advisory Group

Table of Contents

1. Policy Standards

1.1 All workers ensure that in the event of a cardiac or pulmonary arrest that they respond immediately with the correct treatment and care to provide the optimum outcome for the client.

1.2 Every worker, that has direct client contact, is able to instigate basic life support procedures for any person who collapses because of a cardiac/respiratory arrest.

1.3 This Policy must be read in conjunction with the following SOPS:

- Adult Basic Life Support SOP
- Paediatric Basic Life Support SOP
- Recovery Position SOP
- Paediatric Choking SOP
- AED SOP

2. Definitions

Topic	Definition
Resuscitation	The emergency treatment of any condition in which the brain fails to receive enough oxygen.
Cardiac arrest	Is the cessation of normal circulation of the blood due to failure of the heart to contract effectively. If this is unexpected it can be termed a sudden cardiac arrest. It may be ascertained by an absence of detectable signs of life and an absence of palpable pulsation in a major artery.
Pulmonary (respiratory) arrest	Respiratory arrest can be divided into two major components, both of which require urgent management. It is very unusual for either to occur without being preceded by detectable clinical deterioration. • Absolute: A sudden and complete cessation of breathing. • Functional: Ventilatory or respiratory function is so reduced from the normal that oxygenation and/or removal of carbon dioxide is reduced to a level that threatens life.
Anaphylaxis	This is an acute systemic, multi-system and very severe Type 1 hypersensitivity allergic reaction. This may occur after ingestion, skin contact, injection or inhalation of an allergen.
Do not attempt resuscitation (DNAR/DNACPR)	A directive made by a doctor that resuscitation of a client should not be attempted.
Advance directive or living will	Instructions given by an individual specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity.

Lasting Power of Attorney (LPA) for Health & Welfare	An LPA covers decisions about an individual's social care and/ or health. It comes into effect if the individual loses mental capacity, or if the individual no longer want to make decisions for themselves .
ReSPECT	***ReSPECT*** is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.
Ceiling of Care	The concept of **Ceiling of Care** is relevant in this setting and derives from the ACP. The aim is to provide guidance to admitting staff who do not know the patient, so that there is continuity with the patients' previously expressed wishes, and/or limitations to their **treatment** are clear.
Cardiopulmonary resuscitation (CPR)	CPR can be defined as any immediate emergency treatment aimed at restoring spontaneous circulation and breathing. CPR can be attempted on any individual where cardiac and respiratory function ceases. See reasons for not commencing CPR in 'section 5.5'.
Basic life support (BLS)	The initial assessment of a client leading to a situation where airway management, rescue breathing, and chest compressions may be required.
Enhanced resuscitation skills	This incorporates basic life support, the safe use of automated external defibrillators (AEDs) and the use of other pieces of equipment, such as, suction, airways, oxygen, and pulse oximeters. The proper use of this equipment can further support workers to manage a client in cardiac arrest until such time as the client is handed over to an appropriate person i.e. a doctor or a paramedic.
Advanced life support (ALS)	This incorporates basic life support, the use of defibrillators and the use of further skills, including drugs and advanced airway management. This can help to further support a client in cardiac arrest until such time as the client is handed over to an appropriate person i.e. a doctor or a paramedic.
Immediate Life Support (ILS)	This incorporates basic life support skills including defibrillation and basic airway adjuncts, which can be used to help save lives prior to the arrival of the ambulance/cardiac arrest team.

3. Roles & Responsibilities

3.1 The general overall organisational roles and responsibilities are set out in the policy document, 'Policy for Drafting, Approval and Review of Policies and Standing Operating Procedures (SOP).

3.2 The following table outlines the responsibilities of the key people involved in this Policy.

Role	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.
Individual workers	Individual workers must: • Be aware of and comply with Acacium Group policies procedures and guidance • Report any signs of allergic reaction or dermatitis to Acacium Group line manager and occupational health at the earliest opportunity • Report any sign of allergic reaction or dermatitis to Acacium Group line manager/occupational health as per escalation process at the earliest opportunity • Promote confidentiality, sharing information with partners on a need to know basis • Take part in training, including attending updates so that they maintain their skills and are familiar with procedures • All practitioners registered and non-registered should access regular supervision and support in line with local procedures • All staff should maintain accurate comprehensive and legible records, with records being stored securely in line with local guidance
Line Manager/ Appropriate other	To make sure all workers are aware of, and comply with, this policy through induction, internal training and supervision.
Clinical Advisory Group (CAG)	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

4. Resuscitation Adults – General Guidelines

4.1 **Assessment of risk**

4.1.1 For the purposes of this Policy, an infant is under 1 year of age, a child is between 1 year and puberty, and an adult is from puberty onwards.

4.1.2 Assessment of risk and planning are integral to safe management of resuscitation and all workers will be expected to contribute to these processes. See the Acacium Group Clinical Risk Management Policy.

4.1.3 , During a pandemic or where infectious diseases are involved, wherever possible clients who are at risk of acute deterioration or cardiac arrest should be identified early. Appropriate steps to prevent cardiac arrest and avoid unprotected CPR should be taken. Use of Physiological track and trigger systems (e.g. NEWS2/PEWS in the acute setting) will enable early detection of acutely ill patients.

4.2 **Infection prevention and control**

4.2.1 In line with the RCUK COVID-19 Guidance in April 2022, Acacium Group continue to recommend the use of FFP3 masks or respirators during aerosol generating procedures associated with

resuscitation when treating a patient with suspected or confirmed COVID-19. The donning of other aspects of AGP PPE should not lead to a delay in patient treatment.

4.2.2 The RCUK suggest consideration is given to the risks from the patient, virus, procedures undertaken, practitioner susceptibility and environment/setting and local policies and procedures, including risk assessments should be followed.

https://www.resus.org.uk/library/additional-guidance/guidance-covid-19 10/08/2022

4.2.3 If assisted ventilation is required, this should be carried out using a Bag Valve Mask (BVM) where one is provided. The standard universal precautions must be applied when dealing with body fluids. See also the Acacium Group Infection Prevention and Control Policy.

4.2.4 Ensure that all PPE is removed safely in line with local/national policies for donning and doffing of PPE, to avoid cross contamination and dispose of in clinical waste bags as per local guidelines. Hand hygiene has an important role in decreasing transmission. Thoroughly wash hands with soap and water.

4.3 **Consent**

4.3.1 In an emergency situation, the worker providing care must make decisions based on the best interests of the client. Carers and relatives are not in a position to make decisions based on the best interests of the client, though they may be consulted. The exception to this is if there is a valid LPA for Health & Social Care in place and documentary evidence has been provided. All decisions made in an emergency situation must be fully documented and the rationale provided. See also the Acacium Group Consent Policy for Adults and Children.

4.4 **Exceptions to resuscitation and/or emergency care**

4.4.1 Any client who collapses with no sign of respirations and/or an absent pulse will have cardiopulmonary resuscitation (CPR) attempted on them, followed by an urgent transfer to hospital via an ambulance, unless:

- There is an advance directive not to have CPR
- A 'Do not attempt resuscitation' order/ReSPECT Documentation (DNAR/DNACPR or other equivalent documentation) has been given and is documented
- Please note that the parents of a child who has a DNAR/DNACPR in place are able to change their mind at any time (unless it has been agreed by a high court).
- With the exemption that a clinical decision has been reached by an authorised clinician that any attempt would be futile, the emergency services/Crash/emergency response Team must still be contacted.

4.4.2 When the wishes of the client are unknown, cardiopulmonary resuscitation (CPR) should be initiated if cardiac or pulmonary arrest occurs.

4.5 **Do not attempt resuscitation (DNAR/DNACPR) ReSPECT**

4.5.1 When a 'DNAR/DNACPR' decision ReSPECT Document is in place it will have been made under the following circumstances where:

- CPR is not in accord with the recorded, sustained wishes of the client who is mentally competent
- CPR is not in accord with a valid applicable advance directive (anticipatory refusal, advance statement or living will). The worker would be expected to be informed by the hospital consultant or GP looking after the client's care if an advance directive or living will is in place. A copy must be obtained and filed in the client's care records.

4.6 **An advance directive or living will**

4.6.1 An advance directive or living will is legally binding, provided the client:

- Intended it to apply in that particular situation/set of circumstances
- Was mentally competent at the time it was made
- Was not under duress or influenced by someone else at the time
- Was aware of the relevant risks or complications.

4.6.2 In reality, the existence of the document is likely to be the only evidence of compliance with these criteria. However, if in doubt – resuscitate.

4.6.3 An advance directive may not be applicable for an individual under the age of 18 years, but the wishes of the client should be accommodated if possible. The clients wishes must be overseen and agreed with the authorised clinician and documentation put in place. Please see Acacium Group CLIN 06 Consent Policy.

4.6.4 If a decision is to be made in the community setting, the GP has responsibility for a 'DNAR/DNACPR' decision, unless this has already been made by a hospital specialist. This decision should be made after appropriate consultation and consideration of all aspects of the client's condition, an assessment of which should include the likely clinical outcome and the client's known wishes.

4.6.5 The authorised clinician will record the client's decision regarding CPR on a 'Do not attempt resuscitation/DNAR/DNACPR' form. This will be filed at the front of the client's notes (or in the patient's main place of residence/care setting and communicated to the patient and/or family/NOK.

4.6.6 Age alone must not influence CPR status nor presence of learning disability alone must not influence CPR status. Where no 'advance directive', 'living will' or DNAR/DNACPR exists, resuscitation must be commenced within the limits of the knowledge and skills of the worker, and the available resources.

4.6.7 The instruction not to commence resuscitation must be clearly documented in the care record in the form of the original 'DNAR/DNACPR' form as:

- 'Not for resuscitation'
- 'Do not attempt resuscitation'.
- When a DNAR/DNACPR decision has been made, or there is an advance directive for the refusal of CPR, it must be clearly communicated to the workers and documented in the client's notes. The records should state:
  - The reason why the DNAR/DNACPR decision has been made
  - Whether or not the client and/or relatives have been included in the discussion and whether or not there is a record of their views
  - The clinical reasons for a decision have been documented.

4.6.8 Workers must inform the hospital consultant or GP where a 'DNAR/DNACPR' instruction does not comply with best practice, i.e. it does not state a date of entry, time limit, the indication leading to the 'DNAR/DNACPR' decision and a doctor's signature. This would render the instruction invalid. At the start of care the worker must be informed of the client's resuscitation status. If it is not provided it must be assumed that under all circumstances the client is for resuscitation. NB:

- A 'DNAR/DNACPR' order will only be in relation to CPR and does not affect any other type of care offered. Therefore, all other care or treatment must be given as planned
- Any 'advance directives' will detail what care or treatment can and cannot be started or withdrawn. All care or treatment outside of this must continue as planned

4.7 **Rescue breaths (mouth to mouth resuscitation)**

4.7.1 If you feel confident, comfortable and are competently trained giving chest compressions with rescue breaths, then you should proceed as such, however, if you're not completely confident/comfortable/unsure administering rescue breathes, you should attempt hands-only CPR instead (continuous compressions). Caution should be used if a patient is suspected or confirmed to have COVID-19 or any other infectious disease such as TB and it may be appropriate to use continuous compressions only. https://www.resus.org.uk/library/additional-guidance/guidance-covid-19

4.7.2 The best outcomes occur when chest compressions are given with bag-valve-mask (BVM) ventilation but if workers are not competent to use a BVM then chest compressions alone should be performed at a rate of 100 -120 per minute. In adults, rescue breaths are less important than chest compressions. In paediatrics, rescue breaths are very important, this is because in adults the primary cause of cardiopulmonary arrest is cardiac in origin, whereas in paediatrics the primary cause is respiratory failure. To emphasise the priority of chest compressions in adults, it is recommended that, in adults, CPR should start with chest compressions rather than initial ventilations. For further information, please refer to:

- Adult Basic Life Support SOP
- Paediatric Basic Life Support SOP
- Adult Foreign Body Airway Obstruction SOP
- Paediatric Foreign Body Airway Obstruction SOP

4.7.3 If the ventilation using a BVM fails to make the chest rise and fall, as in normal breathing, then before making the next attempt:

- Check their mouth and remove any obstruction (never perform a blind sweep)
- Recheck that there is adequate head tilt and chin lift.

4.7.4 Do not attempt to make more than two BVM breaths each time before recommencing chest compressions.

4.8 **Neck breathers**

4.8.1 It is the responsibility of the CCG/Trust/Client lead or department to ensure that the additional equipment is available to ventilate a neck-breather client in the event of a cardiac, or respiratory arrest and the healthcare workers responsibility to ensure the equipment is checked as per local guidelines.

5. Resuscitation Procedure: Adults

5.1 Resuscitation Council UK state that the minimum standard for immediate response to cardiac arrest in any setting is that:

- There is prompt recognition of cardiorespiratory arrest
- Appropriate help is summoned immediately
- CPR is started immediately
- A defibrillator if available, is applied without delay and (if an AED) its instructions are followed
- Defibrillation is attempted for a shockable rhythm within 3 minutes of collapse

5.2 **Early warning signs**

5.2.1 In the out of hospital or community setting 999 should be used, or, in the hospital setting 2222 or the appropriate escalation to e.g. Outreach/Medical Emergency Team, (as per local escalation policy) should be called if any combination of these early warning signs occurs:

- Cyanosis

- Irregular pulse
- Pain, especially radiating down the left arm
- Lower than expected blood pressure
- Reduced responsiveness, and/or is cold and clammy

5.2.2 In the community setting if relatives or carers are available, get them to call 999. If the client is alone but there are two workers, the senior worker should assess the client whilst the other worker summons help. If the client is alone and the worker is unaccompanied then the worker should summon help via 999 before commencing CPR. Activate the speaker on the mobile phone and immediately start CPR assisted by the dispatcher.

5.2.3 It is essential that signs of life are checked (look, listen, feel) prior to commencing the CPR policy. If there is no initial response to the vital sign check, the client must be turned onto his/her back and the airway opened using a head tilt and chin lift. This is achieved by:

- Placing your hand on the forehead and gently tilting the head back
- With your fingertips under the point of the chin, lift the chin to open the airway.
- If trained to do so, a jaw thrust may be used as an alternative to maintain the airway

5.2.4 Check the client's mouth for any obstruction, this is achieved by:

- Visually inspecting the mouth for any obstruction
- Removing any obstruction with suction, if available. Never undertake a blind sweep
- Dentures that are a good fit should be left in situ to aid ventilations.

5.2.5 Checks for signs of breathing should be performed for approximately 10 seconds and the look-listen-feel approach should be used to determine if they are breathing normally:

- Look for their chest raising or falling
- Start CPR in any unresponsive person with absent or abnormal breathing
- Slow laboured breathing (agonal breathing) should be considered as a sign of cardiac arrest

5.2.6 In addition, workers should check for:

- Other signs of life, such as:
  - Response to stimuli,
  - Normal breathing, rather than abnormal gasps
  - Spontaneous movement
  - Check pulse if appropriately trained and competent

5.2.7 In the first few minutes after cardiac arrest, a client may be barely breathing, or taking infrequent, slow, noisy gasps (known as agonal breathing). Do not confuse this with normal breathing. If you have any doubt whether breathing is normal, act as if they are not breathing normally and prepare to start CPR.

5.2.8 If there are no other 'signs of life', commence CPR. CPR should only be withheld if it is certain that there is a definite pulse.

5.2.9 If the client is breathing normally the following action needs to be taken:

- Place them in the recovery position. See the Acacium Group Recovery Position SOP
- Send or call for help or call for an ambulance. Depending on the setting, you may have to leave the client alone to do this.

5.2.10 After calling for an ambulance/Crash/Emergency response Team, check for any signs of circulation (signs of life) by observing for signs of:

- Movement

- Cyanosis
- Carotid pulse on adults (if you are competent to do so).

5.2.11 If there is no response to the vital signs check, the appropriate CPR procedure should be instigated. Please refer to the resuscitation SOPs.

6. Adult CPR Process

6.1 Please refer to the Adult Basic Life Support SOP.

6.2 If there is more than one rescuer present, each person should take it in turns to perform CPR (by placing the hand in the middle of the chest, interlock fingers, press down to a depth of at least 5 cm but not more than 6 cm, at a rate of 100–120 min with as few interruptions as possible.), for two minutes each to prevent fatigue. The rescuers must ensure minimal delay during the change-over. Oxygen and suction machines may be used if these are available.

6.3 **Do not stop to check the client or discontinue CPR, unless the client starts to show signs of regaining consciousness, such as coughing, opening his/her eyes, speaking, or moving purposefully, AND starts to breathe normally.**

6.4 **Regurgitation during CPR**

6.4.1 Regurgitation of stomach contents is common during CPR. If regurgitation occurs:

- Turn the client away from you
- Keep them on their side and prevent them from falling onto their front
- Ensure that their head is turned towards the floor and their mouth is open at the lowest point, thus allowing vomit to drain away
- Do not attempt to clear any residual debris from their mouth with your fingers. You can use suction of this is available.
- Immediately turn the client onto their back, re-establish an airway, continue rescue breathing and continue chest compressions at the recommended rate (Ratio 30:2).

6.5 **Unable to give rescue breathes**

6.5.1 In the event you are not able to deliver rescue breathes, the chest compressions should be continuous until:

- Qualified help arrives and is able to take over i.e. paramedics/Crash/Emergency response Team
- The client shows signs of recovering consciousness, such as coughing, opening their eyes, speaking, or moving purposefully AND starts to breathe normally
- You become exhausted.

7. Resuscitation: Children

7.1 Definition of age categories.

- A new born is an infant just after birth
- An infant is under the age of 1 year
- A child is between 1 year and 18years of age

7.2 Airway ventilation:

- Open the child's airway: In infants, keep the head in a neutral position, place your hand on the child's forehead, and two fingers on the bony part of the chin. In children, keep the head in the sniffing position, place your hand on the child's forehead, and two fingers on the bony part of the chin

- An initial 5 rescue breathes should be given

7.3 Chest compressions: Compress the chest by 1/3 of its depth, which is approximately 4cm for an infant and 5cm for a child and never deeper than 6cm limit for an adult:

- Use two fingers for an infant under 1 year as a single rescuer
- Use one or two hands for a child over 1 year, as needed, to achieve an adequate depth of compression
- The heel of one hand for children under 8 (unless you are unable to achieve the depth of 1/3), two hands for children over 8. The risk of using two hands for a smaller child is intrathoracic trauma
- In order to be consistent with the adult BLS guidelines, the recommended compression rate is 100 – 120 per minute, Ratio 30:2 (if trained in paediatrics BLS then a ratio of 15:2) using a BVM
- It is better to use the adult BLS than none at all if a worker is unsure about how to do CPR with children.

7.4 If you are on your own, perform CPR for 1 minute before going for help.

8. Foreign Body Airway Obstruction (formerly known as Choking)

8.1 **Choking adults:**

- Recognition of foreign body obstruction is the key to a successful outcome
- It is important not to confuse this emergency with other medical conditions
- Foreign bodies may cause either mild or severe airway obstruction
- It is important to ask the conscious victim 'Are you choking?'
- Please refer to the Resus 04: Choking Adult SOP.

8.2 **Choking paediatrics:**

- When a foreign body enters the airway, the child reacts immediately by coughing in an attempt to expel it. A spontaneous cough is likely to be more effective than any manoeuvre a rescuer might perform
- If the cough is absent or ineffective the child will become asphyxiated rapidly
- The majority of choking events in children occur during play or whilst eating, when a carer is usually present. Events are, therefore, frequently witnessed, and interventions are usually initiated when the child is conscious
- Choking in paediatrics is characterised by the sudden onset of respiratory distress associated with coughing, gagging or stridor
- Please refer to the Resus 05: Paediatric Choking SOP.

9. Post Resuscitation

9.1 If CPR has commenced and the client is roused/recovers prior to an ambulance/Crash/Emergency response Team arriving then the client should be placed in the recovery position. See the Acacium Group Recovery Position SOP.

9.2 Community workers must contact their Line Manager/appropriate other as soon as possible after the event for support following the incident. All attempts at resuscitation must be entered on the Datix system and reported as an incident. Learning from a positive or negative incident can be disseminated across the organisation. See the Acacium Group Reporting and Managing Incidents Policy.

9.3 Healthcare settings – If the worker feels they need support they should contact the Healthcare professional in charge as soon as possible after the event for support following the incident. The

worker may also wish to contact their agency e.g. Clinical Team. All attempts at resuscitation must be entered via the appropriate reporting process. Learning from a positive or negative incident can be disseminated across the organisation. See the Acacium Group Reporting and Managing Incidents Policy.

9.4 Ensure that all documentation has been completed.

9.5 **Information for Ambulance team/crew on transfer to hospital**

9.5.1 All clients resuscitated in the community must be transferred to the local acute hospital for further assessment and care, unless the client documentation states otherwise. The information to be given to the paramedics is:

- Client's age
- Diagnosis/medical/psychiatric history
- History of the incident
- Prescribed medications
- Notes to be made available.

9.6 **Record keeping**

9.6.1 Full documentation must be recorded in the client's nursing notes when there has been a need to initiate resuscitation and/or other emergency procedures including dates, times, and actions.

9.6.2 An incident must be recorded on Datix for any such emergencies

10. Training

10.1 All workers with clinical responsibilities must participate in annual resuscitation training to ensure that they are competent and have reached an agreed standard of proficiency. This is a Core skill requirement upon commencement of employment. The training will be proportionate, and relevant to the roles and responsibilities of each worker.

10.2 It is the responsibility of the division/busones to organise and publicise educational sessions, and to keep records of attendance.

10.3 All workers that care for adults and children are expected to be proficient in basic paediatric and adult life support techniques. Therefore, if a worker looks after adults and children/young people, they are expected to attend training for both age groups.

10.4 Those who care solely for adults may only need to attend training for adult life support and those who care solely for children may only be required to attend paediatric life support training, however this will depend on training requirements for the role and local policies.

10.5 The chest, forehead and face of the manikin will be wiped using disinfectant/alcohol wipes in between each learner and allowed to dry naturally before the next learner takes their turn.

11. Implementation Plan

11.1 For **consultation, ratification and dissemination** of this Policy, see the Policy for Drafting, Approval and Review of Policies and SOPs; CORP10 Policy on Policies.

11.2 This Policy will be implemented through:

- Communication of the Policy to all relevant workers

- Communication of the Policy to all stakeholders
- Raising awareness and understanding of the Policy and related processes throughout the organisation through committee meetings, workers' meetings, Acacium Group Pages, the website and general communication
- Through induction programmes and related training.

11.3 **Audit and monitoring:**

11.3.1 Acacium Group will regularly audit its approach to resuscitation to ensure compliance with this Policy and the relevant SOPs.

11.3.2 Processes for monitoring the effectiveness of the Policy include:

- Audits of specific areas of practice
- Evidence of learning across the organisation
- Incident reporting procedure
- Appraisal and Personal Development Plan (PDP).

12. Associated Policies / SOPs

Policies

CLIN 06 Consent
CLIN 07 Infection Prevention and Control Policy
CLIN 09 Safeguarding Vulnerable Adults Policy
CLIN 08 Safeguarding Children Policy
CLIN 14 Health Records Management Policy
CLIN 43 Deprivation of Liberties and MCA Policy
CORP03 Whistleblowing for Internal Employees Policy
CORP04 Whistleblowing for Associate Workers and External Parties Policy
ORG 03 Health & Safety Policy
CORP11 Risk Management Strategy Policy
CLIN 51 NEWS2 Policy
CLIN 53 PEWS Policy

SOPs

SOP RESUS 01 Adult Basic Life Support
SOP RESUS 02 Paediatric Basic Life Support
SOP RESUS 03 Recovery Position
SOP RESUS 04 Adult Choking
SOP RESUS 05 Paediatric Choking
SOP RESUS 06 AED

13. References

- Resuscitation Council UK, 2021. Basic life support resuscitation guidelines. https://www.resus.org.uk/library/2021-resuscitation-guidelines/adult-basic-life-support-guidelines
- Nursing and Midwifery Council, 2015. The Code: Standards of conduct, performance and ethics for nurses. NMC. Updated to reflect Nursing Associates 10/10/2018 https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
- The Mental Capacity Act 2005 (MCA).
- Department of Health, 2001. Reference guide to consent for examination or treatment, (updated 2nd edition, July 2009). DH.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

- The Human Rights Act 1998 (HRA) incorporating the European Convention on Human Rights (effective 02 October 2000) HMSO.
- BMA, Resuscitation Council for the UK & RCN, 2016. Decisions relating to cardiopulmonary resuscitation. A joint statement from the BMA, the Resuscitation Council (UK) and the RCN. London: British Medical Association.
- The Care Tribunal (Amendment) Regulations (Northern Ireland) 2009 (No.249).
- The Establishments and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2008 (No.346)
- Resuscitation Council UK – Requirements for Resuscitation Training and Facilities for Cardiovascular Prevention and Rehabilitation Programmes 2018 https://www.resus.org.uk/library/quality-standards-cpr/requirements-resuscitation-training-and-facilities-cardiovascular
- https://www.gov.uk/government/publications/novel-coronavirus-2019-ncov-interim-guidance-for-first-responders/interim-guidance-for-first-responders-and-others-in-close-contact-with-symptomatic-people-with-potential-2019-ncov
- https://www.resus.org.uk/about-us/news-and-events/resuscitation-council-uk-position-covid-19-guidance-september-2020

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1. This Policy is based on the Resuscitation Council guidance for basic life skills, support, legislation and national guidance, as set out in the table below.

Act, National policies, guidance and legislation	Explanation
Mental Capacity Act (2005) (MCA) Mental Capacity Act (Northern Ireland) 2016 Adults with Incapacity Act (Scotland) 2000	Provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. A client who does not have the necessary mental capacity to take a treatment decision must receive treatment that is in his/her best interests.
Human Rights Act (1998) (HRA)	With reference to CPR the following articles of the Act apply: • Article 2: The right to life • Article 3: The right to be free from degrading or inhuman treatment • Article 10: The right to freedom of expression, which includes the right to hold opinions and receive information • Article 14: The right to be free from discriminatory practices in respect of these rights. A failure to provide cardiopulmonary resuscitation (CPR) could be a breach of a client's/service user's right to life under the Human Rights Act. A failure to discuss a resuscitation decision with a client may breach a client's/service user's rights to self-determination under the Act, i.e. the client has a right to be informed about decisions that are taken which affect him/her.
Health & Safety at Work Act 1974 (HASAWA)	Acacium Group has a duty to ensure the health and safety of its workers who, in turn, must ensure they make full use of the provisions made by Acacium Group for their health and safety. In terms of resuscitation, this requires all workers to use standard infection control procedures and pocket masks when provided.
Resuscitation Council UK 2015	Resuscitation guidelines. Basic life skills.
A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing	'Decisions relating to cardiopulmonary resuscitation.' London: BMA Ethics Department, October 2007. Full guideline available on the BMA's website at: www.bma.org.uk/cpr.
Do Not Attempt Cardiopulmonary Resuscitation	Integrated policy on 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR).

(DNACPR) Integrated Adult Policy August 2016	
National Health Service Litigation Authority. Risk management standards (NHSLA, 2007). – updated 2013-2014	Resuscitation.
Resuscitation Council (UK), 2011. Resuscitation guidelines with reference to Northern Ireland Training.	Following the recent revisions to the UK resuscitation guidelines, the Health and Safety Executive Northern Ireland (HSENI) has informed all HSENI approved training providers involved in the delivery of first aid at work, of the timetable by which they should be compliant with the changes to UK resuscitation protocols. This means HSENI approved training organisations must: • ensure all trainers and assessors are fully conversant of the changes before 01 April 2011 • the delivery of new protocols to students should start by 01 April 2011 • all existing training materials, such as presentations explaining the protocols, need to be revised by 01 April 2011.
The Health and Safety (First-Aid) Regulations (Northern Ireland) 1982	First aid at work - mutual recognition arrangement between the Health and Safety Executive for Great Britain (HSE) and the Health and Safety Executive for Northern Ireland (HSENI).
Care Quality Commission (CQC). Essential standards of quality and safety. March 2010 - revised and updated 2015 to Fundamental Standards	Regulator standards for England. The CQC 13 Fundamental standards are the standards below which care must never fail.
Regulation and Quality Improvement Authority (RQIA) 2005 and 2009	'The RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services'. The reviews undertaken by the RQIA are based on the 2006 'Quality standards for health and social care'. • The Care Tribunal (Amendment) Regulations (Northern Ireland) 2008 (No.249) • The Establishments and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2008 (No.346) In 2009, the duties of the Mental Health Commission were also transferred to the RQIA. • Nurse Agency Minimum Standards 2008 • Domiciliary Care Agency Minim Standards 2011
Health and Social Care Act 2008 – updated 2012 (HSCA)	The relevant part of the HSCA to this Policy is the introduction of the Care Quality Commission which is an integrated regulator for health and adult social care, bringing together existing health and social care regulators under one regulatory body. The CQC has new powers to ensure safe and high-quality services.
Social Care and Social Work Improvement Scotland September 2011 (SCSWIS)	The independent regulator of social care and social work services across Scotland is SCSWIS. They regulate, inspect, and support,

	improvement of care, social work and child protection services for the benefit of the people who use them.
Care Inspectorate Wales (CIW). National Minimum Standards 2004	The independent regulator of social care and social services across Wales is the CIW. National Minimum Standards for domiciliary care (2004). National Minimum Standards for nurse agencies (2003), The Children and Families (Wales) Measure 2010.
Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing - 2016	Provides the latest guidelines to all establishments that face decisions about attempting cardiopulmonary resuscitation (CPR), including hospitals, general practices, care homes, hospices and ambulance services. It states that policies must be readily available and understood by all relevant staff and should also be available to the public.
Resuscitation Council UK – Requirements for Resuscitation Training and Facilities for Cardiovascular Prevention and Rehabilitation Programmes 2018	Requirements for the management of cardiorespiratory arrest occurring during cardiovascular prevention and rehabilitation programmes both in acute hospitals and elsewhere.

2. Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.