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**Adult Basic Resuscitation Policy**

**[Date of Issue]**

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# Introduction

This Adult Basic Life Support Policy is based upon the Resuscitation Council UK (2021) guidelines for adult basic life support and anaphylaxis. Recognising and responding appropriately in a timely manner to critically unwell/arresting individuals is essential to improving outcomes, and this policy aims to provide staff with the knowledge to achieve this.

The full Adult Basic Life Support algorithm can be found here [Adult Basic Life Support Algorithm 2021.pdf (resus.org.uk)](https://www.resus.org.uk/sites/default/files/2021-04/Adult%20Basic%20Life%20Support%20Algorithm%202021.pdf)

# Policy Statement

[Company Name] are committed to ensuring that all persons in life-threatening situations requiring resuscitation support receive timely, efficient and appropriate assessments and interventions. In addition to ensuring that all staff provide assessments and responses within the scope of their training and practice.

# Scope

This policy and the procedures apply to all staff providing services for [Company Name].

The Registered Manager is responsible for ensuring that all staff receive the appropriate training and are competent and confident in the application of Adult Basic Life Support.

# Procedures

All staff at [Company Name] must be able to recognise a cardiac arrest, call for help and start resuscitation within the limits of their abilities. At a minimum, all staff must be competent and confident in basic life support and have attended the mandatory training.

# Cardiopulmonary Resuscitation (CPR)

**Step 1: Safety**

Ensure that the person’s surroundings and any bystanders are safe before approaching. Apply all appropriate personal protective equipment (PPE), where available as soon as possible, and use safe manual handling techniques when repositioning the person during resuscitation.

**Step 2. Check the person for a response**

Check to see whether any collapsed person is able to respond with a firm shake of the shoulders and loudly asking: “Are you alright?”

**Step 3A. If the person responds** [DELETE if company have no medical personnel available on-site]

Call for help and request an urgent medical assessment. While awaiting review, assess the person using the ABCDE (Airway, Breathing, Circulation, Disability, Exposure) approach.

**Step 3A. If the person responds** [DELETE if company have medical personnel available on-site]

If the person responds leave them in their current position, as long as they are in no further danger, try to determine what is wrong, call for help if needed and reassess the person’s condition regularly.

**Step 3B. If the person does not respond**

Call for help (if not done already) and turn the person onto their back, followed by:

* **Airway** - open the airway using head tilt and chin lift. If there is a risk of cervical spine injury use a jaw thrust instead (chin lift can be used with manual in-line stabilisation, if there are enough people available). If life-threatening airway obstruction persists, add a head tilt in small increments until the airway is open.
* **Breathing** – maintain the airway and in under 10 seconds look, listen and feel to determine if the person is breathing (if appropriately trained check for carotid pulse at the same time):
  + look for chest movement (breathing or coughing)
  + look for any other movement or signs of life
  + listen at the person’s mouth for breath sounds
  + feel for air on your cheek.

Agonal breathing (occasional, irregular gasps) is a sign of cardiac arrest and agonal breathing with limb movement can occur during chest compressions as cerebral perfusion improves, but this is not indicative of a Return of Spontaneous Circulation (ROSC). In isolation, changes in skin colour (e.g., pallor, cyanosis) do not necessarily indicate a cardiac arrest. If there is any doubt as to whether the person’s breathing is normal, prepare to start CPR.

**Step 4. Call an ambulance (999)**

Stay with the person and, where possible, ask another person to call 999. Otherwise, call yourself and place the phone on speaker, where possible.

**Step 5. If the person is not breathing and has a pulse (respiratory arrest)**

A diagnosis of respiratory arrest should only be made by someone confident in assessing the breathing and pulse, along with other signs of life.

If there is any doubt as to the type of arrest proceed with CPR and treat as a cardiac arrest.

**Step 6. Send for an automated external defibrillator (AED)**

**If an external defibrillator is not available onsite** the ambulance dispatcher will identify a local Automated External Defibrillator (AED).

If another person is available send them to collect/find an AED, if you are alone and are unsure of the AEDs location, do not leave the person and instead start CPR.

**Step 7. Circulation**

Start CPR (30 chest compressions followed by two ventilations):

* place the heel of one hand in the centre of the person’s chest (middle of the lower half of the sternum) and place the heel of the other hand on top, interlocking the fingers
* keep the arms straight, positioning the shoulders vertically above the person’s chest
* compress to a depth of 5–6 cm at a rate of 100–120 compressions per minute
* allow the chest to recoil slightly after each compression, taking approximately the same amount of time for compression and relaxation
* minimise any interruptions to chest compressions.

If there is another person who is able to assist, with minimal interruption and during planned pauses, rotate performing chest compressions every 2 minutes, or sooner if needed.

After 30 chest compressions open the airway again and provide rescue breaths via mouth-to-mouth or a pocket mask if available. Maintain an inspiratory time of around 1 second and avoid rapid or forceful breaths. If there are clinical reasons to avoid mouth-to-mouth contact, or you are unable to do this, continue chest compressions until help or airway equipment arrives.

Continue CPR until emergency responders arrive and you are told to stop, you become exhausted or there is clear return of spontaneous circulation (ROSC).

Responders should refer to the latest advice

**Step 8. If an AED arrives**

Switch on the AED and attach the electrode pads to the person’s bare chest. If multiple people are present continue CPR while this occurs. Follow the spoken/visual directions and ensure that nobody touches the person or surrounding area while the AED analyses the rhythm. If a shock is indicated, deliver the shock by pushing the shock button as directed (if not fully automated), ensuring that nobody is touching the person. Immediately restart CPR at a ratio of 30:2 and continue as directed by the voice/visual prompts. If no shock is indicated, continue CPR and respond as directed by the voice/visual prompts. Prepare to handover to emergency services using either a SBAR (Situation, Background, Assessment, Recommendation) or RSVP (Reason, Story, Vital signs, Plan) format.

**Step 9. Recovery position**

If CPR is successful and you are confident that the person is breathing normally but remains unresponsive, place them in the recovery position (see below for steps).

**[Delete as appropriate] Resuscitation of victims of drowning**

Carry out a primary survey as above. Commence chest compressions do not give rescue breaths.

Continue to perform CPR until:

* emergency help arrives and takes over
* the person starts showing signs of life and starts to breathe normally
* you are too exhausted to continue (if there is a helper, you can change over every one-to-two minutes, with minimal interruptions to chest compressions)
* or a defibrillator is ready to be used (if the helper returns with a defibrillator, ask them to switch it on and follow the voice prompts while you continue with CPR).

Many casualties that drown may bring up stomach contents, be prepared to roll them onto their side to clear their airway.

**Cross contamination**

CPR to unknown victims can increase the risk of cross contamination and infections. The risk is often small, and the responder should consider the benefits vs risk of providing CPR to someone in cardiac arrest who will likely die if not treated.

First responders should consider the latest advice from the NHS [website](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) but staff should also be guided by their employers advice.

Due to the current increased risk that a client could have COVID-19, Resuscitation Council UK advises that:

* If a first responder is unable to check for breathing by placing the face close to the victim’s, and there is doubt as to whether the victim is breathing or is in cardiac arrest, chest compressions should be started until help arrives.
* Ensure you communicate COVID-19 is suspected when you call 999.
* If there is a perceived risk that the victim has COVID-19, first responders should place a towel or a cloth over the victim’s mouth or nose and continue with chest compression only CPR and early defibrillation (where possible) until help arrives.
* If a first responder has access to Personal Protective Equipment (PPE) this should be worn at all times.
* Following compression only CPR, hands should be washed thoroughly with soap and water.

# Choking

Choking Algorithm can be found here [Adult Choking Algorithm 2021.pdf (resus.org.uk)](https://www.resus.org.uk/sites/default/files/2021-04/Adult%20Choking%20Algorithm%202021.pdf)

Staff must be able to recognise airway obstruction due to choking, as opposed to other causes of respiratory distress. If the person is conscious and responsive it is important to ask: “Are you choking?”.

If they are able to speak, cough and breathe they have a mild obstruction. If the person is unable to speak, has a weakening cough or is struggling or unable to breathe, they have a severe airway obstruction. Aggressive interventions for choking in a mild airway obstruction may cause harm and worsen the obstruction, and clients should, therefore, be encouraged to independently cough in the first instance.

* **Step 1. Suspect choking**

If the person is eating and experiences respiratory arrest, be alerted to choking and ask: “Are you choking?”.

* **Step 2. Encourage cough**

Encourage the person to cough independently before intervening.

* **Step 3. Perform back blows**

If the person is unable to cough or their coughs becomes ineffective, perform up to five back blows as follows:

* + stand to the side and slightly behind the person
  + support the chest with one hand and lean the person forwards to avoid the foreign object falling further into the airway
  + give up to five sharp blows between the shoulder blades with the heel of the other hand (pause between each one to assess if the blockage has cleared).
* **Step 4. Perform abdominal thrusts**

If back blows are ineffective, perform up to five abdominal thrusts as follows:

* stand behind the person and put both arms around the upper part of the abdomen
* lean the person forwards
* clench your fist and place it between the navel and ribcage
* grasp this hand with the other hand and pull sharply inwards and upwards
* repeat up to five times (pausing between to assess if the blockage has cleared)
* if the obstruction remains, continue alternating between five back blows and five abdominal thrusts.
* **Step 5. Start CPR**

If the person becomes unresponsive, start CPR procedures as detailed above.

If the obstruction is cleared and choking is resolved, foreign material may still remain in the upper or lower airways and cause complications at a later time. If the person presents with a persistent cough, difficulty swallowing, or the sensation of an obstruction they should be advised to seek medical advice, along with those who received abdominal thrusts or chest compressions, as internal injuries may have occurred.

# Recovery Position

If a person is unconscious and unresponsive but breathing normally, place them in the recovery position before going for help as follows:

* remove any glasses and carefully check pockets for potential hazards
* kneel next to the person and ensure both of their legs are straight
* place the arm nearest to you out at a right angle to the body, elbow bent with the hand palm-up
* bring the far arm across the chest and hold the back of the hand against the victim’s cheek nearest to you
* with your other hand, grasp the far leg just above the knee and pull it up, keeping the foot on the ground
* keeping their hand pressed against the cheek, pull on the far leg to roll the victim towards you on to their side
* adjust the upper leg so that both the hip and knee are bent at right angles
* tilt the head back to make sure that the airway remains open
* if necessary, adjust the hand under the cheek to keep the head tilted and facing downwards to allow any liquid material to drain from the mouth
* check breathing regularly
* be prepared to start CPR immediately if the victim deteriorates or stops breathing normally.

# Anaphylaxis

[Emergency Anaphylaxis Guidance](https://www.resus.org.uk/library/additional-guidance/guidance-anaphylaxis/emergency-treatment)

Staff must understand how to recognise an anaphylactic reaction, acknowledging that it is likely when all of the following three criteria are met:

* sudden onset and rapid progression of symptoms
* life-threatening airway and/or breathing and/or circulation problems
* skin and/or mucosal changes (flushing, urticaria, angioedema)

In addition, this should be supported by whether the person has been exposed to an allergen that they have a known reaction to. Staff should remember that:

* skin or mucosal changes alone are not a sign of an anaphylactic reaction
* skin and mucosal changes can be subtle or absent in up to 20% of reactions
* anaphylaxis can also present with gastrointestinal symptoms (e.g., vomiting, abdominal pain and incontinence).

Use an ABCDE approach to assess the person and consider alternative diagnoses, such as life-threatening asthma, vasovagal episodes, panic attacks, etc. Where anaphylaxis is suspected:

* remove/stop the trigger (allergen), if possible
* call an ambulance (999) immediately
* position person comfortably, lying flat with feet up if possible
* give adrenaline, with the person’s own medication (e.g., EpiPen) if trained and competent to do so
* start CPR process if the person progresses into cardiorespiratory arrest
* prepare to handover to emergency services using either a SBAR (Situation, Background, Assessment, Recommendation) or RSVP (Reason, Story, Vital signs, Plan) format.

# Monitoring

The effectiveness of this policy will be monitored through routine auditing, along with any associated adverse incidents or serious events. Staff attendance of mandatory training will also be routinely audited to ensure 100% attendance.

# Related Policies

* Deteriorating Person Policy
* First Aid Policy
* Handover Policy
* Incident Management Policy
* Training and Induction Policy

# Legislation and Guidance

**Guidance**

* [Adult basic life support Guidelines | Resuscitation Council UK](https://www.resus.org.uk/library/2021-resuscitation-guidelines/adult-basic-life-support-guidelines#guidelines), 2021
* [Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers | Resuscitation Council UK](https://www.resus.org.uk/library/additional-guidance/guidance-anaphylaxis/emergency-treatment), 2021

# Summary of Review

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| --- | --- |
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