Rescue Breaths – November 2022 update – 1st Response Trainers

First aid - Rescue Breaths

On 10 August 2022 the Resuscitation Council UK issued updated guidance for CPR with regards to Covid-19 and recommended that we revert to following the 2021 guidelines for resuscitation. In practice this means that is it encouraged to revert to teaching and giving rescue breaths as follows:

Following 30 chest compressions - Give 2 rescue breaths
Provided that it is safe to do so, and the rescuer is trained, willing and able to perform mouth-to-mouth ventilations, having established good quality chest compressions in the first instance, 2 breaths should be given, immediately followed by 30 compressions continuing in this ratio of 30 compressions to 2 breaths.

Delays to chest compressions should always be minimised and no more than 10 seconds should be taken to give 2 ventilations.

Where barrier devices and pocket masks are used - assembling these devices takes too long for a single rescuer to achieve, so if unwilling/unable to give direct mouth-to-mouth, consider delaying use of barrier devices and perform continuous uninterrupted chest compressions until more rescuers arrive.

If unable, unwilling or unsure how to give artificial ventilations, perform continuous chest compressions until additional help is available and ventilation established.

As a result, and following a paper presented and accepted at the Safer Guiding Working group the advice to first aiders in Girlguiding will now be that they should revert to providing rescue breaths, especially if the patient is a child, if it is safe, they are trained and that they are willing to do so.

1st Response Training

We considered how to teach and practice rescue breaths safely whilst acknowledging the wide variety of training, resources and perception of risk amongst our trainers and members. We also considered cost and sustainability concerns. It has been agreed that trainers don't all need to follow the same method and trainers should adopt the method most appropriate to them and their course participants.

These options are:

1. **To continue to not practice rescue breaths.**

   This would be appropriate for adults where compression only CPR is instructed by call-handlers anyway. It is less appropriate for children, and we are a youth organisation. Where trainers or participants are not satisfied that they can

practice safely – then compression only CPR should be taught. Compression only CPR is shown to be as effective as CPR with rescue breaths in the first few minutes of cardiac arrest in an adult.

2. **Using one manikin per participant per session – and changing lungs in between sessions and disinfecting.**

   Please note any manikin manufacturers would recommend this and this is what many professional training organisations e.g. St John Ambulance would be able to do. It should be noted that some trainers, including those who train professionally may have access to sufficient manikins to be able to do this. But many trainers have only one or a few manikins and there is not sufficient time on a course to be able to change lungs between all participants. There is also additional cost involved in this, and concerns about the amount of single use plastic used.

3. **Using barrier devices e.g. Mannikin shields or pocket masks.**

   Mannikin shields are inexpensive (£12 for a roll of 36) and should probably be recommended. Pocket masks could be used if the trainer is trained in using them. They cost around £8 each. If cost is an issue, then they can be cleaned between participants and a new valve with filter (less than £1 each) provided for each participant.

It should remain that the demonstration of chest compressions and use of AED should be compulsory skills in training courses, but rescue breaths need not be.