Rethinking Basic Life Support Training Delivery: A Scalable, Workforce-Driven Model

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Background

The Challenge: Ensuring all staff with a duty of care have practical training in Basic Life Support (BLS) meeting the Resuscitation Council UK (2026) Community Standards.

The Scale
Large residential school and college with with 1000+ staff working across clinical, clinical, education and residential areas. areas.

The Training Capacity
Traditional instructor-led, classroom-based delivery relied heavily on a small clinical education team.

Non-compliance
Annual BLS refreshers were limited to key clinical and leadership staff.

The Innovation

A new training model was developed to enable organization-wide annual access to BLS practical for over 1000 staff in diverse roles. The model adopted a blended learning approach…

1 Online learning
Core knowledge, in-house videos and assessment for learning

2 Practical skills station
Short 30 min, small-group CPR and AED practice

3 Objective meaningful feedback
Feedback enabled manikin with facilitator coaching

4 Delivered by HCAs
Completion of BLSi instructor course along side supervision upskilled HCAs to deliver skills stations.

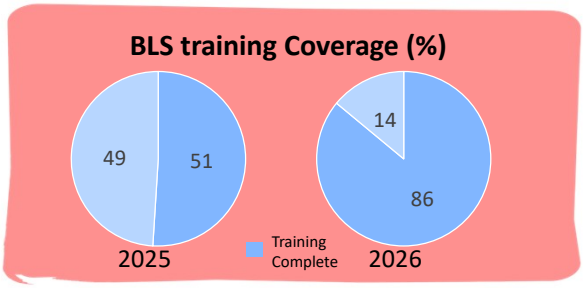
5 Accessible Practical
More frequent sessions offered 24/7 to cater for the entire workforce

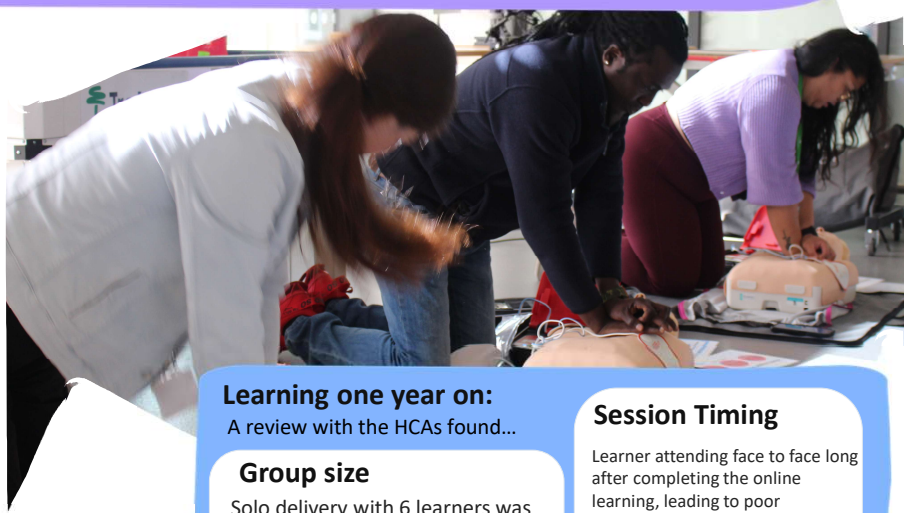
Golden thread: learner confidence, role clarity and consistent emergency response

…providing objective, practical and feedback consistent BLS sessions annually to a large work force.

Impact

Training coverage increased within one year.





Learner feedback

Learner evaluation supports the acceptability and educational value of the format.

Practical session quantitative feedback (n=25)

100%	100%	100%	92%
agreed small-group format supported learning	agreed manikin feedback feedback helped CPR technique	Agreed HCA facilitator feedback was useful	agreed practical station improved confidence in emergencies

Learner voice

The feedback from the dummy was really useful to know strengths or areas to improve.

The practical session was really helpful as you got to practice and see how well you were doing. Then you adjusted to make it better.

I feel more confident to support.

Online Training Feedback

- Well received and prepares learners for practical skill-station.
- Ongoing review needed to keep video content current, clarify completion expectations

Learning one year on:

A review with the HCAs found…

Group size
Solo delivery with 6 learners was challenging.
We are now planning for 2 instructors per 6 learners to enable HCAs to better meet needs.

Session Timing
Learner attending face to face long after completing the online learning, leading to poor performance.
Cap set on booking system ensuring face to face not bookable if online was complete >6 weeks.

Key Takeaways

Protect hands-on practice time
Move knowledge acquisition online, protect so face-to-face for CPR & AED practice, feedback and confidence-building.

Build instructor capacity safely
Develop support staff (e.g. HCAs), with clear competency pathway, supervision and define session expectations.

Use objective feedback to improve consistency
Use QCPR manikins to support consistent feedback, reduce variation between sessions and help learners recognise and improve their technique.

References: Resuscitation Council UK (RCUK) (2026) *Quality Standards: CPR and AED training in the community*. Last updated January 2026. Available at: https://www.resus.org.uk/library/quality-standards-cpr/quality-standards-cpr-and-aed-training-community (Accessed: 24 April 2026).
RCUK (n.d.) *Basic Life Support Instructor Course (BLSi)*. Available at: https://www.resus.org.uk/BLSi (Accessed: 24 April 2026).