United International Journal for Research & Technology

Volume 07, Issue 10, 2026 | Open Access | ISSN: 2582-6832

Basic Life Support Readiness among Healthcare Professionals in Public and Private Health Facilities: A Comparative Study

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***Abstract*—** This study assessed and compared Basic Life Support readiness among healthcare professionals in public and private health facilities. Using a quantitative descriptive-comparative design, the study involved 200 licensed healthcare professionals, including physicians, nurses, respiratory therapists, medical technologists, and other allied health workers. Data were gathered using a validated structured questionnaire that measured demographic profile, BLS knowledge, psychomotor skills, confidence, and challenges encountered during BLS training. Descriptive statistics, independent samples t-test, and one-way ANOVA were used to analyze the data. Findings showed that respondents had a high level of knowledge readiness, with an overall correct response rate of 84%, and a very high level of psychomotor skills, with an overall mean of 4.23. Confidence readiness was also high, with an overall mean of 4.00. Significant differences in BLS readiness were found according to age, profession, years of experience, previous BLS training, and type of healthcare facility, while sex showed no significant difference. Public facility respondents had significantly higher readiness than private facility respondents. Although overall training challenges were low, moderate concerns were noted in refresher training needs, psychomotor skill performance, equipment access, and hands-on practice time. The findings support the need for regular refresher training, simulation-based drills, and standardized BLS competency monitoring across healthcare facilities.

***Keywords*—** Basic Life Support, BLS readiness, healthcare professionals, public and private health facilities, emergency preparedness.

I. INTRODUCTION

Basic Life Support (BLS) remains one of the most essential competencies expected of healthcare professionals because medical emergencies can occur unexpectedly in any healthcare setting. Cardiac arrest, respiratory arrest, airway obstruction, and other life-threatening conditions require immediate recognition and timely intervention before advanced medical care becomes available.

In these situations, the ability of healthcare workers to initiate cardiopulmonary resuscitation, provide rescue breathing, manage the airway, activate the emergency response system, and use an automated external defibrillator can directly influence patient survival. For this reason, BLS readiness is not only a technical skill requirement but also a fundamental component of patient safety, emergency preparedness, and quality healthcare delivery.

BLS refers to a set of emergency procedures intended to maintain circulation and ventilation during cardiac or respiratory emergencies. These procedures include chest compressions, rescue breathing, airway management, foreign body airway obstruction management, and AED use. The International Liaison Committee on Resuscitation emphasized that early and proper application of BLS procedures increases the likelihood of patient survival until advanced life support becomes available.

Similarly, the American Heart Association highlighted that BLS training improves healthcare providers' ability to respond rapidly, communicate effectively, and perform coordinated emergency actions during cardiac events. In the healthcare environment, where delays can result in irreversible brain injury or death, mastery of these procedures is critical.

Healthcare professionals are expected to possess adequate knowledge, psychomotor skills, and confidence in performing BLS. Knowledge provides the theoretical foundation for understanding the correct sequence of emergency response, compression depth and rate, ventilation requirements, AED procedures, and post-shock actions. Psychomotor skills involve the actual performance of BLS procedures, such as proper hand placement, effective chest compressions, airway opening, ventilation technique, and AED pad placement. Confidence, meanwhile, influences the willingness and ability of a healthcare worker to act decisively during stressful emergency situations. These three dimensions are closely connected: knowledge guides action, psychomotor skills enable correct performance, and confidence supports timely decision-making.

Previous studies cited in the manuscript support the importance of BLS training in strengthening emergency preparedness. Bhat et al. reported that early use of BLS techniques during sudden cardiac arrest improves patient survival. Chandra et al. found significant improvements in healthcare professionals' CPR knowledge and skills after structured BLS training. Becker et al. emphasized that regular recertification programs help healthcare workers maintain proficiency and readiness. These findings suggest that BLS readiness is not acquired through theoretical learning alone but must be reinforced through repeated training, practical exposure, and competency evaluation.

Simulation-based learning has also been identified as an effective strategy for improving BLS performance. Issenberg et al. reported that simulation training enhances psychomotor skills, decision-making, teamwork, and confidence among healthcare professionals. Zendejas et al. similarly found that simulation-based medical education improves technical skills and clinical decision-making. In BLS education, simulation allows healthcare workers to practice emergency procedures in controlled but realistic scenarios. This is particularly important because real cardiac or respiratory emergencies are high-pressure events where hesitation, poor coordination, or incorrect sequencing may compromise patient outcomes.

Despite the established value of BLS training, challenges remain in ensuring consistent readiness among healthcare professionals. The manuscript cited studies indicating that time constraints, heavy workloads, limited resources, inadequate institutional support, and insufficient access to refresher training can affect participation in BLS programs and long-term skill retention. Hodgett et al. noted that limited hands-on practice may contribute to persistent gaps in resuscitation knowledge. Rivedal et al. also identified poor practice opportunities and limited equipment as barriers to effective CPR training. These challenges are important because BLS competence can deteriorate when healthcare workers are not given enough opportunities for repeated practice, assessment, and retraining.

In the Philippine context, BLS readiness among healthcare workers is especially important because healthcare institutions serve not only as treatment centers but also as critical points of emergency response. The Department of Health Administrative Order No. 155 s. 2004 emphasizes the need to improve BLS training among healthcare professionals to strengthen disaster preparedness and patient survival during cardiac emergencies. In local healthcare settings, particularly in areas where access to tertiary care may be limited or transport time may be prolonged, healthcare professionals must be capable of stabilizing patients during the early and most critical moments of an emergency. This makes BLS readiness a relevant public health concern as well as a clinical competency requirement.

The manuscript situates the study in Daraga, Albay, where selected public and private healthcare facilities serve patients with varying emergency needs. Public and private facilities may differ in patient volume, emergency exposure, training resources, institutional protocols, and availability of equipment. These differences may influence the readiness of healthcare professionals to perform BLS. Public facilities, for example, may encounter higher patient loads and more frequent emergency cases, while private facilities may

vary in terms of training frequency and exposure to critical incidents. Comparing BLS readiness across facility types can therefore provide useful evidence for improving institutional training programs and standardizing emergency preparedness.

The problem addressed in this study is that, although BLS training is widely recognized as essential, readiness among healthcare professionals may not be uniform across knowledge, skills, confidence, demographic groups, and facility types. Some healthcare workers may have prior training but still show gaps in specific procedures such as AED operation, post-shock management, rescue breathing, or compression quality. Others may experience challenges related to limited hands-on practice, lack of refresher training, or inadequate access to training equipment. These gaps can affect emergency response performance and may reduce the effectiveness of life-saving interventions during actual clinical emergencies.

This study therefore examined Basic Life Support readiness among healthcare professionals in public and private health facilities through a comparative approach. Specifically, it assessed the demographic profile of respondents, determined their level of readiness in terms of knowledge, psychomotor skills, and confidence, examined whether significant differences existed according to selected demographic variables and type of healthcare facility, and identified the challenges encountered during BLS training. By presenting evidence on both readiness levels and training-related barriers, the study provides a basis for strengthening BLS training programs, improving competency monitoring, and enhancing emergency preparedness among healthcare professionals in both public and private healthcare settings.

II. METHODOLOGY

This study employed a quantitative descriptive-comparative research design to assess and compare the Basic Life Support readiness of healthcare professionals in public and private health facilities. The descriptive approach was used to determine the respondents' level of BLS readiness in terms of knowledge, psychomotor skills, and confidence, while the comparative approach was used to examine differences in readiness according to selected demographic variables and type of healthcare facility. The respondents were 200 licensed healthcare professionals working in selected public and private health facilities in Daraga, Albay, including physicians, nurses, respiratory therapists, medical technologists, and other allied healthcare workers. Non-clinical personnel, students, interns, and individuals currently undergoing BLS training were excluded from the study.

Data were gathered using a validated structured questionnaire designed to measure BLS readiness across several domains. The instrument included sections on demographic profile, BLS knowledge, psychomotor skills, confidence/readiness, and challenges encountered during BLS training. The knowledge component consisted of multiple-choice questions based on the 2020 International Liaison Committee on Resuscitation and American Heart Association guidelines, while the psychomotor skills, confidence, and training challenges were assessed using Likert-scale items. The questionnaire was validated by experts in nursing research and emergency healthcare, and a pilot test was conducted to assess its reliability before actual data collection.

Permission to conduct the study was obtained from the selected healthcare institutions before data collection. Eligible respondents were informed about the purpose, procedure, and significance of the study, and informed consent was secured prior to participation. Data were collected either through printed questionnaires or Google Forms and were checked, coded, tabulated, and analyzed using IBM SPSS Statistics version 22. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were used to summarize the respondents' profile and BLS readiness levels. Inferential statistics were also applied: independent samples t-test was used for variables with two groups, while one-way analysis of variance was used for variables with more than two groups. Tukey's Honest Significant Difference post hoc test was conducted when ANOVA results were significant, with the level of significance set at 0.05.

III. RESULTS

Demographic profile of healthcare professionals

The demographic profile shows that the respondents were predominantly young healthcare professionals, with more than half belonging to the 21–30 age group. This suggests that the healthcare workforce included in the study was largely composed of early-career professionals who may still be actively exposed to institutional training programs, clinical skill development, and continuing professional education. The high proportion of respondents with 1–4 years of experience further supports this observation, indicating that many participants were still in the early stages of professional practice.

Table 1. *Demographic Profile of the Respondents*

Variable	Category	f	%
Age	21–30 years	113	56.50
	31–40 years	54	27.00
	41–50 years	32	16.00
	51 years and above	1	0.50
Sex	Male	42	21.00
	Female	158	79.00
Profession	Physician	20	10.00
	Nurse	118	59.00
	Respiratory Therapist	24	12.00
	Medical Technologist	33	16.50
	Others	5	2.50
Years of Experience	Less than 1 year	34	17.00
	1–4 years	72	36.00
	4–8 years	39	19.50
	More than 8 years	55	27.50
Previous BLS Training	Yes	190	95.00
	No	10	5.00

The sex distribution shows that female respondents represented the majority of the sample. This pattern is understandable because nurses composed the largest professional group in the study, and nursing remains a female-dominated profession in many healthcare settings. Since nurses frequently serve as frontline responders during patient deterioration, cardiac arrest, and respiratory emergencies, their strong representation in the sample is relevant to the assessment of BLS readiness.

In terms of profession, nurses formed the largest group, followed by medical technologists, respiratory therapists, physicians, and other healthcare workers. This distribution reflects the multidisciplinary nature of emergency response in healthcare facilities. Although physicians may lead clinical decision-making, nurses, respiratory therapists, and allied health professionals are often directly involved in immediate recognition, CPR initiation, airway support, AED use, and coordination during emergencies.

The finding that 95% of respondents had previous BLS training is particularly important. It indicates that most healthcare professionals had formal exposure to BLS concepts and procedures before participating in the study. This high training exposure may explain the generally high to very high readiness scores observed in the succeeding tables. The finding is consistent with the manuscript's cited literature, particularly Nguyen et al. (2020), which emphasized the importance of continuous training in maintaining emergency preparedness among healthcare workers. It is also aligned with the American Heart Association's

emphasis on regular BLS training as a core requirement for effective emergency response.

Level of Basic Life Support readiness among healthcare professionals

The findings on knowledge readiness indicate that healthcare professionals had an overall high level of BLS knowledge, with an overall correct response rate of 84%. This suggests that most respondents had adequate theoretical understanding of BLS principles, including chest compression depth, airway obstruction management, ventilation after return of spontaneous circulation, rescue breathing, and the Adult Chain of Survival.

The highest correct response was observed in the recommended chest compression depth for adults, followed by management of complete airway obstruction and ventilation management after ROSC. These results suggest that respondents were familiar with commonly emphasized BLS concepts, especially those repeatedly discussed in formal training, clinical practice, and emergency response protocols. This is consistent with the American Heart Association (2020), which highlights high-quality chest compressions, early recognition, and timely intervention as essential elements of effective resuscitation.

However, some knowledge areas received only moderate scores. These included the correct procedure in operating an AED, immediate action after delivering an AED shock, the BLS sequence based on the 2020 ILCOR guidelines, and infant chest compression technique.

These lower-scoring indicators suggest that while general BLS knowledge was strong, procedural sequencing and AED-related decision-making require further reinforcement.

This is important because AED use is a critical survival intervention in cardiac arrest, and incorrect post-shock action may delay effective CPR continuation.

Table 2. *Level of Basic Life Support Readiness*

Knowledge Indicator	Correct Responses	%	Interpretation
BLS sequence based on 2020 ILCOR guidelines	72	60	Moderate
Ventilation management after ROSC	114	95	Very High
Infant age classification in BLS	88	73	High
Exclusions in Adult Chain of Survival	96	80	High
AED use for patients with implanted devices	110	92	Very High
Immediate action after AED shock	71	59	Moderate
Pediatric rescue breathing in single-rescuer CPR	113	94	Very High
Complete airway obstruction in conscious adults	115	96	Very High
Initial assessment steps in BLS	90	75	High
Correct AED operation procedure	70	58	Moderate
First step in BLS activation	112	93	Very High
Adult CPR compression-to-ventilation ratio	98	82	High
Recommended adult compression depth	117	98	Very High
Recommended compression rate during CPR	85	71	High
Post-shock management in AED use	101	84	High
Rescue breathing rate for non-breathing patient with pulse	109	91	Very High
Purpose of high-quality chest compressions	95	79	High
Rescuer switching interval during two-person CPR	111	93	Very High
Infant chest compression technique	76	63	Moderate

Components of Adult Chain of Survival	113	94	Very High
Overall	—	84	High

The finding supports Hodgett et al. (2019), who reported that gaps in resuscitation knowledge may persist when healthcare workers have limited hands-on practice or insufficient refresher training. It is also consistent with ILCOR (2020), which emphasizes the importance of standardized, updated, and repeated BLS training to ensure that responders correctly perform CPR, AED use, and airway management. Therefore, while the respondents demonstrated generally high knowledge readiness, training programs should give greater focus to AED operation, post-shock procedures, BLS sequencing, and pediatric-related BLS concepts.

The psychomotor skills results show that healthcare professionals demonstrated a very high overall level of performance, with an overall mean of 4.23. This indicates that respondents were generally capable of performing the essential physical and procedural components of BLS. Their strongest areas were AED operation, airway management, and team coordination, all of which were interpreted as very high.

Table 3. *Psychomotor Readiness in Basic Life Support*

Psychomotor Skill Indicator	Mean	Interpretation
Scene safety and victim assessment	4.12	High
Activation of emergency response system	4.20	High
Chest compression technique	4.18	High
Airway management	4.23	Very High
Ventilation technique	4.19	High
AED operation	4.24	Very High
Team coordination	4.22	Very High
Overall Performance	4.23	Very High

Note. Interpretation: 4.21–5.00 = Very High; 3.41–4.20 = High; 2.61–3.40 = Moderate; 1.81–2.60 = Low; 1.00–1.80 = Very Low.

The very high rating in AED operation appears encouraging, especially when compared with the lower knowledge score on correct AED procedure in Table 2. This may suggest that respondents were more confident or competent in physically following AED prompts and attaching pads than in answering theoretical or sequence-based AED questions. In practice, AED devices provide step-by-step instructions, which may make actual performance easier than recalling the complete procedure in a written assessment.

Airway management also received a very high rating, suggesting that respondents were able to perform key airway-opening techniques such as head-tilt/chin-lift. This is an important BLS competency because effective airway management supports ventilation and oxygenation during emergencies. Team coordination was also rated very high, showing that respondents could communicate clearly and alternate roles during BLS performance. This finding is relevant because resuscitation is rarely an individual task in hospital settings; effective emergency response requires communication, delegation, and coordinated action.

The findings are supported by Zendejas et al. (2021), who reported that simulation-based medical education improves technical skills, clinical decision-making, and confidence. Similarly, Issenberg et al. (2021) emphasized that simulation training enhances psychomotor skills and teamwork among healthcare professionals. The very high psychomotor performance in this study may therefore be attributed to prior BLS exposure, clinical experience, and repeated practice during training. However, the relatively lower mean scores in scene safety,

emergency response activation, chest compression technique, and ventilation technique suggest that these areas should still be reinforced during return demonstrations and competency evaluations.

In Table 4, the respondents demonstrated a high overall level of confidence in performing BLS, with an overall mean of 4.00. This indicates that healthcare professionals generally perceived themselves as prepared to respond to emergencies and perform BLS procedures when needed. The highest mean was observed in recognizing cardiac arrest, followed by confidence in performing BLS without supervision and proper use of an AED.

Confidence in recognizing cardiac arrest is a critical finding because early recognition is the first step in initiating timely BLS.

Delayed identification of cardiac arrest may result in delayed CPR and defibrillation, which can reduce survival outcomes. The high confidence in performing BLS without supervision also suggests that many respondents believed they could act independently during emergencies, which is particularly important in settings where immediate physician presence may not always be available.

Table 4. *Confidence Readiness in Performing Basic Life Support*

Confidence Indicator	Mean	Interpretation
Confident in recognizing cardiac arrest	4.16	High
Can perform chest compressions effectively on an adult	3.92	High
Can properly use an AED	4.04	High
Can perform rescue breathing correctly	3.77	High
Can remain calm and focused during emergencies	3.99	High
Confident to perform BLS even without supervision	4.07	High
Understands role as first responder in cardiac emergencies	4.02	High
Overall Performance	4.00	High

However, the lowest mean was found in performing rescue breathing correctly. Although still interpreted as high, this finding indicates that rescue breathing remains a relatively weaker area of confidence compared with other BLS components.

This may be due to anxiety about ventilation technique, proper seal, chest rise, infection risk, or uncertainty in coordinating compressions and breaths. This result is consistent with the manuscript's findings on training challenges, where difficulty in psychomotor skills and the need for refresher training were identified.

The findings align with Santos (2021), who noted that structured BLS training improves confidence and competence in emergency response.

They also support Becker et al. (2021), which emphasized that regular recertification helps sustain readiness and proficiency. Overall, the high confidence level among respondents is a positive indicator, but confidence should be continuously validated through actual performance-based assessment, simulation drills, and refresher training.

Significant differences exist in Basic Life Support readiness when healthcare professionals are grouped according to selected demographic characteristics and type of healthcare facility.

The results show significant differences in BLS readiness according to age, profession, years of experience, and previous BLS training.

However, no significant difference was found according to sex. These findings suggest that readiness is influenced more by professional exposure, training, and experience-related factors than by biological or gender-related characteristics.

Table 5. Differences in BLS Readiness by Selected Demographic Variables

Variable	Test Used	Test Value	p-value	Interpretation
Age	One-Way ANOVA	F = 3.591	.029	Significant
Sex	t-test	t = -0.036	.971	Not Significant
Profession	One-Way ANOVA	F = 2.718	.031	Significant
Years of Experience	One-Way ANOVA	F = 2.907	.036	Significant overall only
Previous BLS Training	t-test	t = 2.386	.018	Significant

Age was significantly associated with BLS readiness, with respondents aged 31–40 years showing higher readiness than those aged 21–30 years. This may be explained by greater clinical exposure, accumulated experience, and more opportunities to participate in emergency-related training. Healthcare professionals in their 30s may have developed stronger judgment, confidence, and procedural familiarity compared with younger professionals who are still gaining experience.

Profession was also significantly associated with readiness. Physicians, respiratory therapists, and medical technologists showed higher readiness than those categorized under "Others." This may reflect differences in clinical roles, emergency exposure, and training requirements. Physicians and respiratory therapists are commonly involved in emergency care, airway management, and resuscitation procedures, while medical technologists may also encounter urgent clinical situations requiring rapid response. The lower readiness among the "Other" group may indicate the need for more inclusive and standardized BLS training across all healthcare roles.

Previous BLS training was significantly associated with higher readiness. Respondents with BLS training had a higher mean readiness score than those without training. This is one of the most important findings because it directly supports the value of formal BLS education. It confirms that training exposure contributes to preparedness, confidence, and ability to perform emergency procedures.

The significant overall effect of years of experience suggests that length of service may influence readiness, although post hoc results did not identify specific pairwise differences. This means that experience may contribute to readiness in general, but the differences between specific experience groups were not strong enough after adjustment.

These findings are consistent with Peberdy et al. (2014), who emphasized the role of timely assessment and trained response in improving resuscitation outcomes. They also align with Nguyen et al. (2020), which highlighted continuous training as a key factor in emergency preparedness. The absence of a significant difference according to sex indicates that BLS readiness is achievable across male and female healthcare professionals when training and clinical exposure are available.

The comparison between public and private healthcare facilities showed a significant difference in BLS readiness. Healthcare professionals from public facilities obtained a higher mean readiness score than those from private facilities. This finding suggests that facility type may influence BLS preparedness, possibly due to differences in emergency case exposure, institutional training systems, available resources, or frequency of drills and competency assessments.

Table 6. Difference in BLS Readiness by Type of Healthcare Facility

Healthcare Facility	Mean	SD	t-value	p-value	Decision
Public (N=100)	4.11	0.62			
Private (N=100)	3.88	0.86	2.115	.036	Reject H_0

Public healthcare facilities often manage a larger patient volume and may encounter more emergency cases, referrals, and high-acuity conditions. This greater exposure may strengthen the readiness of healthcare professionals by increasing their familiarity with emergency response situations. Public hospitals may also have more structured disaster response units, mandatory training programs, or institutional protocols related to emergency preparedness.

In contrast, private healthcare facilities may vary in terms of training frequency, equipment availability, staffing patterns, and exposure to emergency cases. The lower mean readiness score among private facility respondents does not necessarily indicate poor readiness, since their mean was still within a high range. However, the significant difference suggests that private facilities may benefit from more standardized and frequent BLS training, simulation drills, and competency monitoring.

This finding is consistent with the American Heart Association (2020), which emphasizes that ongoing education, team-based training, and adherence to updated BLS guidelines are necessary for effective emergency response. It also supports Al-Qurashi et al. (2022), cited in the manuscript, which found that healthcare workers in emergency-related or high-exposure departments tend to demonstrate higher BLS readiness than those in less exposed areas. Therefore, facility-based differences should be addressed through consistent training standards across both public and private healthcare institutions.

Challenges encountered by healthcare professionals during Basic Life Support training, particularly those related to hands-on practice, equipment availability, psychomotor skill performance, and refresher training needs

The overall level of challenges encountered during BLS training was interpreted as low, suggesting that respondents did not generally perceive major barriers to BLS training participation or learning. However, several specific challenges were rated moderate and should be considered important areas for improvement. These included the need for refresher or follow-up training, difficulty performing psychomotor skills such as compression depth or rate, limited access to training equipment, and insufficient hands-on practice time.

Table 7. *Challenges Encountered During BLS Training*

Training Challenge	Mean	SD	Interpretation
Time for hands-on practice was not enough to master BLS skills	2.61	1.11	Moderate
Number of participants made it difficult for everyone to practice adequately	2.55	1.12	Low
Limited access to training equipment affected learning experience	2.71	1.16	Moderate
Difficulty remembering correct BLS sequence and procedures	2.43	1.10	Low
Anxiety or nervousness during return demonstrations	2.59	1.09	Low
Training venue was not conducive to effective learning	2.46	0.99	Low
Difficulty balancing work schedule and attending training	2.55	1.14	Low
Pace of instruction was too fast	2.32	0.95	Low
Difficulty performing psychomotor skills such as compression depth or rate	2.75	1.08	Moderate
Need for refresher or follow-up training to retain BLS skills	2.86	1.29	Moderate
Overall Mean	2.58	1.10	Low

Note. Interpretation: 4.21–5.00 = Very High; 3.41–4.20 = High; 2.61–3.40 = Moderate; 1.81–2.60 = Low; 1.00–1.80 = Very Low.

The highest-rated challenge was the need for refresher or follow-up training. This finding is important because BLS knowledge and skills may decline over time if not reinforced. Even healthcare professionals who have completed BLS training may experience reduced confidence or skill accuracy without regular practice. This supports Becker et al. (2021), who emphasized the importance of regular recertification in maintaining BLS proficiency and readiness.

Difficulty performing psychomotor skills was also identified as a moderate challenge. This is consistent with the lower confidence score in rescue breathing and the need to reinforce compression quality, ventilation technique, and AED procedures. Psychomotor skills require repetition, feedback, and supervised practice. Without sufficient return demonstrations, healthcare professionals may understand the concepts but still struggle with accurate performance during real emergencies.

Limited access to training equipment and insufficient hands-on practice time were also notable challenges. These findings support Rivedal et al. (2019), who identified limited practice opportunities and equipment constraints as barriers to effective CPR training. Hodgett et al. (2019) similarly noted that inadequate repetition and limited practical exposure may reduce training effectiveness.

Although the overall challenge level was low, the moderate indicators reveal specific gaps that healthcare institutions should address. Training programs should include more frequent refresher courses, adequate manikins and AED trainers, smaller trainee-to-instructor ratios, structured return demonstrations, and simulation-based drills. These interventions may help sustain knowledge, improve technical accuracy, and strengthen readiness across both public and private healthcare facilities.

IV. CONCLUSION & RECOMMENDATION

This study concluded that healthcare professionals in public and private health facilities generally demonstrated favorable readiness to perform Basic Life Support, with high knowledge readiness, very high psychomotor skills, and high confidence readiness. However, specific gaps were still observed in AED operation, immediate post-shock action, BLS sequencing, infant chest compression technique, rescue breathing, and selected psychomotor skills. Significant differences in readiness were found according to age, profession, years of experience, previous BLS training, and type of healthcare facility, while sex showed no significant difference. Although the overall challenges encountered during BLS training were low, the need for refresher training, limited hands-on practice, equipment access, and difficulty performing psychomotor skills remained important concerns. These findings indicate that healthcare professionals are generally prepared to perform BLS, but sustained competency requires continuous training, simulation-based practice, and regular institutional competency monitoring.

Based on the findings, public and private healthcare facilities should adopt a structured and continuous BLS capacity-building program that includes regular refresher courses, simulation-based drills, return demonstrations, and competency assessments. Training should give greater focus to weaker areas such as AED operation, post-shock management, BLS sequencing, infant chest compression, rescue breathing, compression quality, and emergency response activation. Healthcare administrators and clinical educators should also ensure adequate access to manikins, AED trainers, bag-valve masks, and other training equipment, while providing enough hands-on practice time and maintaining a manageable participant-to-instructor ratio. Since facility type was associated with readiness, private facilities should strengthen standardized BLS training and emergency protocols, while public facilities should sustain their existing readiness programs. BLS readiness should also be integrated into continuing professional development, hospital competency evaluation, and emergency preparedness programs.

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