Journal of the British Islamic Medical Association

Islam & Health

Vol 9 - No. 3 | December 2021 | www.jbima.com

The Lifesavers Method: Teaching Basic Life Support Skills Across Regions and Borders

Bismah Ali[1], Nooruldeen Al-Asali[2], Sameen Nassar[3]

[1]BSc Occupational Therapy Student, London Southbank University; National Director, BIMA Lifesavers

[2]Nooruldeen Al-Asali FHEA, MSc Human Anatomy with Education, Sheffield University; Medical Student, MBBS Medicine and Surgery, Newcastle University; Regional Lead for North East of England, BIMA Lifesavers

[3]Sameen Nassar, Medical Student, MBBS Medicine and Surgery, Newcastle University; Regional Vice-Lead for North East of England, BIMA Lifesavers

Correspondence: *Bismah Ali* *lifesavers@britishima.org*

Introduction

The incidence of out-of-hospital cardiac arrest (OHCA) has become a global health disparity. Globally, it is estimated that less than 10% of patients will survive, after suffering an OHCA[1]. Several studies [2,3] have identified the rate of OHCAs are significantly increasing, however survival rates post-OHCA are higher in patients having received bystander CPR in Western countries.

Initiated in three Mosques in 2014, the British Islamic Medical Association (BIMA)'s Lifesavers project aims to teach basic life-support (BLS) skills across the nation[4]. The project takes a unique approach, led by healthcare professionals from within local communities utilising Mosques as the beating heart of the community. The Lifesavers project aims to bring together local healthcare professionals to unite and inspire one another and serve their local community through teaching universally recognised basic life support skills *i.e., cardiopulmonary resuscitation, recovery position and choking management*. These skills equip communities, irrespective of their age, gender, ethnicity, or social status to save lives and help improve survival rates after out-of-hospital cardiac arrests. Today, the project has evolved to be delivered in over 80 Mosques nationally, and 12 countries internationally, culminating interest from several other countries.

In this article, we have used 'The Project Management Triangle'[5] to identify aspects of the project which facilitate the expansion and replicability of the project, in lieu of socio-economic prospects.

Scope

Whilst recognising the gap in knowledge in ethnic minorities and low-income backgrounds[6], Lifesavers has been replicated in Malawi, Australia, Pakistan, Zimbabwe, Afghanistan, and several other countries; with the vision to continue to cut across borders and expand to Europe, America, and other parts of Africa. The project has culminated interest from many Muslim and non-Muslim community organisations, networks and projects including sports clubs, youth organisations and PTFA networks.

Generally, BLS is taught across most healthcare disciplines and to the majority of its professionals, creating a vast pool of skilled individuals who can be relied on to organise and deliver BLS teaching. The simplicity of BLS allows it to be standardised effectively on both a national and international level through various institutions and organisations that enforce this standardisation. This means that volunteers are likely to be on the same page regarding what information is delivered to participants of the project, with very few differing opinions on the actual substance of the skills to be taught. Along the same lines, resources concerning BLS education [7] are abundant, and the majority are free of charge, easing the development of a comprehensive, interactive programme and flexibility in its delivery by the diverse team of healthcare professionals who teach it.

Cost

Inexpensiveness is another important factor in the success of delivering such a programme, particularly when many BLS courses are costly. The localised, community-led nature of the programme allows for members of a community to come together in support of the project and offer services free of charge. This applies at every level, from the venue (mosque) where the project is delivered, to the audio-video equipment required to deliver the teaching, and importantly, the provision of teaching being on a kind-hearted voluntary basis. This enhances the repeatability of and access to the project as money is not a barrier. At participant level, this ensures that these vital skills can finally reach the communities who need it the most - those of lower socioeconomic status who also happen to suffer from the most health inequalities, including awareness of and ability to carry out BLS in the community.

The cost has further been reduced through delivering the project without CPR Mannequins e.g. Annie's. Encouraging the use of alternatives such as pillows, teddy bears and other improvised methods to demonstrate and teach have reduced the need for logistical planning e.g. resource allocation and allowed the project to expand into remote areas, where resources may not be vastly available.

Time

Now in the eighth year of the project, adjustments have been made annually to optimise the model for maximum efficacy with delivery, considering feedback from attendees. Volunteers ensure audio-visual equipment is tested in advance and in place for the day, with backup options readily available to ensure the event runs smoothly. Our regional training day also ensures standardisation across all mosques hosting the event, allowing volunteers to practice and receive feedback in a simulated environment on the most effective methods to teach the attendees.

On event day itself, a strict timetable is followed to ensure attendees have time to assimilate the information, fully comprehend it and action it, with targeted feedback for each individual participant regarding technique. This is especially important when considering that cardiac output can be linearly related to chest compression depth[8], highlighting the importance of teaching *effective* BLS skills.

Conclusion

The BIMA Lifesavers model has proven to be highly effective in delivering BLS training, reflected in the noted increase in confidence in delivering BLS by attendees. It also provides a unique opportunity to build positive relationships within ethnic minority communities and tackle health disparities at a community level in an accessible manner.

Acknowledgements

We would like to thank all the volunteers, who organised, supported, and delivered Lifesavers 2021 to their local communities.

Conflict of Interest

All authors have been involved within BIMA Lifesavers project in 2021, in voluntary and unpaid roles. BIMA is a not-for-profit and independent organisation. BIMA Lifesavers is the flagship project of BIMA which offers basic life support training to the community. The authors declare no financial conflicts of interest.

References

1. The Lancet. Out-of-hospital cardiac arrest: a unique medical emergency. The Lancet. 2018;391(10124):911.

2. Berdowski J, Berg R, Tijssen J, Koster R. Global incidences of out-of-hospital cardiac arrest and survival rates: Systematic review of 67 prospective studies. Resuscitation. 2010;81(11):1479-1487.

3. Kragholm K, Wissenberg M, Mortensen R, Hansen S, Malta Hansen C, Thorsteinsson K et al. Bystander Efforts and 1-Year Outcomes in Out-of-Hospital Cardiac Arrest. New England Journal of Medicine. 2017;376(18):1737-1747.

4. Lifesavers | British Islamic Medical Association [Internet]. British Islamic Medical Association | British Islamic Medical Association. 2021 [cited 11 November 2021]. Available from: https://www.britishima.org/lifesavers/

5. Atkinson R. Project management: cost, time, and quality, two best guesses and a phenomenon, its time to accept other success criteria. International Journal of Project Management. 1999;17(6):337-342.

6. Yan S, Gan Y, Jiang N, Wang R, Chen Y, Luo Z et al. The global survival rate among adult out-of-hospital cardiac arrest patients who received cardiopulmonary resuscitation: a systematic review and meta-analysis. Critical Care. 2020;24(1).

7. 2021 Resuscitation Guidelines [Internet]. Resuscitation Council UK. 2021 [cited 11 November 2021]. Available from: https://www.resus.org.uk/library/2021-resuscitation-guidelines

8. Babbs C, Voorhees W, Fitzgerald K, Holmes H, Geddes L. Relationship of blood pressure and flow during CPR to chest compression amplitude: Evidence for an effective compression threshold. Annals of Emergency Medicine. 1983;12(9):527-532