A close-up photograph showing a person's hands performing cardiopulmonary resuscitation (CPR) on a mannequin. One hand is positioned on the mannequin's chest, providing compressions, while the other hand holds a clear plastic resuscitation mask with a blue valve. The background is a soft-focus red.

**2020
-2025**

Guidelines and
Standards

ACLS

Advanced Cardiac Life Support

Provider Handbook

By Dr. Karl Disque





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Version 2021.01



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INTRODUCTION TO ACLS

The goal of Advanced Cardiovascular Life Support (ACLS) is to achieve the best possible outcome for individuals who are experiencing a life-threatening event. ACLS is a series of evidence-based responses simple enough to be committed to memory and recalled under moments of stress. These ACLS protocols have been developed through research, patient case studies, clinical studies, and opinions of experts in the field. The gold standard in the United States and other countries is the course curriculum published by the International Liaison Committee on Resuscitation (ILCOR).

Previously, the ILCOR published periodic updates to their Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) guidelines on a five-year cycle, with the most recent update published in 2020. Moving forward, the ILCOR will no longer wait five years between updates; instead, it will maintain the most up-to-date recommendations online at ECCguidelines.heart.org. Health care providers are recommended to supplement the materials presented in this handbook with the guidelines published by the ILCOR and refer to the most current interventions and rationales throughout their study of ACLS.

Refer to the Basic Life Support (BLS) Provider Handbook, also Presented by the Save a Life Initiative, for a more comprehensive review of the BLS Survey. This handbook specifically covers ACLS algorithms and only briefly describes BLS. All ACLS providers are presumed capable of performing BLS correctly. While this handbook covers BLS basics, it is essential that ACLS providers be proficient in BLS first.

While ACLS providers should always be mindful of timeliness, it is important to provide the intervention that most appropriately fits the needs of the individual. Proper utilization of ACLS requires rapid and accurate assessment of the individual's condition. This not only applies to the provider's initial assessment of an individual in distress, but also to the reassessment throughout the course of treatment with ACLS.

ACLS protocols assume that the provider may not have all of the information needed from the individual or all of the resources needed to properly use ACLS in all cases. For example, if a provider is utilizing ACLS on the side of the road, they will not have access to sophisticated devices to measure breathing or arterial blood pressure. Nevertheless, in such situations, ACLS providers have the framework to provide the best possible care in the given circumstances. ACLS algorithms are based on past performances and

results in similar life-threatening cases and are intended to achieve the best possible outcome for the individual during emergencies. The foundation of all algorithms involves the systematic approach of the BLS Survey and the ACLS Survey (using steps ABCD) that you will find later in this handbook.



THE INITIAL ASSESSMENT

Determining whether an individual is conscious or unconscious can be done very quickly. If you notice someone in distress, lying down in a public place, or possibly injured, call out to them.

- *Make sure the scene is safe before approaching the individual and conducting the BLS or ACLS Survey.*
 - *When encountering an individual who is “down,” the first assessment to make is whether they are conscious or unconscious.*
-

If the individual is unconscious, then start with the BLS Survey ([Figure 20](#)) and move on to the ACLS Survey ([Figure 9](#)).

If they are conscious and responsive, obtain consent to provide care and continue assessment and questioning to determine next steps.



BASIC LIFE SUPPORT

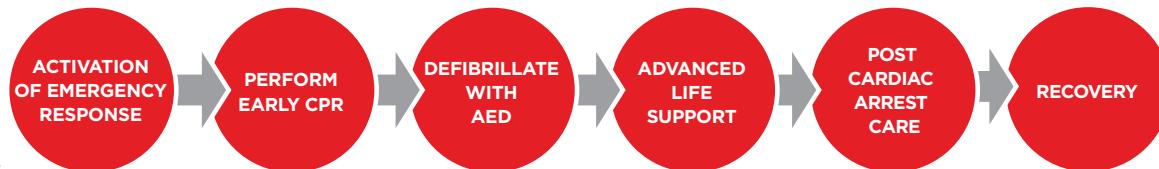
The ILCOR has updated the Basic Life Support (BLS) course over the years as new research in cardiac care has become available. Cardiac arrest continues to be a leading cause of death in the United States. BLS guidelines have changed dramatically, and the elements of BLS continue to be some of the most important steps in initial treatment. General concepts of BLS include:

- Quickly starting the Chain of Survival.
- Delivering high-quality chest compressions for adults, children, and infants.
- Knowing where to locate and understanding how to use an Automated External Defibrillator (AED).
- Providing rescue breathing when appropriate.
- Understanding how to perform as a team.
- Knowing how to treat choking.

INITIATING THE CHAIN OF SURVIVAL

Early initiation of BLS has been shown to increase the probability of survival for an individual dealing with cardiac arrest. To increase the odds of surviving a cardiac event, the rescuer should follow the steps in the Adult Chain of Survival ([Figure 1](#)).

Adult Chain of Survival



[Figure 1](#)



Emergencies in children and infants are not usually caused by the heart. Children and infants most often have breathing problems that trigger cardiac arrest. The first and most important step of the Pediatric Chain of Survival (*Figure 2*) is prevention.

Pediatric Chain of Survival



Figure 2

2020 CPR GUIDELINE CHANGES

Approximately every five years the International Liaison Committee on Resuscitation (ILCOR), updates the guidelines for CPR and ECC (Emergency Cardiac Care).

The content contained herein is based on the most recent ILCOR publications on BLS.

Recommendations for adult basic life support (BLS) from the 2020 Guidelines for CPR and ECC include the following:

- The importance of early initiation of CPR by lay rescuers has been re-emphasized. The risk of harm to the patient is low if the patient is not in cardiac arrest. Bystanders should not be afraid to start CPR even if they are not sure whether the victim is breathing or in Cardiac Arrest.
- A sixth link, Recovery, was added to the Chains of Survival for both Pediatric and Adults.
- Care of the patient after return of spontaneous circulation (ROSC) requires close attention to oxygenation, blood pressure control, evaluation for percutaneous coronary intervention, targeted temperature management, and multimodal neuroprognostication.
- Because recovery from cardiac arrest continues long after the initial hospitalization, patients should have formal assessment and support for their physical, cognitive, and psychosocial needs.
- After a resuscitation, debriefing for lay rescuers, EMS providers, and hospital-based healthcare workers may be beneficial to support their mental health and well-being.
- Management of cardiac arrest in pregnancy focuses on maternal resuscitation, with preparation for early perimortem cesarean delivery if necessary to save the infant and improve the chances of successful resuscitation of the mother.



BLS FOR ADULTS

BLS for adults focuses on doing several tasks simultaneously. In many situations, more than one person is available to do CPR. This choreographed method includes performing chest compressions, managing the airway, delivering rescue breaths, and using the AED, all as a team. By coordinating efforts, a team of rescuers can save valuable seconds when time lost equals damage to the heart and brain.

Simple Adult BLS Algorithm

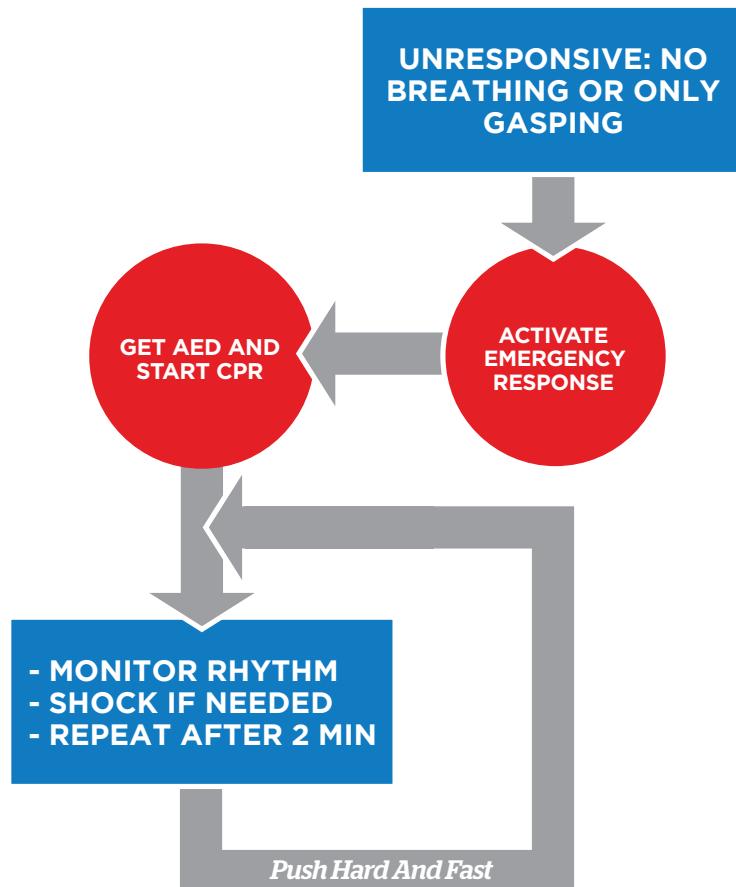


Figure 3



ONE-RESCUER BLS/CPR FOR ADULTS

Be Safe

- If inside, watch for dangers such as construction debris, unsecured weapons, violent individuals, electrical hazards.
- If outside, watch out for downed electrical wires, leaking fuel from car accidents, building collapse, or natural disaster/dangerous weather conditions. (Drowning persons should be removed from the water and dried off; they should also be removed from standing water, such as puddles, pools, gutters, etc.).
- Be sure you do not become injured yourself.

Assess the Person

- Tap hard on their shoulder and shout “Hey, are you OK?” Yell their name if you know it.
- Check to see if the person is breathing. (Agonal breathing, which is occasional gasping and is ineffective, does not count as breathing.)

Call EMS

- Send someone for help and to get an AED.
- If alone, call for help while assessing for breathing and pulse. (The ILCOR emphasizes that cell phones are available everywhere now and most have a built-in speakerphone. Call for help without leaving the person.)

CPR

- Check pulse simultaneously with checking for breathing. Do not pause more than 10 seconds to check for breathing and pulse.
- Begin chest compressions and delivering breaths.

Defibrillate

- Attach the AED when available.
- Listen and perform the steps as directed.

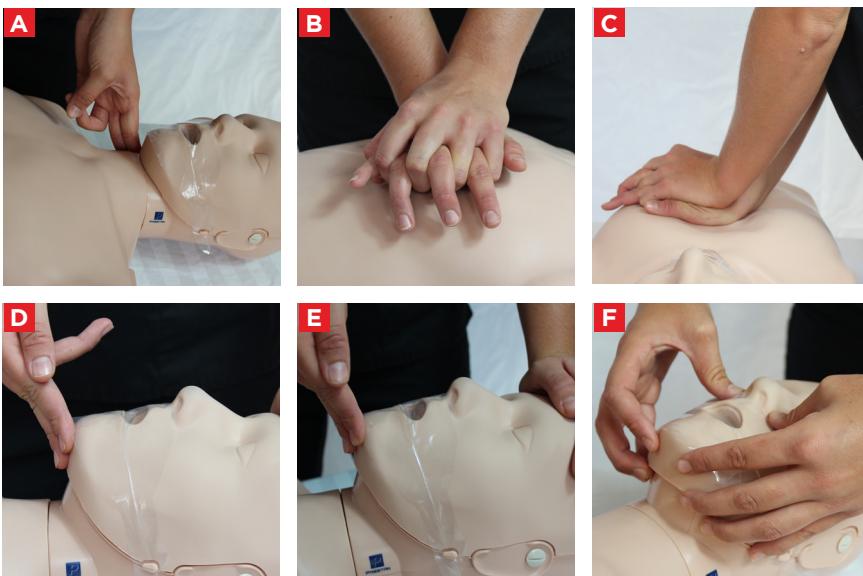


Figure 4

CPR Steps for Adults

1. Check for the carotid pulse on the side of the neck (*Figure 4a*). Keep in mind not to waste time trying to feel for a pulse; feel for no more than 10 seconds. If you are not sure you feel a pulse, begin CPR with a cycle of 30 chest compressions and two breaths.
2. Use the heel of one hand on the lower half of the sternum in the middle of the chest (*Figure 4b*).
3. Put your other hand on top of the first hand (*Figure 4b*).
4. Straighten your arms and press straight down (*Figure 4c*). Compressions should be 2 to 2.4" (5 to 6 cm) into the person's chest and at a rate of 100 to 120 compressions per minute.
5. Be sure that between each compression you completely stop pressing on the chest and allow the chest wall to return to its natural position. Leaning or resting on the chest between compressions can keep the heart from refilling in between each compression and make CPR less effective.
6. After 30 compressions, stop compressions and open the airway by tilting the head and lifting the chin (*Figure 4d & 4e*).
 - a. Put your hand on the person's forehead and tilt the head back.
 - b. Lift the person's jaw by placing your index and middle fingers on the lower jaw; lift up.
 - c. Do not perform the head-tilt/chin-lift maneuver if you suspect the person may have a neck injury. In that case, the jaw-thrust is used.
 - d. For the jaw-thrust maneuver, grasp the angles of the lower jaw and lift it with both hands, one on each side, moving the jaw forward. If their lips are closed, open the lower lip using your thumb (*Figure 4f*).
7. Give a breath while watching the chest rise. Repeat while giving a second breath. Breaths should be delivered over one second.
8. Resume chest compressions. Switch quickly between compressions and rescue breaths to minimize interruptions in chest compressions.



TWO-RESCUER BLS/CPR FOR ADULTS

Many times there will be a second person available who can act as a rescuer. The ILCOR emphasizes that cell phones are available everywhere now and most have a built-in speakerphone. Direct the second rescuer to call 911 or your local EMS number without leaving the person while you begin CPR. This second rescuer can also find an AED while you stay with the person. When the second rescuer returns, the CPR tasks can be shared:

1. The second rescuer prepares the AED for use.
2. You begin chest compressions and count the compressions out loud.
3. The second rescuer applies the AED pads.
4. The second rescuer opens the person's airway and gives rescue breaths.
5. Switch roles after every five cycles of compressions and breaths. One cycle consists of 30 compressions and two breaths for Adults.
6. Be sure that between each compression you completely stop pressing on the chest and allow the chest wall to return to its natural position. Leaning or resting on the chest between compressions can keep the heart from refilling in between each compression and make CPR less effective. Rescuers who become tired may tend to lean on the chest more during compressions; switching roles helps rescuers perform high-quality compressions.
7. Quickly switch between roles to minimize interruptions in delivering chest compressions.
8. When the AED is connected, minimize interruptions of CPR by switching rescuers while the AED analyzes the heart rhythm. If a shock is indicated, minimize interruptions in CPR. Resume CPR as soon as possible with chest compressions.



Figure 5

ADULT MOUTH-TO-MASK VENTILATION

In one-rescuer CPR, breaths should be supplied using a pocket mask, if available.

1. Give 30 high-quality chest compressions.
2. Seal the mask against the person's face by placing four fingers of one hand across the top of the mask and the thumb of the other hand along the bottom edge of the mask (*Figure 5a*).
3. Using the fingers of your hand on the bottom of the mask, open the airway using the head-tilt/chin-lift maneuver. (Don't do this if you suspect the person may have a neck injury) (*Figure 5b*).
4. Press firmly around the edges of the mask and ventilate by delivering a breath over one second as you watch the person's chest rise (*Figure 5c*).



Figure 6

ADULT BAG-MASK VENTILATION IN TWO-RESCUER CPR

If two people are present and a bag-mask device is available, the second rescuer is positioned at the victim's head while the other rescuer performs high-quality chest compressions. Give 30 high-quality chest compressions.

1. Deliver 30 high-quality chest compressions while counting out loud (*Figure 6a*).
2. The second rescuer holds the bag-mask with one hand using the thumb and index finger in the shape of a "C" on one side of the mask to form a seal between the mask and the face, while the other fingers open the airway by lifting the person's lower jaw (*Figure 6b*).
3. The second rescuer gives two breaths over one second each as you watch the person's chest rise (*Figure 6c*).
4. Practice using the bag valve mask; it is essential to forming a tight seal and delivering effective breaths.



Adult BLS Algorithm

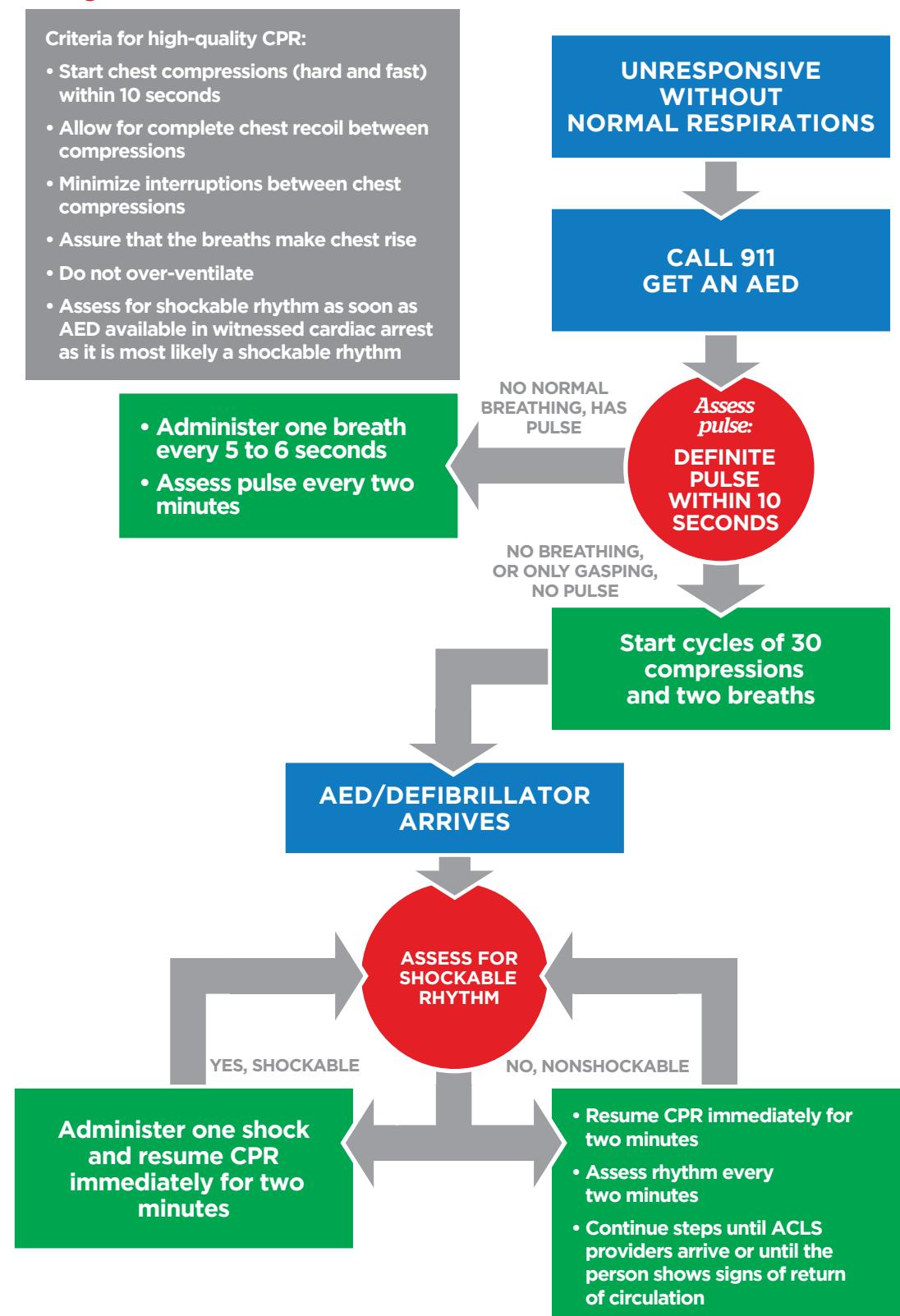


Figure 7



BLS FOR CHILDREN/INFANTS

BLS for children and infants also focuses on doing several tasks simultaneously. In many situations, more than one person is available to do CPR.

This simultaneous and choreographed method includes performing chest compressions, managing the airway, delivering rescue breaths, and using the AED, all as a team. By coordinating efforts, a team of rescuers can save valuable seconds when time lost equals damage to the heart and brain.

ONE-RESCUER BLS/CPR FOR CHILDREN (AGE 1 TO PUBERTY)

Be Safe

- Move the child out of traffic or any unsafe situation.
- Move the child out of water and dry the child. (Drowning children should be removed from the water and dried off; they should also be removed from standing water, such as puddles, pools, gutters, etc.)
- Be sure you do not become injured yourself.

Assess the Child

- Shake the child and talk to them loudly. Also tap their shoulder and shout their name.
- Check to see if the child is breathing while simultaneously checking their carotid pulse. (Agonal breathing, which is occasional gasping and is ineffective, does not count as breathing.)
- Keep in mind not to waste time trying to feel for a pulse; feel for at least 5 seconds but no more than 10 seconds. If you are not sure you feel a pulse, begin CPR with a cycle of 15 chest compressions and two breaths.

Call EMS

- Send someone for help and to get an AED.
- If alone, shout for help while assessing for breathing and pulse. (The ILCOR emphasizes that cell phones are available everywhere now and most have a built-in speakerphone. Call for help without leaving the child.)
- If no one answers and you do not have a cell phone available, perform 2 minutes of CPR before taking a moment to find help.

CPR

- Begin CPR with chest compressions and delivering breaths in a ratio of 15:2.

Defibrillate

- Attach the AED when it becomes available. Use pediatric pads for children under the age of 8 and less than 55 pounds (25 kg).
- Listen to the AED and perform the steps as directed.



CPR STEPS FOR CHILDREN

1. Use the heel of one hand on the lower half of the sternum in the middle of the chest.
2. Put your other hand on top of the first hand.
3. Straighten your arms and press straight down. Compressions should be about two inches (5 cm) into the child's chest and at a rate of 100 to 120 compressions per minute.
4. Be sure that between each compression you completely stop pressing on the chest and allow the chest wall to return to its natural position. Leaning or resting on the chest between compressions can keep the heart from refilling in between each compression and make CPR less effective.
5. After 15 compressions, stop compressions and open the airway by tilting the head and lifting the chin.
 - a. Put your hand on the child's forehead and tilt the head back. Lift the child's jaw by placing your index and middle fingers on the lower jaw; lift up.
 - b. Do not perform the head-tilt/chin-lift maneuver if you suspect the child may have a neck injury. In that case, the jaw-thrust is used. Lift the child's jaw by placing your index and middle fingers on the lower jaw; lift straight up. If their lips are closed, open the lower lip using your thumb.
6. Give a breath while watching the chest rise. Repeat while giving a second breath. Breaths should be delivered over one second.
7. Resume chest compressions. Switch quickly between compressions and rescue breaths to minimize interruptions in chest compressions.



ONE-RESCUER BLS/CPR FOR INFANT (NEWBORN TO AGE 12 MONTHS)

Be Safe

- Move the infant out of traffic or any unsafe situation.
- Move the infant out of water and dry the infant. (Drowning infants should be removed from the water and dried off; they should also be removed from standing water, such as puddles, pools, gutters, etc.)
- Be sure you do not become injured yourself.

Assess the Infant

- Shake the infant and talk to them loudly. Also tap the bottom of their foot and shout their name.
- Check to see if the infant is breathing while simultaneously checking their brachial pulse. (Agonal breathing, which is occasional gasping and is ineffective, does not count as breathing.)
- Keep in mind not to waste time trying to feel for a pulse; feel for at least 5 seconds but no more than 10 seconds. If you are not sure you feel a pulse, begin CPR with a cycle of 15 chest compressions and two breaths.

Call EMS

- Send someone for help and to get an AED.
- If alone, shout for help while assessing for breathing and pulse. (The ILCOR emphasizes that cell phones are available everywhere now and most have a built-in speakerphone. Call for help without leaving the infant.)
- If no one answers and you do not have a cell phone available, perform 2 minutes of CPR before taking a moment to find help.

CPR

- Begin CPR with chest compressions and delivering breaths in a ratio of 15:2.

Defibrillate

- Attach the AED when it becomes available. Use pediatric pads for infants and place the pads in an anterior-posterior position if they would overlap on the front of the chest.
- Listen to the AED and perform the steps as directed.



CPR STEPS FOR INFANTS

1. Place 2 or 3 fingers of one hand on the sternum in the middle of the nipple line (*Figure 47*).
2. Press straight down. Compressions should be 1.5 inches (4 cm) into the infant's chest (or about 1/3 the diameter of the chest) and at a rate of 100 to 120 compressions per minute.
3. Be sure that between each compression you completely stop pressing on the chest and allow the chest wall to return to its natural position. Leaning or resting on the chest between compressions can keep the heart from refilling in between each compression and make CPR less effective.
4. After 15 compressions, stop compressions and open the airway by tilting the head and lifting the chin.
 - a. Put your hand on the infant's forehead and tilt the head back. Lift the infant's jaw by placing your index and middle fingers on the lower jaw; lift up. Aim for a neutral neck position and do not overextend the neck.
 - b. Do not perform the head-tilt/chin-lift maneuver if you suspect the infant may have a neck injury. In that case, the jaw-thrust is used. Lift the infant's jaw by placing your index and middle fingers on the lower jaw; lift straight up. If their lips are closed, open the lower lip using your thumb.
5. Give a breath while watching the chest rise. Repeat while giving a second breath. Breaths should be delivered over one second.
6. Resume chest compressions. Switch quickly between compressions and rescue breaths to minimize interruptions in chest compressions.



Figure 47



CHILD/INFANT MOUTH-TO-MASK VENTILATION

In one-rescuer CPR, breaths should be supplied using a pediatric pocket mask, if available.

1. Deliver 15 high-quality chest compressions while counting out loud.
2. Seal the mask against the child's face by placing four fingers of one hand across the top of the mask and the thumb of the other hand along the bottom edge of the mask (*Figure 48*).
3. Using the fingers of your hand on the bottom of the mask, open the airway using the head-tilt/chin-lift maneuver. (Don't do this if you suspect the child may have a neck injury).
4. Press firmly around the edges of the mask and ventilate by delivering a breath over one second as you watch the child's chest rise.
5. Practice using the pocket mask; it is essential to form a tight seal in delivering effective breaths.



Figure 48

CHILD/INFANT BAG-VALVE-MASK VENTILATION IN TWO-RESCUER CPR

If two people are present and a bag-valve-mask device (BVM) is available, the second rescuer is positioned at the victim's head while the other rescuer performs high-quality chest compressions.

1. Deliver 15 high-quality chest compressions while counting out loud.
2. The second rescuer holds the BVM with one hand using the thumb and index finger in the shape of a "C" on one side of the mask to form a seal between the mask and the face (*Figure 49*), while the other fingers open the airway by lifting the child's lower jaw.
3. The first rescuer squeezes the bag giving two breaths over one second each. Watch for chest rise.
4. Practice using the BVM; it is essential to form a tight seal in delivering effective breaths.



Figure 49



SELF-ASSESSMENT FOR BLS

1. Which of the following is true regarding BLS?
 - a. It is obsolete.
 - b. Recent changes prohibit mouth-to-mouth.
 - c. It should be mastered prior to ACLS.
 - d. It has little impact on survival.
2. What is the first step in the assessment of an individual found “down”?
 - a. Check their blood pressure.
 - b. Check their heart rate.
 - c. Check to see if they are conscious or unconscious.
 - d. Check their pupil size.
3. What factor is critical in any emergency situation?
 - a. Scene safety
 - b. Age of the individual
 - c. Resuscitation status
 - d. Pregnancy status
4. CPR is initiated on an Adult and the person’s pulse returns, but he is not breathing. What ventilation rate should be used for this person?
 - a. 6-8 breaths per minute
 - b. 10-12 breaths per minute
 - c. 18-20 breaths per minute
 - d. Depends on his color
5. Arrange the BLS Chain of Survival in the proper order:
 - a. Look, listen, and feel
 - b. Check responsiveness, call EMS and get AED, defibrillation, and recovery
 - c. Check responsiveness, call EMS and get AED, chest compressions, early defibrillation, and recovery
 - d. Call for help, shock, check pulse, shock, and transport
6. After activating EMS and sending someone for an AED, which of the following is correct for one-rescuer BLS of an unresponsive individual with no pulse?
 - a. Start rescue breathing.
 - b. Apply AED pads.
 - c. Run to get help.
 - d. Begin chest compressions.



ANSWERS

1. C
ACLS providers are presumed to have mastered BLS skills. CPR is a critical part of resuscitating cardiac arrest victims.
2. C
When responding to an individual who is “down,” first determine if they are conscious or not.
3. A
Always assess the safety of the scene in any emergency situation. Do not become injured yourself.
4. B
Most experts recommend a ventilation rate of 10-12 breaths per minute for adults.
5. C
The focus is on early CPR and defibrillation.
6. D
An unresponsive adult without a pulse must receive CPR, and chest compressions should be initiated immediately followed by ventilation.



ADVANCED CARDIAC LIFE SUPPORT

NORMAL HEART ANATOMY AND PHYSIOLOGY

Understanding normal cardiac anatomy and physiology is an important component of performing ACLS. The heart is a hollow muscle comprised of four chambers surrounded by thick walls of tissue (septum). The atria are the two upper chambers and the ventricles are the two lower chambers. The left and right halves of the heart work together to pump blood throughout the body. The right atrium (RA) and the right ventricle (RV) pump deoxygenated blood to the lungs where it becomes oxygenated. This oxygen-rich blood returns to the left atrium (LA) and then enters the left ventricle (LV). The LV is the main pump that delivers the newly oxygenated blood to the rest of the body.

Blood leaves the heart through a large vessel known as the aorta. Valves between each pair of connected chambers prevent the backflow of blood. The two atria contract simultaneously, as do the ventricles, making the contractions of the heart go from top to bottom. Each beat begins in the RA. The LV is the largest and thickest-walled of the four chambers, as it is responsible for pumping the newly oxygenated blood to the rest of the body. The sinoatrial (SA) node in the RA creates the electrical activity that acts as the heart's natural pacemaker. This electrical impulse then travels to the atrioventricular (AV) node, which lies between the atria and ventricles. After pausing there briefly, the electrical impulse moves on to the His – Purkinje system, which acts like wiring to conduct the electrical signal into the LV and RV. This electrical signal causes the heart muscle to contract and pump blood.

By understanding the normal electrical function of the heart, it will be easy to understand abnormal functions. When blood enters the atria of the heart, an electrical impulse that is sent out from the SA node conducts through the atria resulting in atrial contraction.

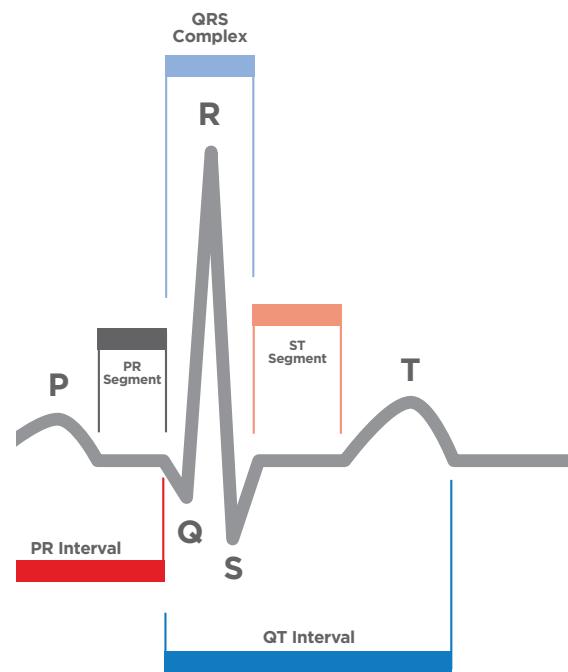


Figure 8



This atrial contraction registers on an electrocardiogram (ECG) strip as the P wave. This impulse then travels to the AV node, which in turn conducts the electrical impulse through the Bundle of His, bundle branches, and Purkinje fibers of the ventricles causing ventricular contraction. The time between the start of atrial contraction and the start of ventricular contraction registers on an ECG strip as the PR interval. The ventricular contraction registers on the ECG strip as the QRS complex. Following ventricular contraction, the ventricles rest and repolarize, which is registered on the ECG strip as the T wave. The atria also repolarize, but this coincides with the QRS complex, and therefore, cannot be observed on the ECG strip. Together a P wave, QRS complex, and T wave at proper intervals are indicative of normal sinus rhythm (NSR) (*Figure 8*). Abnormalities that are in the conduction system can cause delays in the transmission of the electrical impulse and are detected on the ECG. These deviations from normal conduction can result in dysrhythmias such as heart blocks, pauses, tachycardias and bradycardias, blocks, and dropped beats. These rhythm disturbances will be covered in more detail further in the handbook.

THE ACLS SURVEY (A-B-C-D)

AIRWAY

Monitor and maintain an open airway at all times. The provider must decide if the benefit of adding an advanced airway outweighs the risk of pausing CPR. If the individual's chest is rising without using an advanced airway, continue giving CPR without pausing. However, if you are in a hospital or near trained professionals who can efficiently insert and use the airway, consider pausing CPR.

BREATHING

In cardiac arrest, administer 100% oxygen. Keep blood O₂ saturation (sats) greater than or equal to 94 percent as measured by a pulse oximeter. Use quantitative waveform capnography when possible. Normal partial pressure of CO₂ is between 35 to 40 mmHg. High-quality CPR should produce a ETCO₂ between 10 to 20 mmHg. If the ETCO₂ reading is less than 10 mmHg after 20 minutes of CPR for an intubated individual, then you may consider stopping resuscitation attempts.

CIRCULATION

Obtain intravenous (IV) access, when possible; intraosseous access (IO) is also acceptable. Monitor blood pressure with a blood pressure cuff or intra-arterial line if available. Monitor the heart rhythm using pads and a cardiac monitor. When using an AED, follow the directions (i.e., shock a shockable rhythm). Give fluids when appropriate. Use cardiovascular medications when indicated.

DIFFERENTIAL DIAGNOSIS

Start with the most likely cause of the arrest and then assess for less likely causes. Treat reversible causes and continue CPR as you create a differential diagnosis. Stop only briefly to confirm a diagnosis or to treat reversible causes. Minimizing interruptions in perfusion is key.

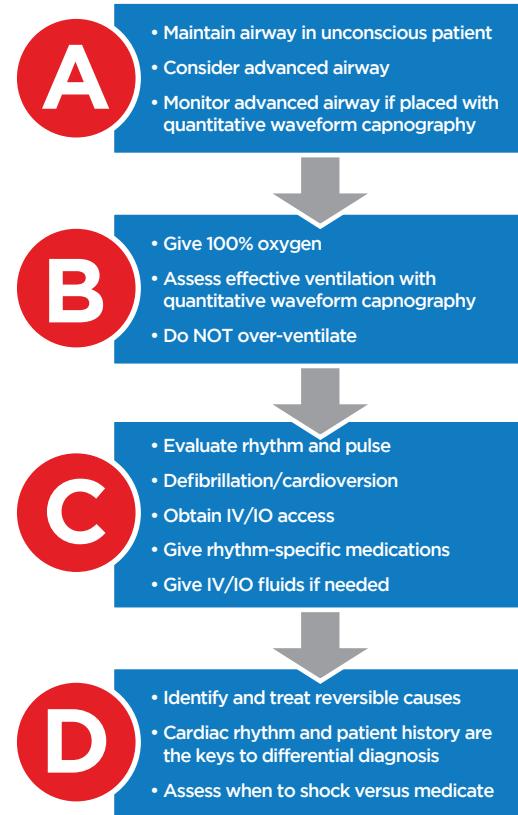


Figure 9

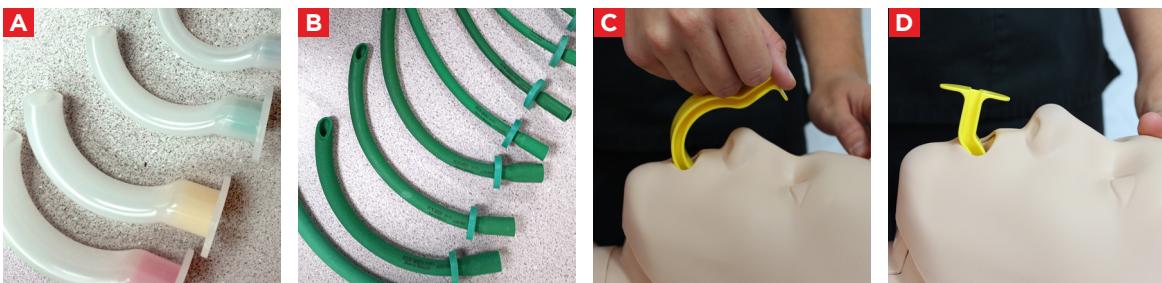


Figure 10

AIRWAY MANAGEMENT

If bag-mask ventilation is adequate, providers may defer insertion of an advanced airway. Health care providers should make the decision as to the appropriateness of placing an advanced airway during the ACLS Survey. The value of securing the airway must be balanced against the need to minimize the interruption in perfusion that results in halting compressions during airway placement.

Basic airway equipment includes the oropharyngeal airway (OPA) and the nasopharyngeal airway (NPA). The primary difference between an OPA (*Figure 10a*) and a NPA (*Figure 10b*) is that an OPA is placed in the mouth (*Figure 10c and 10d*) while an NPA is inserted through the nose. Both airway equipment terminate in the pharynx. The main advantage of an NPA over an OPA is that it can be used in either conscious or unconscious individuals because the device does not stimulate the gag reflex.

Advanced airway equipment includes the laryngeal mask airway, laryngeal tube, esophageal-tracheal tube, and endotracheal tube. Different styles of these supraglottic airways are available. If it is within your scope of practice, you may use advanced airway equipment when appropriate and available.



BASIC AIRWAY ADJUNCTS

OROPHARYNGEAL AIRWAY (OPA)

The OPA is a J-shaped device that fits over the tongue to hold the soft hypopharyngeal structures and the tongue away from the posterior wall of the pharynx. OPA is used in individuals who are at risk for developing airway obstruction from the tongue or from relaxed upper airway muscle. A properly sized and inserted OPA results in proper alignment with the glottis opening.

If efforts to open the airway fail to provide and maintain a clear, unobstructed airway, then use the OPA in unconscious victims. An OPA should not be used in a conscious or semiconscious individual, because it can stimulate gagging, vomiting, and possible aspiration. The key assessment to determine if an OPA can be placed is to check if the individual has an intact cough and gag reflex. If so, do not use an OPA.

NASOPHARYNGEAL AIRWAY (NPA)

The NPA is a soft rubber or plastic uncuffed tube that provides a conduit for airflow between the nares and the pharynx. It is used as an alternative to an OPA in individuals who need a basic airway management adjunct.

- *Only use an OPA in unresponsive individuals with NO cough or gag reflex. Otherwise, an OPA may stimulate vomiting, laryngeal spasm, or aspiration.*
- *An NPA can be used in conscious individuals with intact cough and gag reflex. However, use carefully in individuals with facial trauma due to the risk of displacement.*
- *Keep in mind that the individual is not receiving 100% oxygen while suctioning. Interrupt suctioning and administer oxygen if any deterioration in clinical picture is observed during suctioning.*

Unlike the oral airway, NPAs may be used in conscious or semiconscious individuals (individuals with intact cough and gag reflex). The NPA is indicated when insertion of an OPA is technically difficult or dangerous. NPA placement can be facilitated by the use of a lubricant. Never force placement of the NPA as severe nosebleeds may occur. If it does not fit in one nare, try the other side. Use caution or avoid placing NPAs in individuals with obvious facial fractures.

SUCTIONING

Suctioning is an essential component of maintaining a patent airway. Providers should suction the airway immediately if there are copious secretions, blood, or vomit. Attempts at suctioning should not exceed 10 seconds. To avoid hypoxemia, follow suctioning attempts with a short period of 100% oxygen administration.

Monitor the individual's heart rate, oxygen saturation, and clinical appearance during suctioning. If a change in monitoring parameters is seen, interrupt suctioning and administer oxygen until the heart rate returns to normal and until clinical condition improves. Assist ventilation as warranted.



BASIC AIRWAY TECHNIQUE

INSERTING AN OPA

STEP 1: Clear the mouth of blood and secretions with suction if possible.

STEP 2: Select an airway device that is the correct size for the person.

- Too large of an airway device can damage the throat.
- Too small of an airway device can press the tongue into the airway.

STEP 3: Place the device at the side of the person's face. Choose the device that extends from the corner of the mouth to the earlobe.

STEP 4: Insert the device into the mouth so the point is toward the roof of the mouth or parallel to the teeth.

- Do not press the tongue back into the throat.

STEP 5: Once the device is almost fully inserted, turn it until the tongue is cupped by the interior curve of the device.

INSERTING AN NPA

STEP 1: Select an airway device that is the correct size for the person.

STEP 2: Place the device at the side of the person's face. Choose the device that extends from the tip of the nose to the earlobe. Use the largest diameter device that will fit.

STEP 3: Lubricate the airway with a water-soluble lubricant or anesthetic jelly.

STEP 4: Insert the device slowly, moving straight into the face (not toward the brain).

STEP 5: It should feel snug; do not force the device into the nostril. If it feels stuck, remove it and try the other nostril.

TIPS ON SUCTIONING

- *OPAs too large or too small may obstruct the airway.*
- *NPAs sized incorrectly may enter the esophagus.*
- *Always check for spontaneous respirations after insertion of either device.*

- When suctioning the oropharynx, do not insert the catheter too deeply. Extend the catheter to the maximum safe depth and suction as you withdraw.
- When suctioning an endotracheal (ET) tube, keep in mind the tube is within the trachea and that you may be suctioning near the bronchi or lung. Therefore, sterile technique should be used.
- Each suction attempt should be for no longer than 10 seconds. Remember the person will not get oxygen during suctioning.
- Monitor vital signs during suctioning and stop suctioning immediately if the person experiences hypoxemia (oxygen sats less than 94%), has a new arrhythmia or becomes cyanotic.



ADVANCED AIRWAY ADJUNCTS

ENDOTRACHEAL TUBE

The endotracheal (ET) tube is an advanced airway alternative. It is a specific type of tracheal tube that is inserted through the mouth or nose. It is the most technically difficult airway to place; however, it is the most secure airway available. Only experienced providers should perform ET intubation. This technique requires the use of a laryngoscope. Fiber optic portable laryngoscopes have a video screen, improve success, and are gaining popularity for field use.

LARYNGEAL MASK AIRWAY

The laryngeal mask airway (LMA) is an advanced airway alternative to ET intubation and provides comparable ventilation. It is acceptable to use the LMA as an alternative to an esophageal-tracheal tube for airway management in cardiac arrest. Experience will allow rapid placement of the LMA device by an ACLS provider.

LARYNGEAL TUBE

The advantages of the laryngeal tube are similar to those of the esophageal-tracheal tube; however, the laryngeal tube is more compact and less complicated to insert. This tube has only one larger balloon to inflate and can be inserted blindly.

ESOPHAGEAL-TRACHEAL TUBE

The esophageal-tracheal tube (sometimes referred to as a combitube) is an advanced airway alternative to ET intubation. This device provides adequate ventilation comparable to an ET tube. The combitube has two separate balloons that must be inflated and two separate ports. The provider must correctly determine which port to ventilate through to provide adequate oxygenation.

- *During CPR, the chest compression to ventilation rate for adults is 30:2.*
- *If advanced airway is placed, do not interrupt chest compressions for breaths. Give one breath every 6 seconds with continuous chest compressions.*



ROUTES OF ACCESS

Historically in ACLS, providers have administered drugs via the intravenous (IV) or the ET route. ET absorption of drugs is poor, and optimal drug dosing is unknown. Therefore, the intraosseous (IO) route is now preferred when IV access is not available. Below are the priorities for vascular access.

INTRAVENOUS ROUTE

A peripheral IV is preferred for drug and fluid administration unless central line access is already available. Central line access is not necessary during most resuscitation attempts, as it may cause interruptions in CPR and complications during insertion. Placing a peripheral line does not require CPR interruption.

If a drug is given via peripheral route of administration, do the following:

1. Intravenously push bolus injection (unless otherwise indicated).
2. Flush with 20 mL of fluid or saline.
3. Raise extremity for 10 to 20 seconds to enhance delivery of drug to circulation.

- *When using peripheral IV route of administration, drugs can take up to two minutes or more to reach central circulation. The effect of medications given may not be seen until even longer. High-quality CPR helps circulate these drugs and is an important part of resuscitation.*
- *Any ACLS drug or fluid that can be administered intravenously can also be given intraosseously.*

INTRAOSSEOUS ROUTE

Drugs and fluids can be delivered safely and effectively during resuscitation via the IO route if IV access is not available.

IO access can be used for all age groups, can be placed in less than one minute, and has more predictable absorption than the ET route.



PHARMACOLOGICAL TOOLS

Use of any of the ALCS medication in Table 1 should be done within your scope of practice and after thorough study of the actions and side effects. This table only provides a brief reminder for those who are already knowledgeable in the use of these medications. Moreover, Table 1 contains only adult doses, indications, and routes of administration for the most common ACLS drugs.

Doses, Routes, and Uses of Common Drug

DRUG	MAIN ACLS USE	DOSE/ROUTE	NOTES
Adenosine	<ul style="list-style-type: none">Narrow PSVT/SVTWide QRS tachycardia, avoid adenosine in irregular wide QRS	<ul style="list-style-type: none">6 mg IV bolus, may repeat with 12 mg in 1 to 2 min.	<ul style="list-style-type: none">Rapid IV push close to the hub, followed by a saline bolusContinuous cardiac monitoring during administrationCauses flushing and chest heaviness
Amiodarone	<ul style="list-style-type: none">VF/pulseless VTVT with pulseTachycardia rate control	<ul style="list-style-type: none">VF/VT: 300 mg dilute in 20 to 30 mL, may repeat 150 mg in 3 to 5 min	<ul style="list-style-type: none">Anticipate hypotension, bradycardia, and gastrointestinal toxicityContinuous cardiac monitoringVery long half-life (up to 40 days)Do not use in 2nd or 3rd-degree heart blockDo not administer via the ET tube route
Atropine	<ul style="list-style-type: none">Symptomatic bradycardia	<ul style="list-style-type: none">0.5 mg IV/IO every 3 to 5 minutesMax dose: 3 mg	<ul style="list-style-type: none">Cardiac and BP monitoringDo not use in glaucoma or tachyarrhythmiasMinimum dose 0.5 mg
	<ul style="list-style-type: none">Specific toxins/overdose (e.g. organophosphates)	<ul style="list-style-type: none">2 to 4 mg IV/IO may be needed	
Dopamine	<ul style="list-style-type: none">Shock/CHFSymptomatic bradycardia	<ul style="list-style-type: none">2 to 20 mcg/kg/minTitrate to desired blood pressure	<ul style="list-style-type: none">Fluid resuscitation firstCardiac and BP monitoring
Epinephrine	<ul style="list-style-type: none">Cardiac Arrest	<ul style="list-style-type: none">Initial: 1.0 mg (1:1000) IV or 2 to 2.5 mg (1:1000)Maintain: 0.1 to 0.5 mcg/kg/min Titrate to desire blood pressure	<ul style="list-style-type: none">Continuous cardiac monitoringNote: Distinguish between 1:1000 and 1:10000 concentrationsGive via central line when possible
	<ul style="list-style-type: none">Anaphylaxis	<ul style="list-style-type: none">0.3-0.5 mg IMRepeat every five minutes as needed	
	<ul style="list-style-type: none">Symptomatic bradycardia/Shock	<ul style="list-style-type: none">2 to 10 mcg/min infusionTitrate to response	
Lidocaine <i>(Lidocaine is recommended when Amiodarone is not available)</i>	<ul style="list-style-type: none">Cardiac Arrest (VF/VT)	<ul style="list-style-type: none">Initial: 1 to 1.5 mg/kg IV loadingSecond: Half of first dose in 5 to 10 minMaintain: 1 to 4 mg/min	<ul style="list-style-type: none">Cardiac and BP monitoringRapid bolus can cause hypotension and bradycardiaUse with caution in renal failure
	<ul style="list-style-type: none">Wide complex tachycardia with pulse	<ul style="list-style-type: none">Initial: 0.5 to 1.5 mg/kg IVSecond: Half of first dose in 5 to 10 minMaintain: 1 to 4 mg/min	
Magnesium Sulfate	<ul style="list-style-type: none">Cardiac arrest/ Pulseless torsades	<ul style="list-style-type: none">Cardiac Arrest: 1 to 2 gm diluted in 10 mL D5W IV/P	<ul style="list-style-type: none">Cardiac and BP monitoringRapid bolus can cause hypotension and bradycardiaUse with caution in renal failureCalcium chloride can reverse hypermagnesemia
	<ul style="list-style-type: none">Torsades de Pointes with pulse	<ul style="list-style-type: none">If not cardiac arrest: 1 to 2 gm IV over 5 to 60 minMaintain: 0.5 to 1 gm/hr IV	
Procainamide	<ul style="list-style-type: none">Wide QRS tachycardiaPreferred for VT with pulse (stable)	<ul style="list-style-type: none">20 to 50 mg/min IV until rhythm improves, hypotension occurs, QRS widens by 50% or MAX dose is givenMAX dose: 17 mg/kgDrip: 1 to 2 gm in 250 to 500 mL at 1 to 4 mg/min	<ul style="list-style-type: none">Cardiac and BP monitoringCaution with acute MIMay reduce dose with renal failureDo not give with amiodaroneDo not use in prolonged QT or CHF
Sotalol	<ul style="list-style-type: none">TachyarrhythmiaMonomorphic VT3rd line anti-arrhythmic	<ul style="list-style-type: none">100 mg (1.5 mg/kg) IV over 5 min	<ul style="list-style-type: none">Do not use in prolonged QT

Table 1



SELF-ASSESSMENT FOR ACLS

1. An individual presents with symptomatic bradycardia. Her heart rate is 32. Which of the following are acceptable therapeutic options?
 - a. Atropine
 - b. Epinephrine
 - c. Dopamine
 - d. All of the above
2. A person with alcoholism collapses and is found to be in Torsades de Pointes. What intervention is most likely to correct the underlying problem?
 - a. Rewarm the individual to correct hypothermia.
 - b. Administer magnesium sulfate 1 to 2 gm IV diluted in 10 mL D5W to correct low magnesium.
 - c. Administer glucose to correct hypoglycemia.
 - d. Administer naloxone to correct narcotic overdose.
3. You have just administered a drug for an individual in supraventricular tachycardia (SVT). She complains of flushing and chest heaviness. Which drug is the most likely cause?
 - a. Aspirin
 - b. Adenosine
 - c. Amiodarone
 - d. Amitriptyline

ANSWERS

1. D
Atropine is the initial treatment for symptomatic bradycardia. If unresponsive, IV dopamine or epinephrine is the next step. Pacing may be effective if other measures fail to improve the rate.
2. B
Hypomagnesemia or low Mg++ is commonly caused by alcoholism and malnutrition. Administration of IV magnesium may prevent or terminate Torsades de Pointes.
3. B
Adenosine is the correct choice for SVT treatment and commonly results in reactions such as flushing, dyspnea, chest pressure, and lightheadedness.



PRINCIPLES OF EARLY DEFIBRILLATION

The earlier the defibrillation occurs, the higher the survival rate. When a fatal arrhythmia is present, CPR can provide a small amount of blood flow to the heart and the brain, but it cannot directly restore an organized rhythm. The likelihood of restoring a perfusing rhythm is optimized with immediate CPR and defibrillation. The purpose of defibrillation is to disrupt a chaotic rhythm and allow the heart's normal pacemakers to resume effective electrical activity.

The appropriate energy dose is determined by the design of the defibrillator—monophasic or biphasic. If you are using a monophasic defibrillator, give a single 360 J shock. Use the same energy dose on subsequent shocks. Biphasic defibrillators use a variety of waveforms and have been shown to be more effective for terminating a fatal arrhythmia. When using biphasic defibrillators, providers should use the manufacturer's recommended energy dose. Many biphasic defibrillator manufacturers display the effective energy dose range on the face of the device. If the first shock does not terminate the arrhythmia, it may be reasonable to escalate the energy delivered if the defibrillator allows it.

To minimize interruptions in chest compressions during CPR, continue CPR while the defibrillator is charging. Be sure to clear the individual by ensuring that oxygen is removed, and no one is touching the individual prior to delivering the shock. Immediately after the shock, resume CPR, beginning with chest compressions. Give CPR for two minutes (approximately five cycles). A cycle consists of 30 compressions followed by two breaths for an adult without an advanced airway. Those individuals with an advanced airway device in place can be ventilated at a rate of one breath every 5 to 6 seconds (or 10 to 12 breaths per minute).



KEYS TO USING AN AUTOMATED EXTERNAL DEFIBRILLATOR

If you look around the public places you visit, you are likely to find an Automated External Defibrillator (AED). An AED is both sophisticated and easy to use, providing life-saving power in a user-friendly device which makes it useful for people who have never operated one and for anyone in stressful scenarios. However, proper use of an AED is very important.

Attach the pads to the upper right side and lower left side of the individual's chest (*Figure 11*). Once the pads are attached correctly, the device will read the heart rhythm. If the pads are not attached appropriately, the device will indicate so with prompts. Once the rhythm is analyzed, the device will direct you to shock the individual if a shock is indicated. A shock depolarizes all heart muscle cells at once, attempting to organize its electrical activity. In other words, the shock is intended to reset the heart's abnormal electrical activity into a normal rhythm.

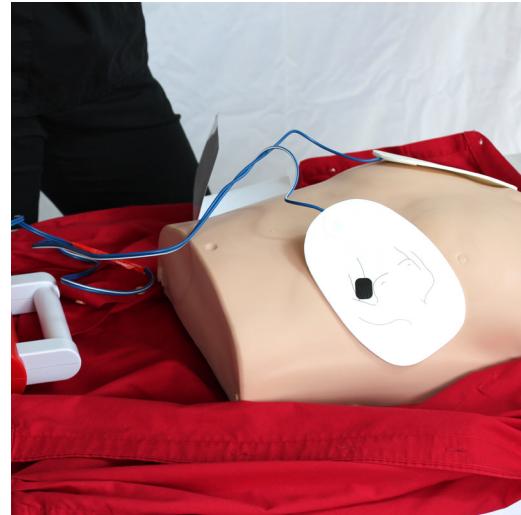


Figure 11

AED Key Points

Assure oxygen is NOT flowing across the patient's chest when delivering shock

Do NOT stop chest compressions for more than 10 seconds when assessing the rhythm

Stay clear of patient when delivering shock

Assess pulse after the first two minutes of CPR

If the end-tidal CO₂ is less than 10 mmHg during CPR, consider adding a vasopressor and improve chest compressions. However, after 20 minutes of CPR for an intubated individual, you may consider stopping resuscitation attempts.

Figure 12



CRITERIA TO APPLY AED

You should use an AED if:

- The individual does not respond to shouting or shaking their shoulders.
- The individual is not breathing or breathing ineffectively.
- The carotid artery pulse cannot be detected.

BASIC AED OPERATION

To use an AED, do the following:

1. Power on the AED.
2. Choose adult or pediatric pads.
3. Attach the pads to bare chest (not over medication patches) and make sure cables are connected. (Dry the chest if necessary.)
4. Place one pad on upper right side and the other on the chest a few inches below the left arm.
5. Clear the area to allow AED to read rhythm, which may take up to 15 seconds.
6. If the AED states “no shock advised”, restart CPR.
7. If the AED indicates a shock is needed, clear the individual, making sure no one is touching them and that the oxygen has been removed. Ensure visually that the individual is clear and shout “CLEAR!”
8. Press the “Shock” button.
9. Immediately resume CPR starting with chest compressions.
10. After two minutes of CPR, analyze the rhythm with the AED.
11. Continue to follow the AED prompts.

- *If the AED is not working properly, continue CPR. Do not waste excessive time troubleshooting the AED. CPR always comes first, and AEDs are supplemental.*
- *Do not use the AED in water.*
- *AED is not contraindicated in individuals with implanted defibrillator/pacemaker; however, do not place pad directly over the device.*



SYSTEMS OF CARE

The ILCOR guidelines describe Systems of Care as a separate and important part of ACLS provider training. These Systems of Care describe the organization of professionals necessary to achieve the best possible result for a given individual's circumstances. They include an overview of the ways life-saving interventions should be organized to ensure they are delivered efficiently and effectively. Hospitals, EMS staff, and communities that follow comprehensive Systems of Care demonstrate better outcomes for their patients than those who do not.

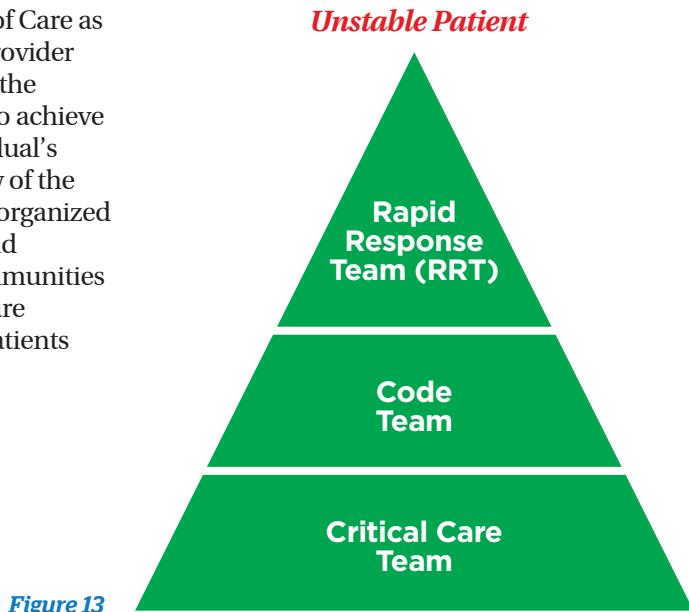


Figure 13

- *Management of life-threatening emergencies requires the integration of a multidisciplinary team that can involve rapid response teams (RRTs), cardiac arrest teams, and intensive care specialists to increase survival rates.*



CARDIOPULMONARY RESUSCITATION

Successful cardiopulmonary resuscitation (CPR) requires the use of it as part of a system of care called the Chain of Survival ([Figure 14](#)). As with any chain, it is only as strong as its weakest link. Thus, everyone must strive to make sure each link is strong. For instance, community leaders can work to increase awareness of the signs and symptoms of cardiac arrest and make AEDs available in public places. EMS crews must stay abreast of updates and innovations in resuscitation and hone the skills required to deliver CPR quickly and effectively. Hospitals should be ready to receive patients in cardiac arrest and provide excellent care. Critical care and reperfusion centers should be staffed by experts and equipped with the latest technology. Because recovery from cardiac arrest continues long after the initial hospitalization, patients should have formal assessment and support for their physical, cognitive, and psychosocial needs.

INITIATING THE CHAIN OF SURVIVAL

Early initiation of BLS has been shown to increase the probability of survival for a person dealing with cardiac arrest. To increase the odds of surviving a cardiac event, the rescuer should follow the steps in the Adult Chain of Survival ([Figure 14](#)).

Adult Chain of Survival

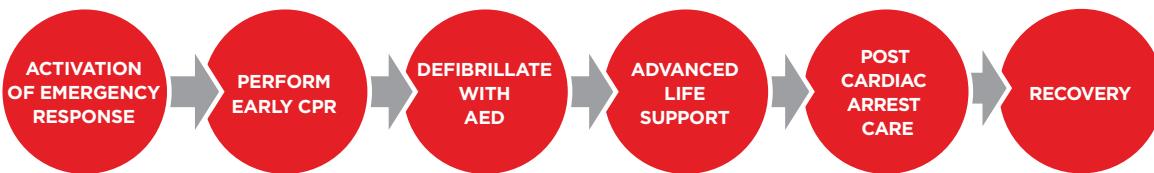


Figure 14



POST-CARDIAC ARREST CARE

Integrated post-cardiac arrest care is the fifth link in the Adult Chain of Survival. The quality of this care is critical to providing resuscitated individuals with the best possible results. When the interventions below are provided, there is an increased likelihood of survival.

Care of the patient after the return of spontaneous circulation (ROSC) requires close attention to oxygenation, blood pressure control, evaluation for percutaneous coronary intervention, targeted temperature management, and multimodal neuroprognostication. Because recovery from cardiac arrest continues long after the initial hospitalization, patients should have formal assessment and support for their physical, cognitive, and psychosocial needs.

After a resuscitation, debriefing for lay rescuers, EMS providers, and hospital-based healthcare workers may be beneficial to support their mental health and well-being.

THERAPEUTIC HYPOTHERMIA

- Recommended for comatose individuals with return of spontaneous circulation after a cardiac arrest event.
- Individuals should be cooled to 89.6 to 93.2 degrees F (32 to 36 degrees C) for at least 24 hours.

OPTIMIZATION OF HEMODYNAMICS AND VENTILATION

- 100% oxygen is acceptable for early intervention but not for extended periods of time.
- Oxygen should be titrated, so that individual's pulse oximetry is greater than 94% to avoid oxygen toxicity.
- Do not over ventilate to avoid potential adverse hemodynamic effects.
- Ventilation rates of 10 to 12 breaths per minute to achieve ETCO₂ at 35 to 40 mmHg.
- IV fluids and vasoactive medications should be titrated for hemodynamic stability.

PERCUTANEOUS CORONARY INTERVENTION

- Percutaneous coronary intervention (PCI) is preferred over thrombolytics.
- Individual should be taken by EMS directly to a hospital that performs PCI.
- If the individual is delivered to a center that only delivers thrombolytics, they should be transferred to a center that offers PCI if time permits.

NEUROLOGICAL CARE

- Neurologic assessment is key, especially when withdrawing care (i.e., brain death) to decrease false-positive rates. Specialty consultation should be obtained to monitor neurologic signs and symptoms throughout the post-resuscitation period.



ACUTE CORONARY SYNDROME

For individuals with acute coronary syndrome (ACS), proper care starts during the call to EMS. First responders must be aware of and look for signs of ACS. Quick diagnosis and treatment yield the best chance to preserve healthy heart tissue. It is very important that health care providers recognize individuals with potential ACS in order to initiate evaluation, appropriate triage, and time management.

ACS Chain of Survival



Figure 15

GOALS OF ACS TREATMENT

Early EMS communication allows for preparation of emergency department personnel and cardiac catheterization lab and staff. Once the ACS patient arrives at the receiving facility, established protocols should direct care. The shorter the time is until reperfusion, the greater the amount of heart tissue that can be saved, and the more optimal the overall outcome.

Major adverse cardiac events (MACE) includes death and non-fatal myocardial infarction. Life-threatening complications of ACS include ventricular fibrillation, pulseless ventricular tachycardia, bradyarrhythmias, cardiogenic shock, and pulmonary edema. EMS should have the capacity to perform ECGs on scene and on the way to the hospital. The receiving hospital should be made aware of possible ACS, especially ST-elevation myocardial infarction elevation (STEMI) and non-ST-elevation myocardial infarction (NSTEMI).

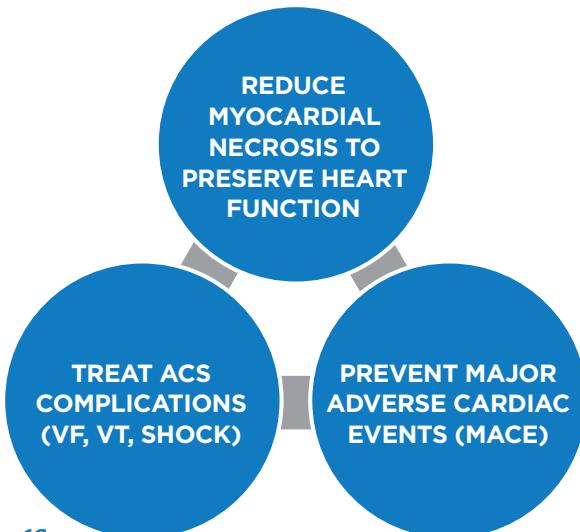


Figure 16



ACUTE STROKE

Outcomes for individuals with stroke have improved significantly due to the implementation of Acute Stroke System of Care. The community is better equipped to recognize stroke as a “brain attack,” and there is greater awareness of the importance of medical care within one hour of symptom onset. Likewise, EMS systems have been enhanced to transport individuals to regional stroke care centers that are equipped to administer fibrinolytics.

Stroke Chain of Survival



Figure 17

GOALS OF ACUTE ISCHEMIC STROKE CARE

The overall goal of stroke care is to minimize brain injury and optimize the individual's recovery. Preferential transport to stroke-capable centers has been shown to improve outcomes. Stroke centers are equipped with resources often not available at smaller community hospitals. The presence of specialists, including neurologists and stroke care specialists, multidisciplinary teams

experienced in stroke care, advanced imaging modalities, and other therapeutic options make transport to stroke centers the most suitable option. The goal of the stroke team, emergency physician, or other experts should be to assess the individual with suspected stroke within ten minutes.

The 8 D's of Stroke Care (Table 2) highlight the major steps of diagnosis and treatment of stroke and key points at which delays can occur.

The 8 D's of Stroke Care

DETECTION	Rapid recognition of stroke symptoms
DISPATCH	Early activation and dispatch of EMS
DELIVERY	Rapid EMS identification, management, and transport
DOOR	Transport to stroke center
DATA	Rapid triage, evaluation, and management in ED
DECISION	Stroke expertise and therapy selection
DRUG	Fibrinolytic therapy, intra-arterial strategies
DISPOSITION	Rapid admission to the stroke unit or critical care unit

Table 2



THE RESUSCITATION TEAM

The ILCOR guidelines for ACLS highlight the importance of effective team dynamics during resuscitation. In the community (outside a health care facility), the first rescuer on the scene may be performing CPR alone. However, a Code Blue in a hospital may bring dozens of responders/providers to a patient's room. It is important to quickly and efficiently organize team members to effectively participate in ACLS. The ILCOR suggests a team structure with each provider assuming a specific role during the resuscitation; this consists of a team leader and several team members. (*Table 3*)

Table 3

TEAM LEADER	TEAM MEMBER
<ul style="list-style-type: none">• Organize the group• Monitor performance• Be able to perform all skills• Direct team members• Provide critique of group performance after the resuscitation effort	<ul style="list-style-type: none">• Understand their role• Be willing, able, and skilled to perform the role• Understand the ACLS sequences• Be committed to the success of the team

Clear communication between team leaders and team members is essential.

It is important to know your own clinical limitations. Resuscitation is the time for implementing acquired skills, not trying new ones. Only take on tasks you can perform successfully. Clearly state when you need help and call for help early in the care of the individual. Resuscitation demands mutual respect, knowledge sharing, constructive criticism, and follow-up discussion (debriefing) after the event.

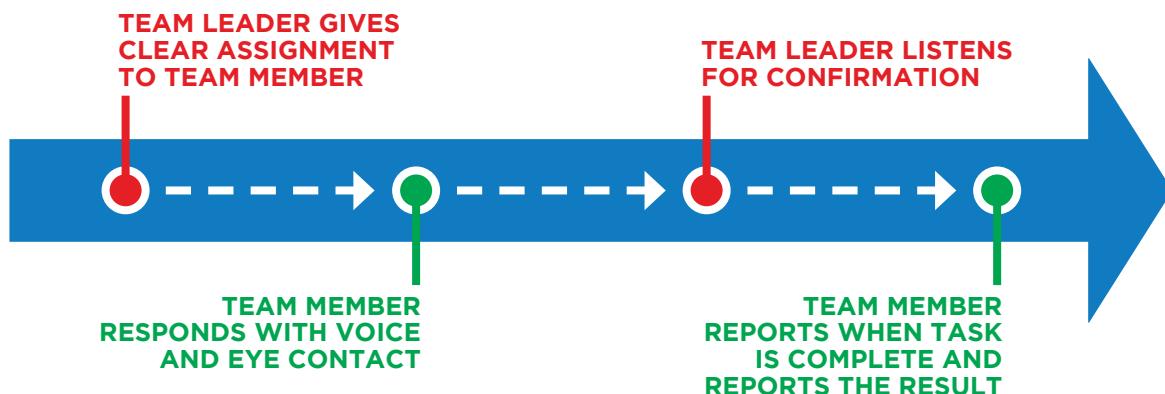


Figure 18
Closed-Loop
Communication



EDUCATION, IMPLEMENTATION, TEAMS

Only about 20% of the individuals who have a cardiac arrest inside a hospital will survive. This statistic prompted the development of a Cardiac Arrest System of Care. Four out of five individuals with cardiopulmonary arrest have changes in vital signs prior to the arrest. Therefore, most individuals who eventually have a cardiac arrest showed signs of impending cardiac arrest. Survival rates could be improved if individuals are identified and treated with ACLS protocols sooner.

Originally, specialized groups of responders within a hospital, called Cardiac Arrest Teams, attended to a patient with recognized cardiac arrest. These teams responded to a Code Blue after someone presumably recognized an active cardiac arrest and sought help. Many believed Cardiac Arrest Teams would improve survival rates, but the results were disappointing. Studies show that survival rates were the same in hospitals with Cardiac Arrest Teams as in those without a team. As a result, hospitals are replacing Cardiac Arrest Teams with Rapid Response Teams (RRTs) or Medical Emergency Teams (METs).

Rather than waiting for loss of consciousness and full cardiopulmonary arrest, RRTs/METs closely monitor patients in order to treat them before the cardiac arrest occurs. These teams combine the efforts of nurses, physicians, and family members to detect an impending cardiac arrest.

RRT/MET ALERT CRITERIA

THREATENED AIRWAY OR LABORED BREATHING	ALTERED MENTAL STATUS
BRADYCARDIA (< 40 BPM) OR TACHYCARDIA (> 100 BPM)	SEIZURE
HYPOTENSION OR SYMPTOMATIC HYPERTENSION	SUDDEN AND LARGE DECREASE IN URINE OUTPUT

Figure 19

When hospitals implement RRTs/METs, there are fewer cardiac arrests, fewer ICU transfers, improved survival rates, and shorter lengths of inpatient stay.



SELF-ASSESSMENT FOR SYSTEMS OF CARE

1. What is the longest a rescuer should pause to check for a pulse?
 - a. 20 seconds
 - b. 10 seconds
 - c. 5 seconds
 - d. Less than two seconds
2. Select the proper pairing regarding CPR for an adult:
 - a. Chest compressions 60 to 80/minute; 2 inches deep (5cm)
 - b. Chest compressions 80/minute; 1.5 inches deep (4cm)
 - c. Chest compressions 100/minute; 3 inches deep (8cm)
 - d. Chest compression 100 to 120 per minute; 2 to 2.4 inches deep (5-6cm)
3. What is the role of the second rescuer during a cardiac arrest scenario?
 - a. Summon help.
 - b. Retrieve AED.
 - c. Perform ventilations.
 - d. All of the above

ANSWERS

1. B
Pulse checks are limited to no more than 10 seconds. If you are unsure whether a pulse is present, begin CPR.
2. D
Chest compression 100 to 120 per minute; 2 to 2.4 inches deep (5-6cm).
3. D
Take advantage of any bystander and enlist their help based on their skill level.



ACLS CASES

RESPIRATORY ARREST

Individuals with ineffective breathing patterns are considered to be in respiratory arrest and require immediate attention. There are many causes of respiratory arrest, including but not limited to cardiac arrest and cardiogenic shock. Resuscitate individuals in apparent respiratory arrest following BLS or ACLS protocols.

Respiratory arrest is an emergent condition in which the individual is either not breathing or is breathing ineffectively.

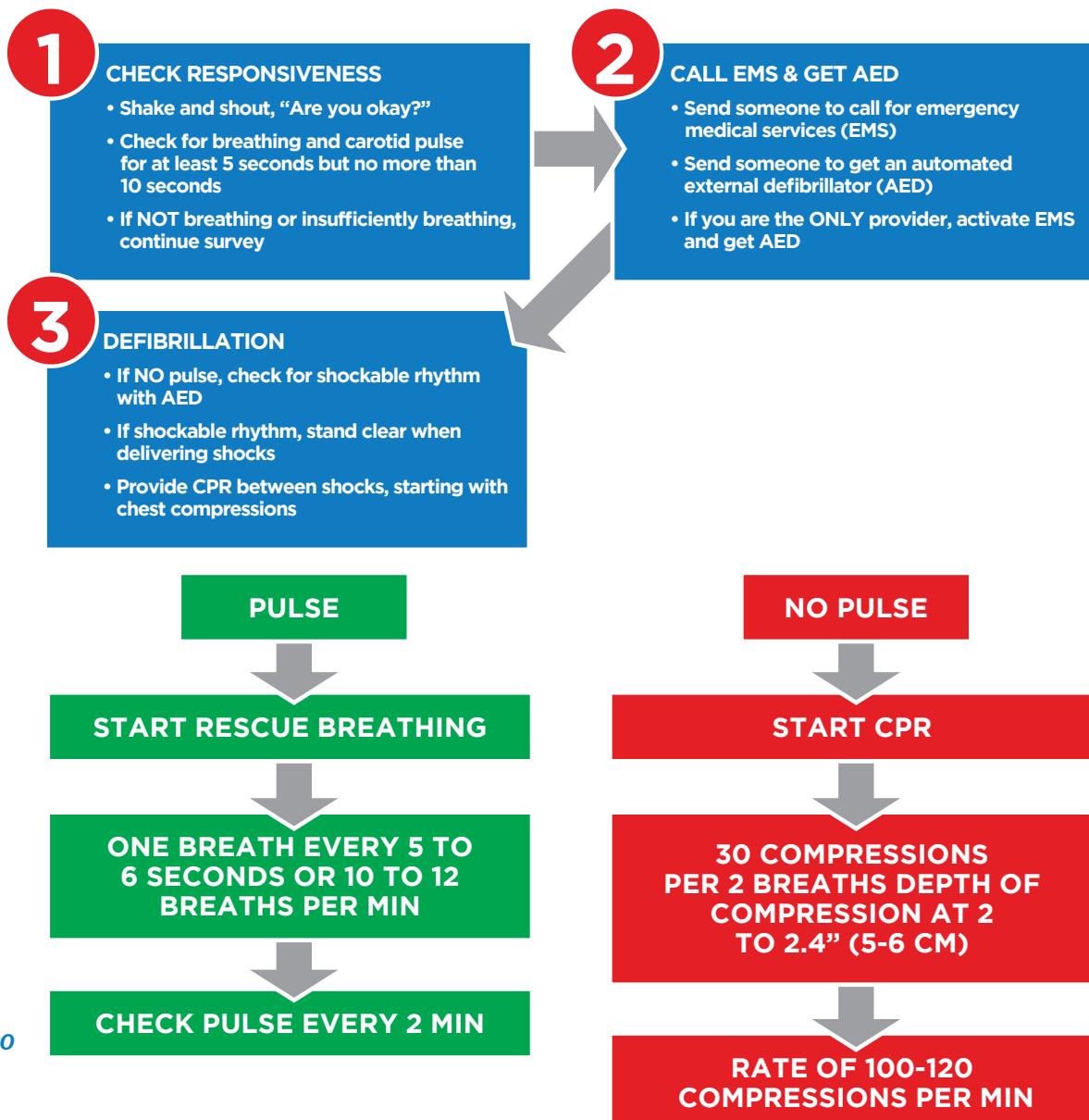
**BLS Survey for Adults**

Figure 20



ACLS Survey

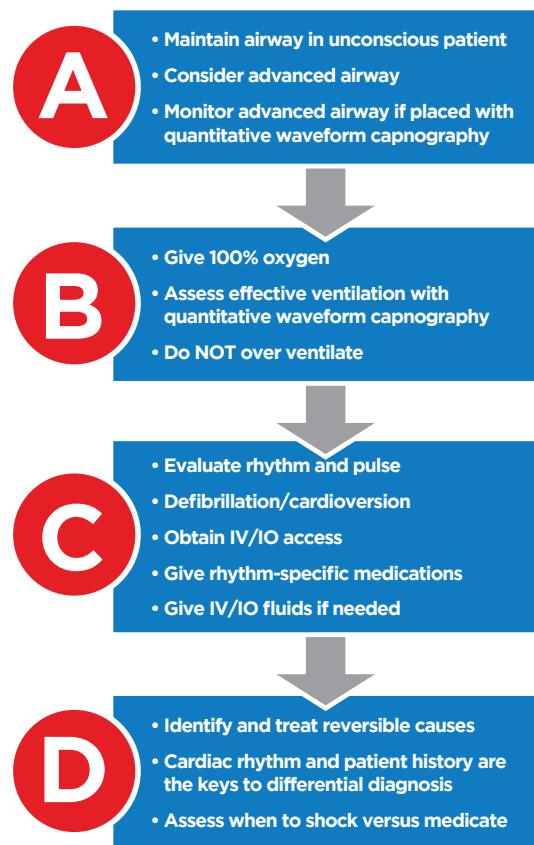


Figure 21

TYPES OF AIRWAYS

ADVANCED	BASIC
ESOPHAGAL-TRACHEAL TUBE	MOUTH-TO-MOUTH/NOSE
ET	BAG-MASK VENTILATION
LARYNGEAL TUBE	OPA
LMA	NPA

Table 4



In Table 4, the airways listed in the left column are considered advanced airways, while those in the right column are basic airways. Although OPAs and NPAs are considered to be basic airways, they require proper placement by an experienced provider. Advanced airway placement requires specialized training which is beyond the scope of ACLS certification. However, all ACLS providers should be familiar with the proper management of advanced airways in order to be part of an effective life support team.

CPR is performed with the individual lying on their back; gravity will cause the jaw, the tongue, and the tissues of the throat to fall back and obstruct the airway. The airway rarely remains open in an unconscious individual without external support.

The first step in any airway intervention is to open the airway. This is accomplished by lifting the chin upward while tilting the forehead back ([Figure 22](#)). The goal is to create a straighter path from the nose to the trachea.

In individuals with suspected neck injury, the cervical spine should be protected and a jaw thrust alone is used to open the airway ([Figure 23](#)). While the standard practice in a suspected neck injury is to place a cervical collar, this should not be done in BLS or ACLS. Cervical collars can compress the airway and interfere with resuscitation efforts. The provider must ensure an open airway regardless of the basic airway used. The provider is obligated to stabilize the head or ask for assistance while maintaining control of the airway.



[Figure 22](#)



[Figure 23](#)

Do not over ventilate (i.e., give too many breaths per minute or too large volume per breath). Both can increase intrathoracic pressure, decrease venous return to heart, diminish cardiac output, as well as predispose individuals to vomit and aspirate gastrointestinal contents.



VENTRICULAR FIBRILLATION AND PULSELESS VENTRICULAR TACHYCARDIA

Ventricular fibrillation (VF) and pulseless ventricular tachycardia (VT) are life-threatening cardiac rhythms that result in ineffective ventricular contractions. VF or VFib (*Figure 24*) is a rapid quivering of the ventricular walls that prevents them from pumping. The ventricular motion of VF is not synchronized with atrial contractions. VT or VTach (*Figure 25*) is a condition in which the ventricles contract more than 100 times per minute. The emergency condition, pulseless VT, occurs when ventricular contraction is so rapid that there is no time for the heart to refill, resulting in undetectable pulse. In both cases, individuals are not receiving adequate blood flow to the tissues. Despite being different pathological phenomena and having different ECG rhythms, the ACLS management of VF and VT are essentially the same. Resuscitation for VF and pulseless VT starts with the BLS Survey.

An AED reads and analyzes the rhythm and determines if a shock is needed. The AED is programmed to only prompt the user to shock VF and VT rhythms. The machine does not know if the individual has a pulse or not. This is the primary reason you should not use an AED in someone with a palpable pulse. ACLS responses to VF and pulseless VT within a hospital will likely be conducted using a cardiac monitor and a manual defibrillator. Thus, the ACLS provider must read and analyze the rhythm. Shocks should only be delivered for VF and pulseless VT. Likewise, antiarrhythmic drugs and drugs to support blood pressure may be used.



Figure 24

RULES FOR VENTRICULAR FIBRILLATION (VF)

REGULARITY	<i>There is no regular shape of the QRS complex because all electrical activity is disorganized.</i>
RATE	<i>The rate appears rapid, but the disorganized electrical activity prevents the heart from pumping.</i>
P WAVE	<i>There are no P waves present.</i>
PR INTERVAL	<i>There are no PR intervals present.</i>
QRS COMPLEX	<i>The ventricle complex varies.</i>

Table 5



**RULES FOR
VENTRICULAR TACHYCARDIA
(REGULAR/RAPID WIDE
COMPLEX TACHYCARDIA)**



Figure 25

REGULARITY	<i>R-R intervals are usual, but not always, regular.</i>
RATE	<i>The atrial rate cannot be determined. Ventricular rate is usually between 150 and 250 beats per minute.</i>
P WAVE	<i>QRS complexes are not preceded by P waves. There are occasionally P waves in the strip, but they are not associated with the ventricular rhythm.</i>
PR INTERVAL	<i>PR interval is not measured since this is a ventricular rhythm.</i>
QRS COMPLEX	<i>QRS complex measures more than 0.12 seconds. The QRS will usually be wide and bizarre. It is usually difficult to see a separation between the QRS complex and the T wave.</i>

Table 6

**RULES FOR
TORSADES DE POINTES
(IRREGULAR WIDE
COMPLEX TACHYCARDIA)**



Figure 26

REGULARITY	<i>There is no regularity.</i>
RATE	<i>The atrial rate cannot be determined. Ventricular rate is usually between 150 and 250 beats per minute.</i>
P WAVE	<i>There are no P waves present.</i>
PR INTERVAL	<i>There are no PR intervals present.</i>
QRS COMPLEX	<i>The ventricle complex varies.</i>

Table 7

VF and pulseless VT are both shockable rhythms. The AED cannot tell if the individual has a pulse or not.



PULSELESS ELECTRICAL ACTIVITY AND ASYSTOLE

Pulseless electrical activity (PEA) and asystole are related cardiac rhythms in that they are both life-threatening and unshockable cardiac rhythms. Asystole is a flat-line ECG (*Figure 27*). There may be subtle movement away from baseline (drifting flat-line), but there is no perceptible cardiac electrical activity. Always ensure that a reading of asystole is not a user or technical error. Make sure pads have good contact with the individual, leads are connected, gain is set appropriately, and the power is on. PEA is one of many waveforms by ECG (including sinus rhythm) without a detectable pulse. PEA may include any pulseless waveform with the exception of VF, VT, or asystole (*Figure 28*).

Hypovolemia and hypoxia are the two most common causes of PEA. They are also the most easily reversible and should be at the top of any differential diagnosis.

If the individual has return of spontaneous circulation (ROSC), proceed to post-cardiac arrest care.

RULES FOR ASYSTOLE AND PEA

A “flat line” is reserved for Asystole definition but PEA includes flat line as well as any other wave (except VF, VT, and SVT).

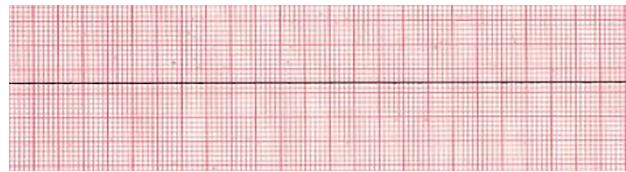


Figure 27

ASYSTOLE REGULARITY	<i>The rhythm will be a nearly flat line.</i>
RATE	<i>There is no rate.</i>
P WAVE	<i>There are no P waves present.</i>
PR INTERVAL	<i>PR interval is unable to be measured due to no P waves being present.</i>
QRS COMPLEX	<i>There are no QRS complexes present.</i>
PEA REGULARITY	<i>Any rhythm including a flat line (asystole).</i>
RATE	<i>Any rate or no rate.</i>
P WAVE	<i>Possible P wave or none detectable.</i>
PR INTERVAL	<i>Possible PR wave or none detectable.</i>
QRS COMPLEX	<i>Possible QRS complex or none detectable.</i>

Table 8

**REVERSIBLE CAUSES**

Figure 28

REVERSIBLE CAUSES OF CARDIAC ARREST	
THE H'S	THE T'S
Hypovolemia	Tension pneumothorax
Hypoxia	Tamponade
H+ (acidosis)	Toxins
Hypo/Hyperkalemia	Thrombosis (coronary)
Hypoglycemia	Thrombosis (pulmonary)
Hypothermia	Trauma (unrecognized)

Table 9

- Always verify that a reading of asystole is not equipment failure. Make sure pads make good contact with the individual, all cables are connected, gain is set appropriately, and the power is on.
- Hypovolemia and hypoxia are easily reversed and are the two most common causes of PEA.

STANDARD DOSE EPINEPHRINE IS VASOPRESSOR OF CHOICE

Epinephrine is still the best choice according to 2020 guidelines. Of sixteen observational studies on timing in the recent systematic review, all found an association between earlier epinephrine and ROSC for patients with nonshockable rhythms, although improvements in survival were not universally seen.

For patients with shockable rhythm, the literature supports prioritizing defibrillation and CPR initially and giving epinephrine if initial attempts with CPR and defibrillation are not successful.



Adult Cardiac Arrest Algorithm

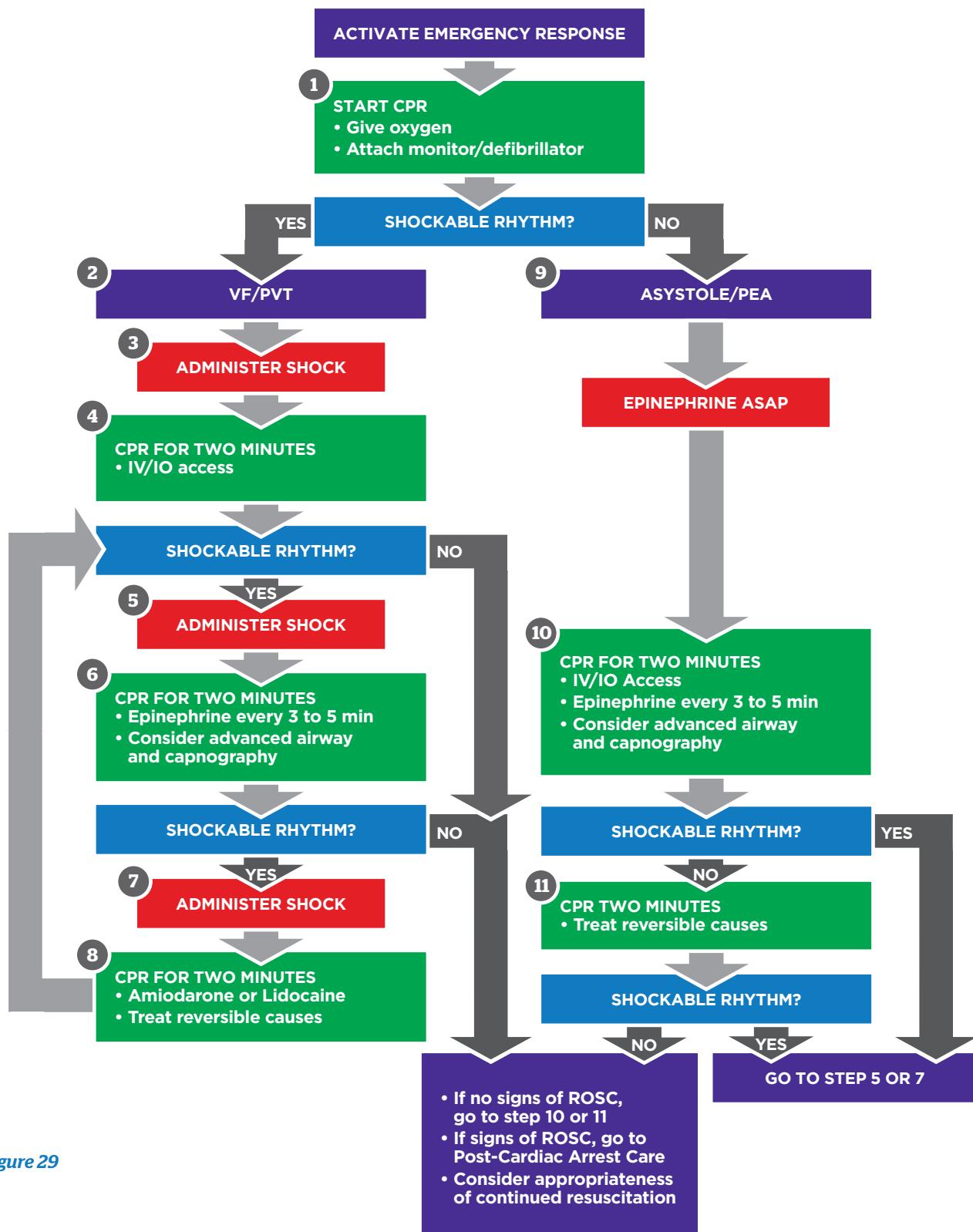


Figure 29



ADULT CARDIAC ARREST

CPR Quality

- Push hard (2-2.4" (5-6 cm)) and fast (100-120 bpm) and allow chest recoil
- Minimize interruptions
- Do not over ventilate
- If no advanced airway, 30:2 compression to ventilation ratio
- Quantitative waveform capnography
 - If ETCO₂ <10 mmHg, attempt to improve CPR quality

Shock Energy

- Biphasic: Biphasic delivery of energy during defibrillation has been shown to be more effective than older monophasic waveforms. Follow manufacturer recommendation (e.g., initial dose of 120 to 200 J); if unknown, use the maximum dose available. Second and subsequent doses should be equivalent and higher doses should be considered.
- Monophasic: 360 J

Return of Spontaneous Circulation

- Return of pulse and blood pressure
- Sudden sustained increase in PETCO₂ (typically ≥ 40 mmHg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Advanced Airway

- Supraglottic advanced airway or ET intubation
- Waveform capnography to confirm and monitor ET tube placement
- 10 breaths per minute with continuous chest compressions

Drug Therapy

- Epinephrine IV/IO Dose: 1 mg, administer as soon as possible then every 3 to 5 minutes after
- Amiodarone IV/IO Dose: first dose is 300 mg bolus, second dose is 150 mg
- Lidocaine: 1st dose: 1-1.5 mg/kg, second dose: 0.5-0.75 mg/kg

Reversible Causes

- | | |
|----------------------|-------------------------------------|
| • Hypovolemia | • Tamponade, cardiac |
| • Hypoxia | • Toxins |
| • H+(acidosis) | • Tension pneumothorax |
| • Hypothermia | • Thrombosis, pulmonary or coronary |
| • Hypo-/hyperkalemia | • Trauma |
| • Hypoglycemia | |



POST-CARDIAC ARREST CARE

If an individual has a return of spontaneous circulation (ROSC), start post-cardiac arrest care immediately. The initial BLS/ACLS processes are meant to save an individual's life, while post-cardiac arrest care is meant to optimize ventilation and circulation, preserve heart and brain tissue/function, and to maintain recommended blood glucose levels. Pay close attention to oxygenation, blood pressure control, need for percutaneous coronary intervention, and ideal temperature management. The 2020 ILCOR Guidelines recommend formal assessment and support for an individual's continued physical, cognitive, and psychosocial needs because recovery from a cardiac arrest event continues long after the initial hospitalization. Be sure to remember to address the mental health needs of the First Responders also, and schedule a debriefing for lay rescuers, EMS providers, and hospital-based healthcare workers after a resuscitation event.

AIRWAY MANAGEMENT

- Early placement of advanced airway
- Manage respiratory parameters:
 - Keep 10 breaths per minute
 - Pulse Ox goal 92-98%
 - Titrate to PaCO_2 35-45 mm Hg
 - Waveform capnography (capnometry) to confirm ETT placement

BLOOD PRESSURE SUPPORT AND VASOPRESSORS

- Obtain early ECG.
- Consider blood pressure support in any individual with systolic blood pressure less than 90 mmHg or mean arterial pressure (MAP) less than 65.
- Unless contraindicated, 1 to 2 liters of IV saline or Lactated Ringer's is the first intervention.
- When blood pressure is very low, consider vasopressors (commonly referred to as "pressors"). Vasopressors and inotropes are medications used to create vasoconstriction or increase cardiac contractility, respectively. Consider using the following:
 - Epinephrine is the pressor of choice for individuals who are not in cardiac arrest.
 - Dopamine and phenylephrine are alternatives to epinephrine.
 - Norepinephrine is generally reserved for severe hypotension or as a last-line agent.
- Titrate the infusion rate to maintain the desired blood pressure.

The Post–Cardiac Arrest Care Algorithm ([Figure 30](#)) was updated to emphasize the need to prevent hyperoxia, hypoxemia, and hypotension.

HYPOTHERMIA

Hypothermia is the only documented intervention that improves/enhances brain recovery after cardiac arrest. Induced hypothermia can be performed in unresponsive individuals and should be continued for at least 24 hours. The goal of induced hypothermia is to maintain a core body temperature between 89.6 to 96.8 degrees F (32 to 36 degrees C) for at least 24 hours by using a cooling device with a feedback loop. Device manufacturers have developed several innovative technologies that improve the ability to affect and manage hypothermia in the post-arrest individual. Hypothermia should be induced and monitored by trained professionals. Induced hypothermia should not affect the decision to perform percutaneous coronary intervention (PCI), because concurrent PCI and hypothermia are reported to be feasible and safe.

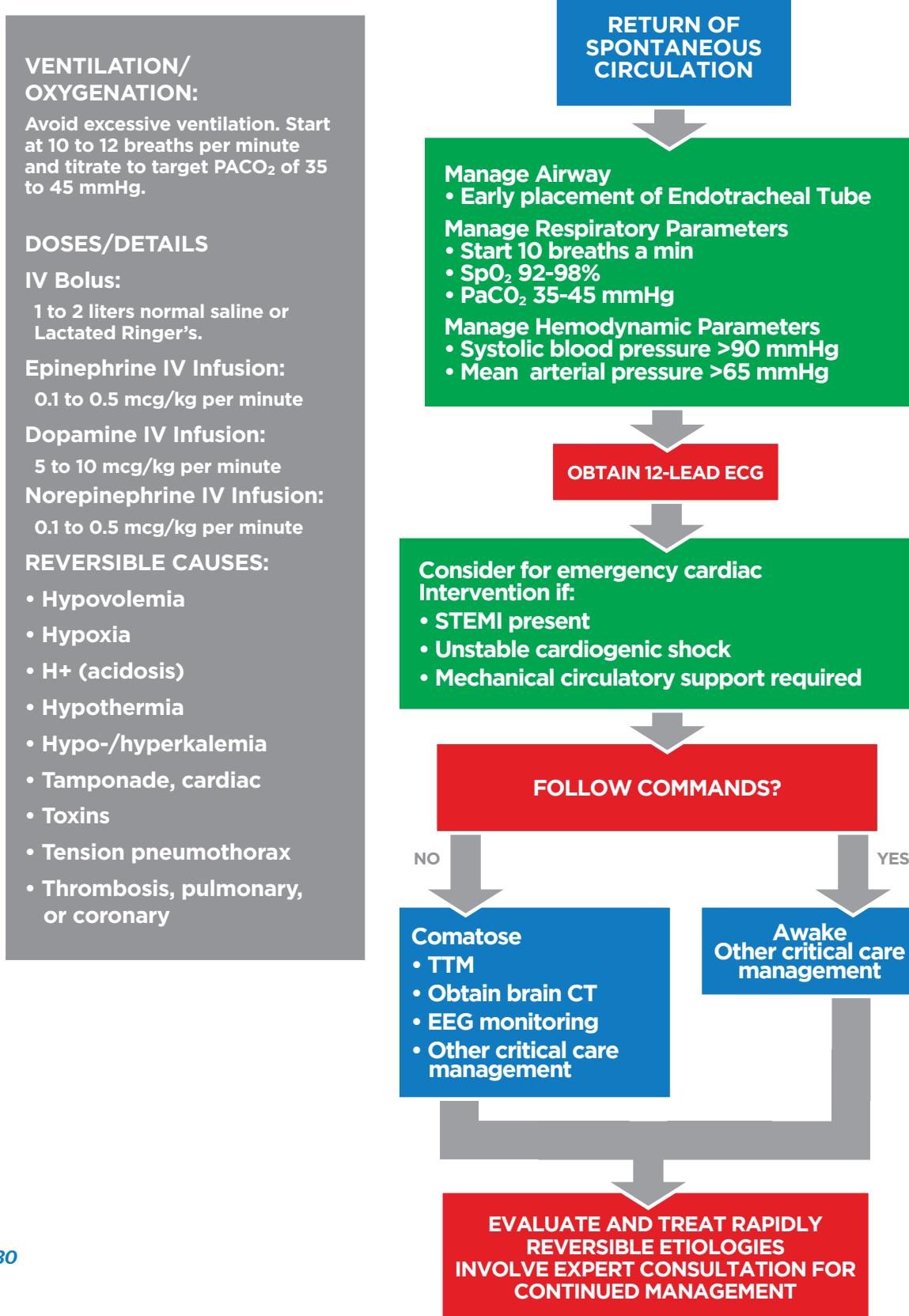
**Adult Immediate Post-Cardiac Arrest Care Algorithm**

Figure 30



RULES FOR SINUS BRADYCARDIA



Figure 31

REGULARITY	<i>R-R intervals are regular; overall rhythm is regular.</i>
RATE	<i>The rate is less than 60 bpm, but usually more than 40 bpm.</i>
P WAVE	<i>There is one P wave in front of every QRS. The P waves appear uniform.</i>
PR INTERVAL	<i>Measures between 0.12 and 0.20 seconds in duration. PR interval is consistent.</i>
QRS COMPLEX	<i>Measures less than 0.12 seconds.</i>

Table 10 & 11

RULES FOR FIRST DEGREE HEART BLOCK



Figure 32

REGULARITY	<i>R-R intervals are regular; overall rhythm is regular.</i>
RATE	<i>The rate depends on the underlying rhythm.</i>
P WAVE	<i>There is one P wave in front of every QRS. The P waves appear uniform.</i>
PR INTERVAL	<i>Measures more than 0.20 seconds in duration. PR interval is consistent.</i>
QRS COMPLEX	<i>Measures less than 0.12 seconds.</i>

RULES FOR 2ND DEGREE TYPE I AV BLOCK (WENCKEBACH/MOBITZ I)



Figure 33

REGULARITY	<i>R-R interval is irregular, but there is usually a pattern to it. The R-R interval gets longer as the PR interval gets longer.</i>
RATE	<i>The ventricular rate is usually slightly higher than the atrial rate due to some atrial beats not being conducted. The atrial rate is usually normal.</i>
P WAVE	<i>P waves are upright and uniform. Most complexes will have a P wave in front of them; however, there will be some that do not have a P wave.</i>
PR INTERVAL	<i>PR interval gets progressively longer until there is a dropped QRS complex.</i>
QRS COMPLEX	<i>Measures less than 0.12 seconds.</i>

Table 12 & 13

RULES FOR 2ND DEGREE TYPE II AV BLOCK (MOBITZ II)



Figure 34

REGULARITY	<i>If there is a consistent conduction ratio, then the R-R interval will be regular. If the conduction ratio is not constant, the R-R interval will be irregular.</i>
RATE	<i>The atrial rate is normal. The ventricular rate is slower, usually 1/2 to 1/3 slower than the atrial rate.</i>
P WAVE	<i>P waves are upright and uniform. There is not a QRS following every P wave.</i>
PR INTERVAL	<i>PR interval can only be measured on conducted beats, and it is usually constant across the strip. It may or may not be longer than a normal PR interval (0.12 seconds).</i>
QRS COMPLEX	<i>Measures less than 0.12 seconds.</i>

**RULES FOR 3RD DEGREE AV BLOCK (COMPLETE HEART BLOCK)**

Figure 35

REGULARITY	<i>R-R interval is regular. P-P interval is also regular.</i>
RATE	<i>The atrial rate is regular and normally 60 to 100. Rate of QRS complexes is dependent on the focus. If the focus is ventricular, the rate will be 20 to 40. If the focus is junctional, the rate will be 40 to 60.</i>
P WAVE	<i>P waves are upright and uniform. There is not a QRS following every P wave.</i>
PR INTERVAL	<i>PR interval can only be measured on conducted beats, and it is usually constant across the strip. It may or may not be longer than a normal PR interval (0.12 seconds).</i>
QRS COMPLEX	<i>Interval may be normal but is more likely to be prolonged.</i>

Table 14

SYMPTOMATIC BRADYCARDIA

Bradycardia is defined as a heart rate of less than 60 beats per minute. While any heart rate less than 60 beats per minute is considered bradycardia, not every individual with bradycardia is symptomatic or having a pathological event. Individuals in excellent physical shape often have sinus bradycardia. Symptomatic bradycardia may cause a number of signs and symptoms including low blood pressure, pulmonary edema, and congestion, abnormal rhythm, chest discomfort, shortness of breath, lightheadedness, and/or confusion. Symptomatic bradycardia should be treated with the ACLS Survey. If bradycardia is asymptomatic but occurs with an arrhythmia listed below, obtain a consultation from a cardiologist experienced in treating rhythm disorders.

SYMPTOMS OF BRADYCARDIA

- Shortness of breath
- Altered mental status
- Hypotension
- Pulmonary edema/congestion
- Weakness/dizziness/lightheadedness



SYMPTOMATIC BRADYCARDIA REVIEW

Sinus Bradycardia

- Normal rhythm with slow rate

First Degree AV Block

- PR interval is longer than 0.20 seconds

Type I Second Degree AV Block

- PR interval increases in length until QRS complex is dropped

Type II Second Degree AV Block

- Constant PR intervals (may be prolonged) before a random QRS is dropped

Third Degree AV Block

- PR and QRS are not coordinated with each other



Adult Bradycardia with Pulse Algorithm

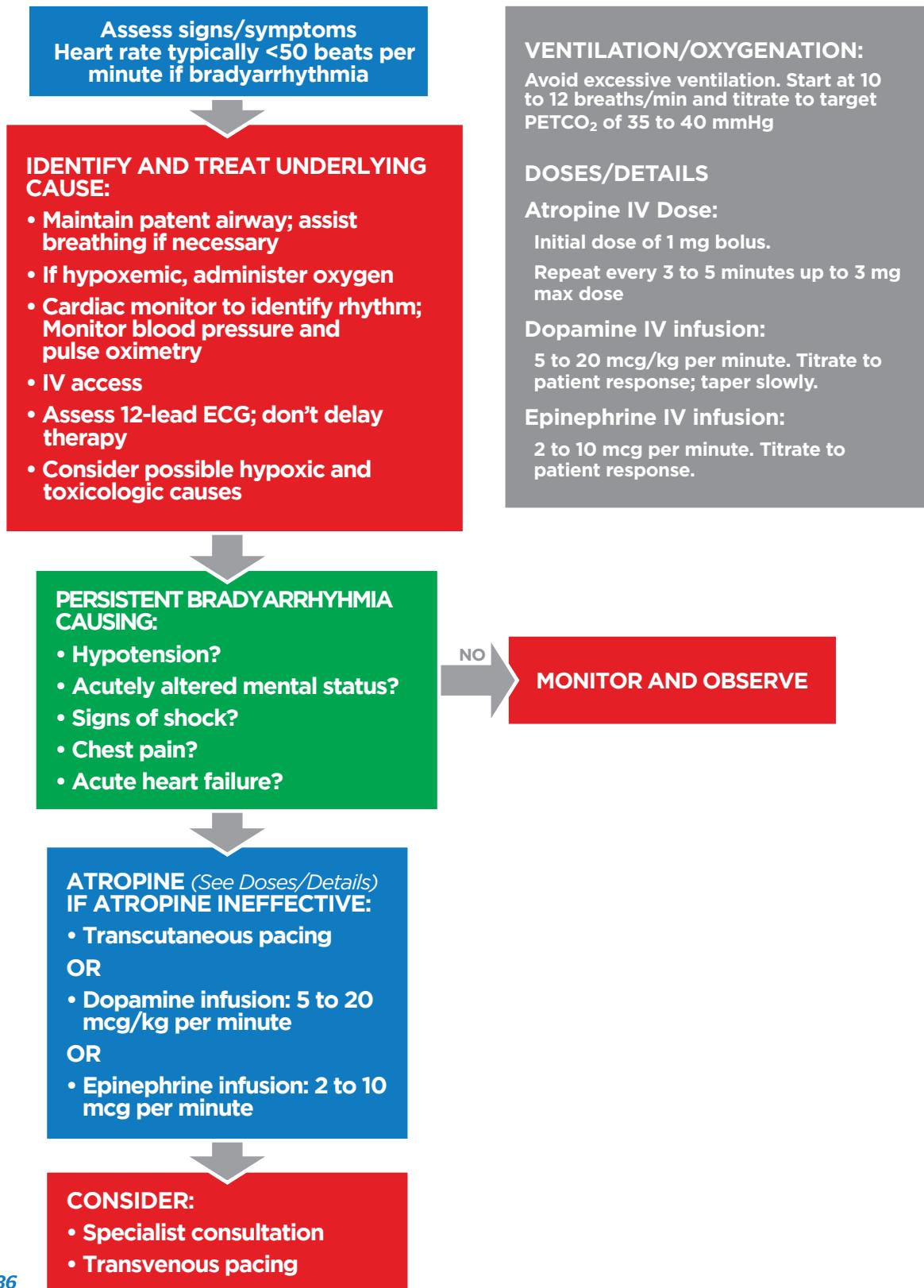


Figure 36



TACHYCARDIA

Tachycardia is a heart rate of greater than 100 beats per minute. When the heart beats too quickly, there is a shortened relaxation phase. This causes two main problems: the ventricles are unable to fill completely, causing cardiac output to decrease; and the coronary arteries receive less blood, causing supply to the heart to decrease.

- Tachycardia is classified as stable or unstable.
- Heart rates greater than or equal to 150 beats per minute usually cause symptoms.
- Unstable tachycardia always requires prompt attention.
- Stable tachycardia can become unstable.

SYMPTOMS OF TACHYCARDIA

- | | |
|------------------------------|--------------------------------------|
| • Hypotension | • Chest pain/discomfort |
| • Sweating | • Shortness of breath |
| • Pulmonary edema/congestion | • Weakness/dizziness/lightheadedness |
| • Jugular venous distension | • Altered mental state |

SYMPTOMATIC TACHYCARDIA WITH HEART RATE > 150 BPM

1. **If the individual is unstable, provide immediate synchronized cardioversion.**
 - Is the individual's tachycardia producing hemodynamic instability and serious symptoms?
 - Are the symptoms (i.e., pain and distress of acute myocardial infarction (AMI)) producing the tachycardia?
2. **Assess the individual's hemodynamic status and begin treatment by establishing IV, giving supplementary oxygen and monitoring the heart.**
 - Heart rate of 100 to 130 bpm is usually the result of underlying process and often represents sinus tachycardia. In sinus tachycardia, the goal is to identify and treat the underlying systemic cause.
 - Heart rate greater than 150 bpm may be symptomatic; the higher the rate, the more likely the symptoms are due to the tachycardia.
3. **Assess the QRS Complex.**

If at any point you become uncertain or uncomfortable during the treatment of a stable patient, seek expert consultation.

Adenosine may cause bronchospasm; therefore, adenosine should be given with caution to patients with asthma.

Synchronized cardioversion is appropriate for treating wide complex tachycardia of unknown type. Prepare for synchronized cardioversion as soon as a wide complex tachycardia is detected.

REGULAR NARROW COMPLEX TACHYCARDIA (PROBABLE SVT)

- Attempt vagal maneuvers.
- Obtain 12-lead ECG; consider expert consultation.
- Adenosine 6 mg rapid IVP; if no conversion, give 12 mg IVP (second dose); may attempt 12 mg once.

**IRREGULAR NARROW COMPLEX TACHYCARDIA (PROBABLE A-FIB)**

- Obtain 12-lead ECG; consider expert consultation.
- Control rate with diltiazem 15 to 20 mg (0.25 mg/kg) IV over two minutes or beta-blockers.

REGULAR WIDE COMPLEX TACHYCARDIA (PROBABLE VT)

- Obtain 12-lead ECG; consider expert consultation.
- Convert rhythm using amiodarone 150 mg IV over 10 minutes.
- Perform elective cardioversion.

IRREGULAR WIDE COMPLEX TACHYCARDIA

- Obtain 12-lead ECG; consider expert consultation.
- Consider anti-arrhythmic.
- If Torsades de Pointes, give magnesium sulfate 1 to 2 gm IV; may follow with 0.5 to 1 gm over 60 minutes.

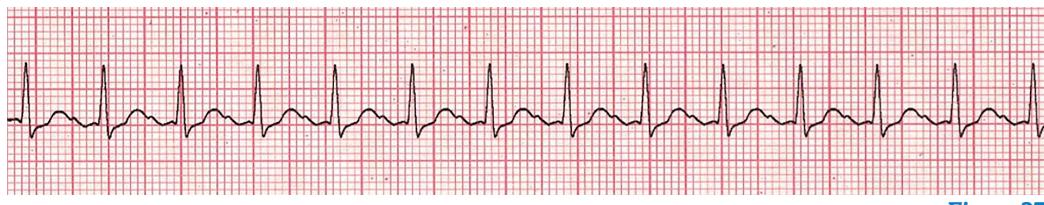
STABLE AND UNSTABLE TACHYCARDIA**RULES FOR SINUS TACHYCARDIA**

Figure 37

REGULARITY	<i>R-R intervals are regular; overall rhythm is regular.</i>
RATE	<i>The rate is over 100 bpm but usually less than 150 bpm.</i>
P WAVE	<i>There is one P wave in front of every QRS. The P waves appear uniform.</i>
PR INTERVAL	<i>Measures between 0.12-0.20 seconds in duration. PR interval is consistent.</i>
QRS COMPLEX	<i>Measures less than 0.12 seconds.</i>

Table 15



RULES FOR ATRIAL FLUTTER



Figure 38

REGULARITY	The atrial rate is regular. The ventricular rate will usually be regular, but only if the AV node conducts the impulses in a consistent manner. Otherwise, the ventricular rate will be irregular.
RATE	The atrial rate is normally between 250 to 350. Ventricular rate depends on conduction through the AV node to the ventricles.
P WAVE	The P waves will be well defined and have a "sawtooth" pattern to them.
PR INTERVAL	Due to the unusual configuration of P waves, the interval is not measured with atrial flutter.
QRS COMPLEX	QRS measures less than 0.12 seconds.

RULES FOR ATRIAL FIBRILLATION (A-FIB) IRREGULAR NARROW COMPLEX TACHYCARDIA

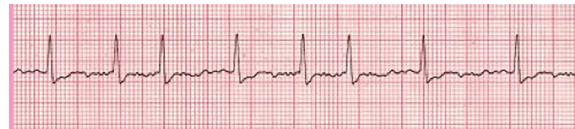


Figure 39

REGULARITY	The R-R intervals are irregular; therefore, overall rhythm is irregularly irregular. The ventricles conduct from different atrial foci causing the irregularity.
RATE	Atrial rate usually exceeds 350. If the ventricular rate is between 60 and 100 bpm, this is known as "controlled" A-Fib. If the ventricular rate is more than 100, it is considered A-Fib with Rapid Ventricular Response (RVR), also known as uncontrolled A-Fib.
P WAVE	Due to the atria firing so rapidly from multiple foci, there are no obvious P waves in the rhythm. The baseline appears chaotic because the atria are fibrillating, therefore no P waves are produced.
PR INTERVAL	Because there are no P waves, PR interval cannot be measured.
QRS COMPLEX	QRS measures less than 0.12 seconds.

Table 15 & 16

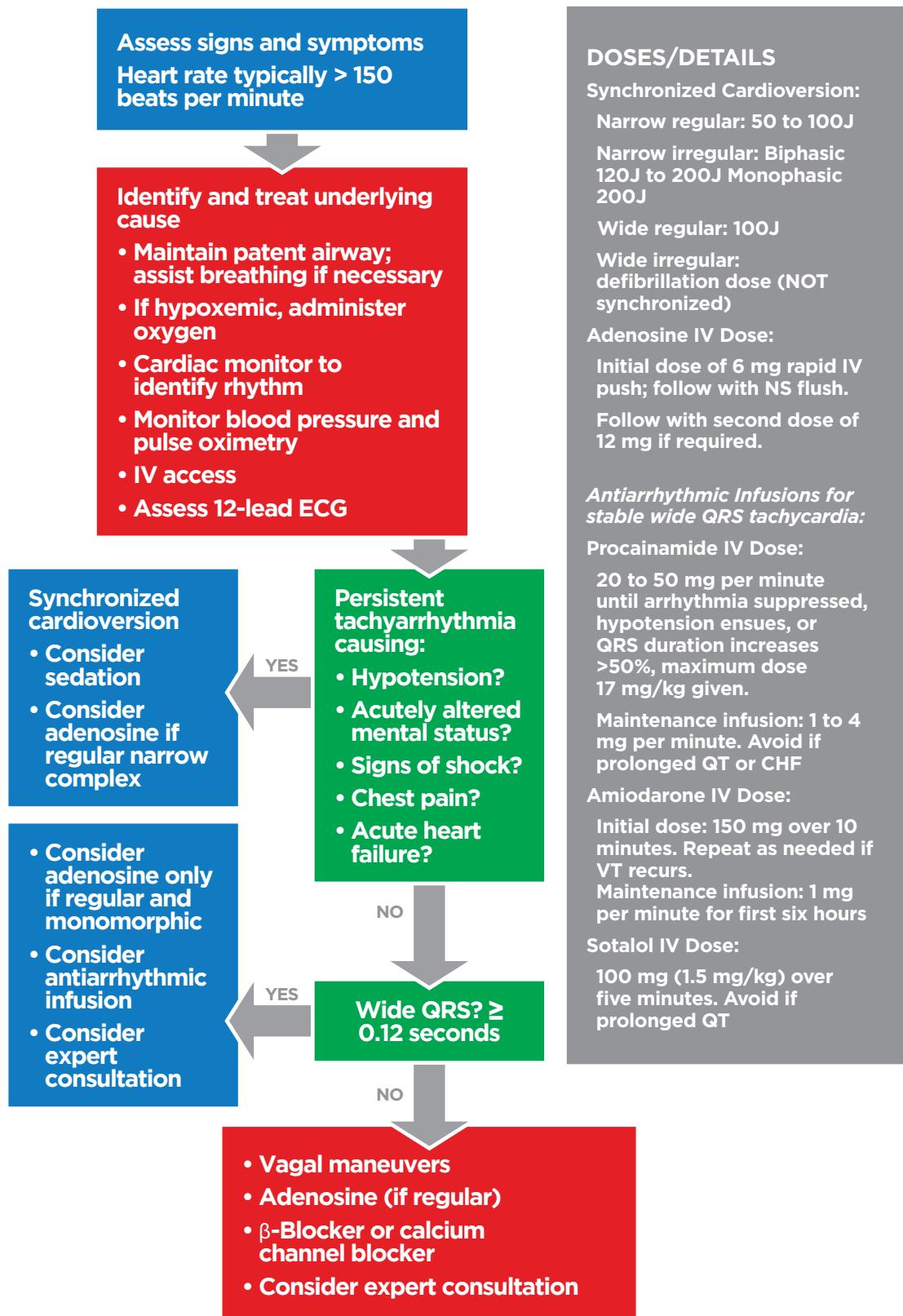
**Adult Tachycardia with Pulse Algorithm**

Figure 40



ACUTE CORONARY SYNDROME

Acute coronary syndrome (ACS) is a collection of clinical presentations including unstable angina, non-ST-elevation myocardial infarction (NSTEMI) and ST-elevation myocardial infarction (STEMI). ACS is classically recognized by one or more of the following symptoms: crushing chest pain, shortness of breath, pain that radiates to the jaw, arm or shoulder, sweating, and/or nausea or vomiting. It is important to note that not all individuals with ACS will present with these classic findings, particularly women and individuals with diabetes mellitus. It is impossible to determine a specific cardiac event from the ACS symptoms; therefore, ACS symptoms are managed in the same way.

Every individual with these symptoms should be evaluated immediately. If an individual appears to be unconscious, begin with the BLS Survey and follow the appropriate pathway for advanced care. If the individual is conscious, proceed with the pathway below.

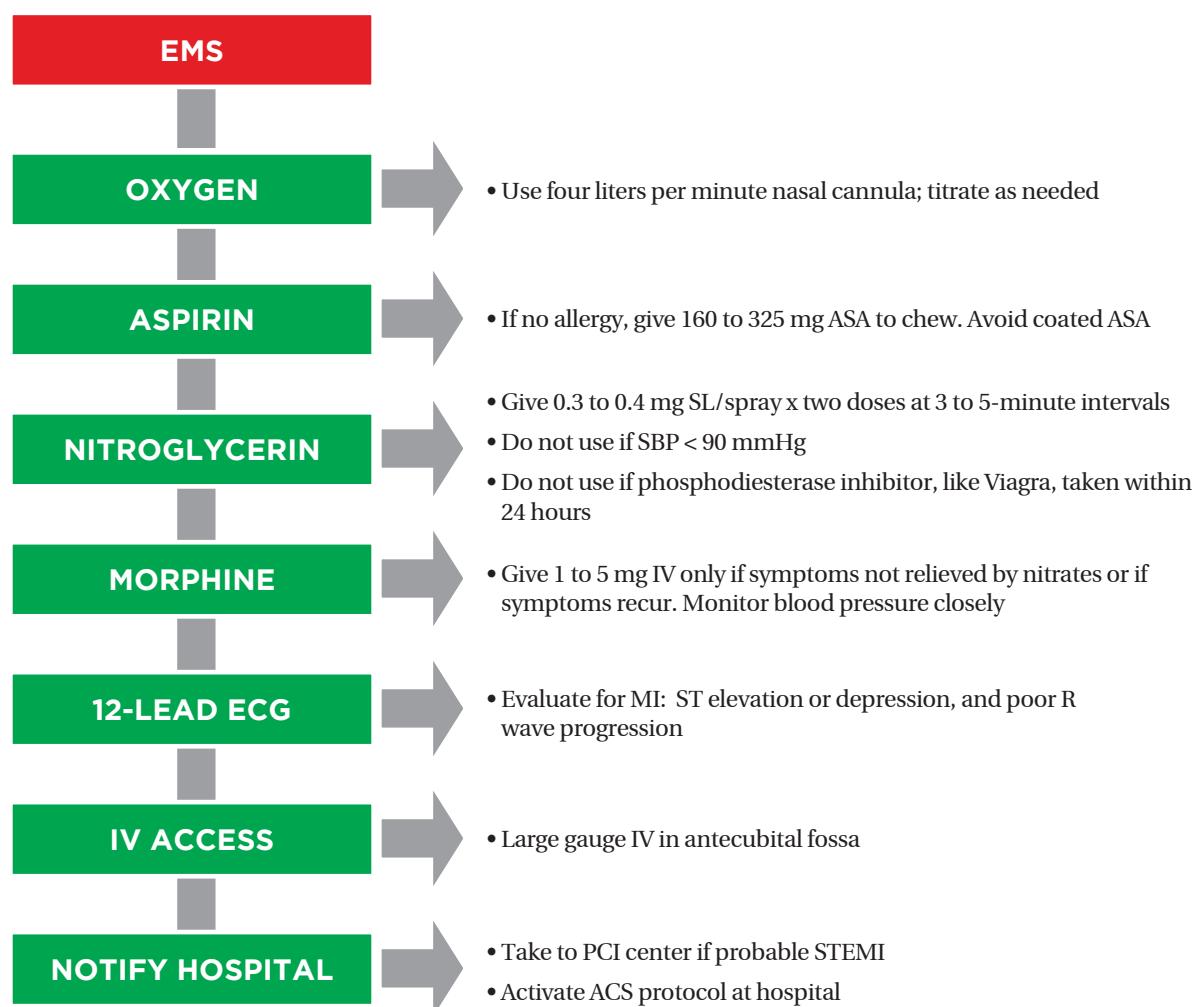


Figure 41



Adult Coronary Syndrome Algorithm

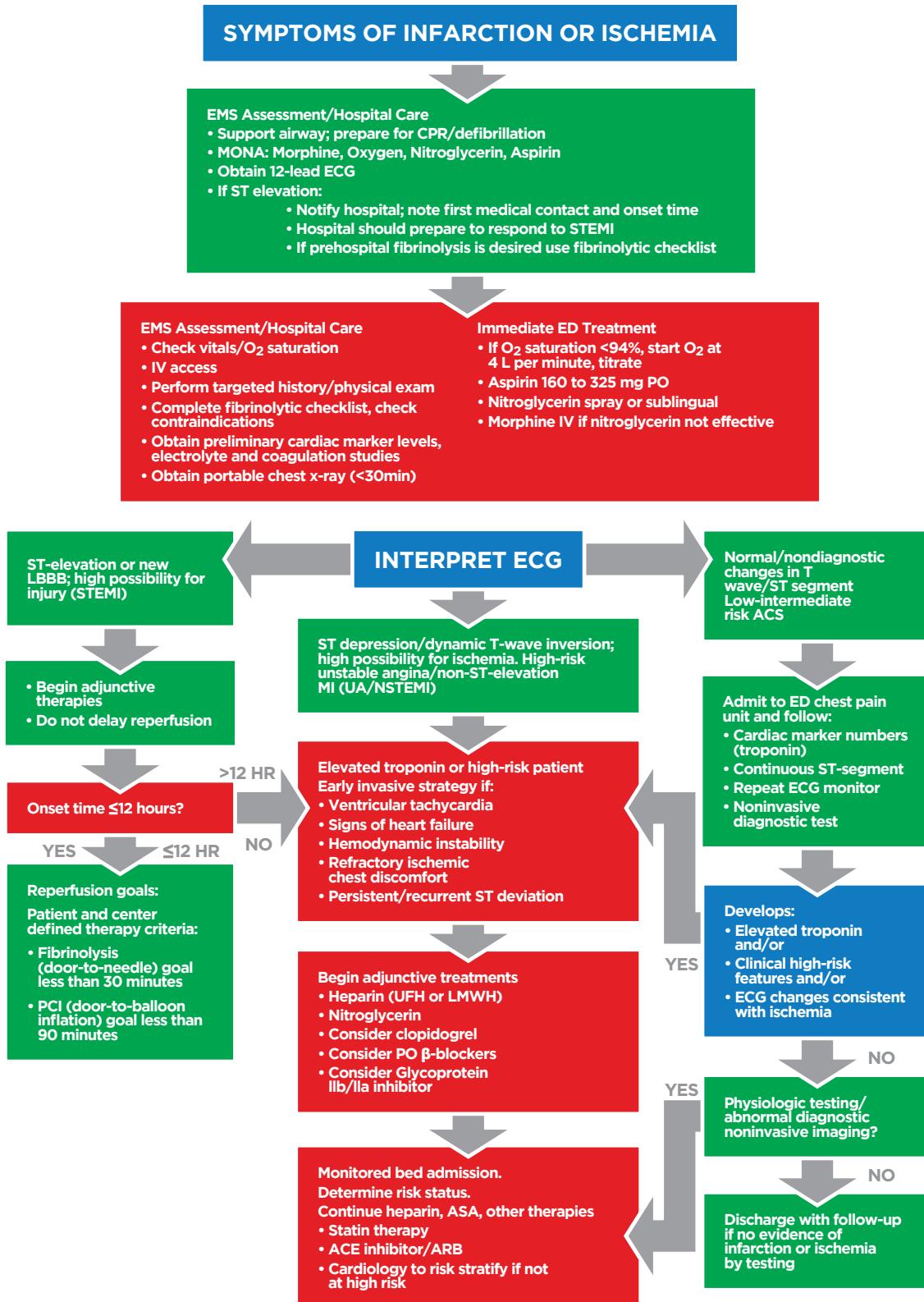


Figure 42



ACUTE STROKE

Stroke is a condition in which normal blood flow to the brain is interrupted. Strokes can occur in two variations: ischemic and hemorrhagic. In ischemic stroke, a clot lodges in one of the brain's blood vessels, blocking blood flow through the blood vessel. In hemorrhagic stroke, a blood vessel in the brain ruptures, spilling blood into the brain tissue. Ischemic stroke and hemorrhagic stroke account for 87% and 13% of the total incidents, respectively. In general, the symptoms of ischemic and hemorrhagic strokes are similar. However, the treatments are very different.

SYMPTOMS OF STROKE

- Weakness in the arm and leg or face
- Vision problems
- Confusion
- Nausea or vomiting
- Trouble speaking or forming the correct words
- Problems walking or moving
- Severe headache (hemorrhagic)

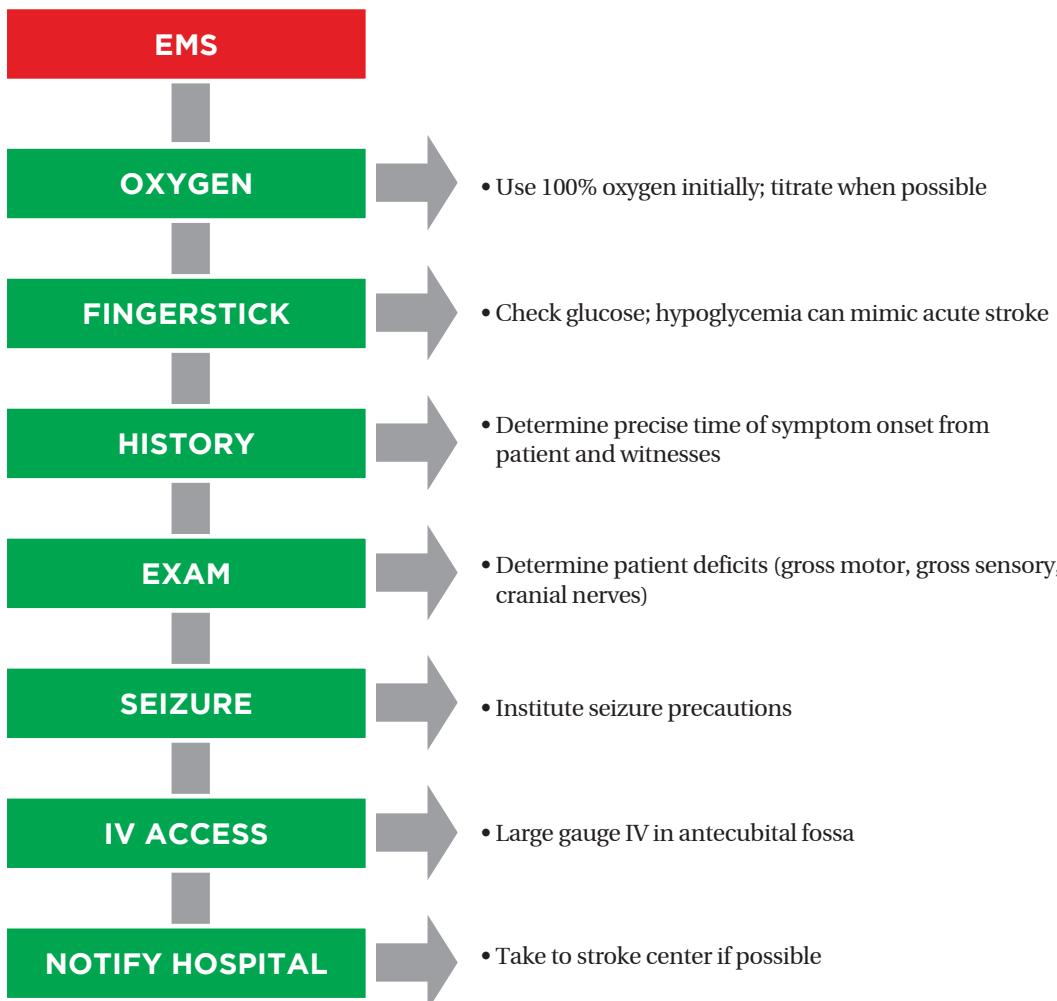


Figure 43



Clinical signs of stroke depend on the region of the brain affected by decreased or blocked blood flow. Signs and symptoms can include: weakness or numbness of the face, arm, or leg, difficulty walking, difficulty with balance, vision loss, slurred or absent speech, facial droop, headache, vomiting, and change in level of consciousness. Not all of these symptoms are present, and the exam findings depend on the cerebral artery affected.

The Cincinnati Prehospital Stroke Scale (CPSS) is used to diagnose the presence of stroke in an individual if any of the following physical findings are seen: facial droop, arm drift, or abnormal speech. Individuals with one of these three findings as a new event have a 72% probability of an ischemic stroke. If all three findings are present, the probability of an acute stroke is more than 85%. Becoming familiar and proficient with the tool **FAST** utilized by the rescuers' EMS system is recommended. Mock scenarios and practice will facilitate the use of these valuable screening tools.

FAST: Face Drooping, Arm Weakness, Speech, and Time Symptoms Started

Individuals with ischemic stroke who are not candidates for fibrinolytic therapy should receive aspirin unless contraindicated by true allergy to aspirin. All individuals with confirmed stroke should be admitted to Neurologic Intensive Care Unit if available. Stroke treatment includes blood pressure monitoring and regulation per protocol, seizure precautions, frequent neurological checks, airway support as needed, physical/occupational/speech therapy evaluation, body temperature checks, and blood glucose monitoring. Individuals who received fibrinolytic therapy should be followed for signs of bleeding or hemorrhage. Certain individuals (age 18 to 79 years with mild to moderate stroke) may be able to receive tPA (tissue plasminogen activator) up to 4.5 hours after symptom onset. Under certain circumstances, intra-arterial tPA is possible up to six hours after symptom onset. When the time of symptom onset is unknown, it is considered an automatic exclusion for tPA. If time of symptom onset is known, the National Institute of Neurological Disorders and Stroke (NINDS) has established the time goals below.

Figure 44

10 MINUTES OF ARRIVAL	25 MINUTES OF ARRIVAL	60 MINUTES OF ARRIVAL	180 MINUTES OF ARRIVAL
<ul style="list-style-type: none">• General assessment by expert• Order urgent CT scan without contrast	<ul style="list-style-type: none">• Perform CT scan without contrast• Neurological assessment• Read CT scan within 45 minutes	<ul style="list-style-type: none">• Evaluate criteria for use and administer fibrinolytic therapy ("clot buster")• Fibrinolytic therapy may be used within three hours of symptom onset (4.5 hours in some cases)	<ul style="list-style-type: none">• Admission to stroke unit

- *Before giving anything (medication or food) by mouth, you must perform a bedside swallow screening. All acute stroke individuals are considered NPO on admission.*
- *The goal of the stroke team, emergency physician, or other experts should be to assess the individual with suspected stroke within 10 minutes of arrival in the emergency department (ED).*
- *The CT scan should be completed within 25 minutes of the individual's arrival in the ED and should be read within 45 minutes.*



EMERGENCY DEPARTMENT STAFF

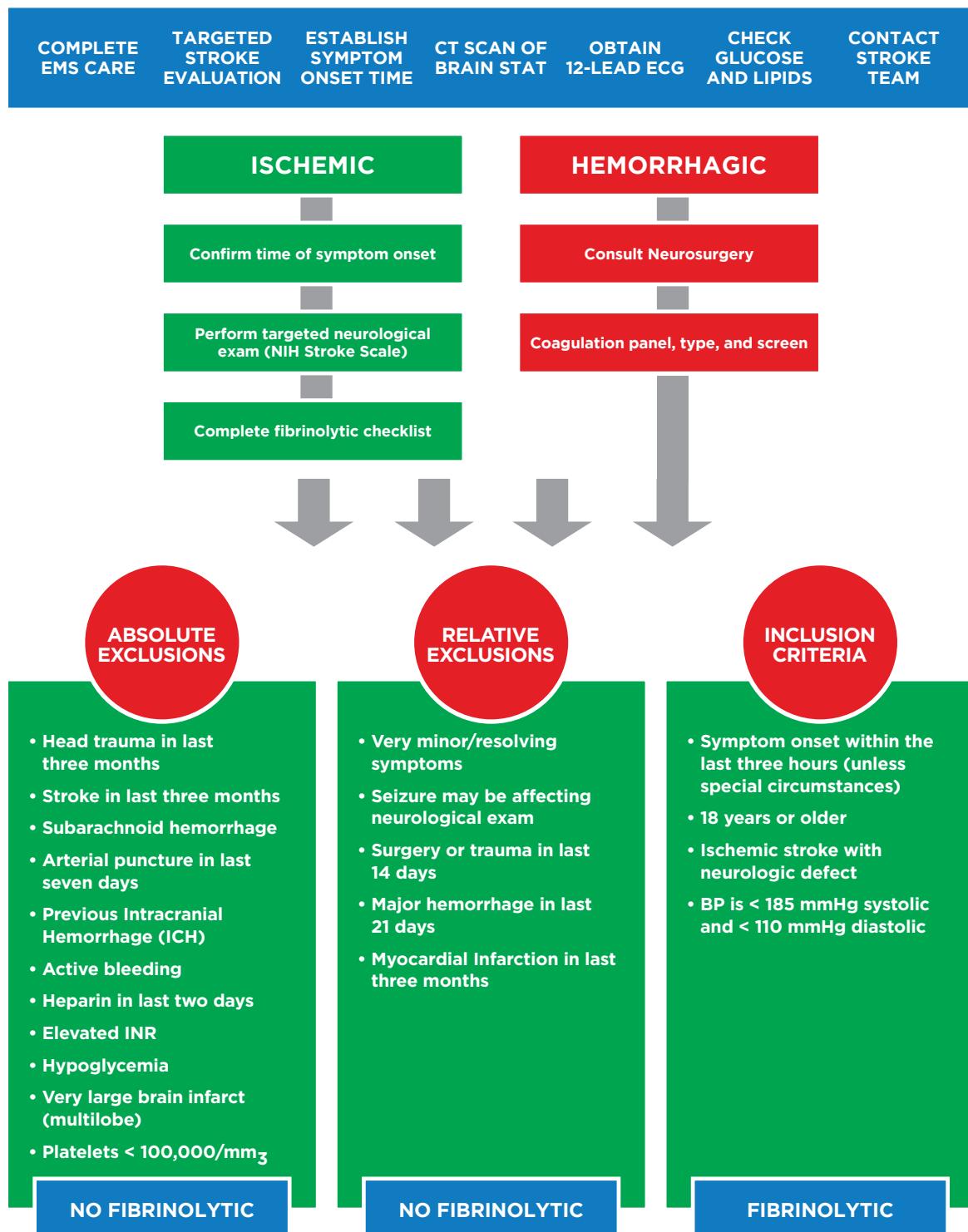
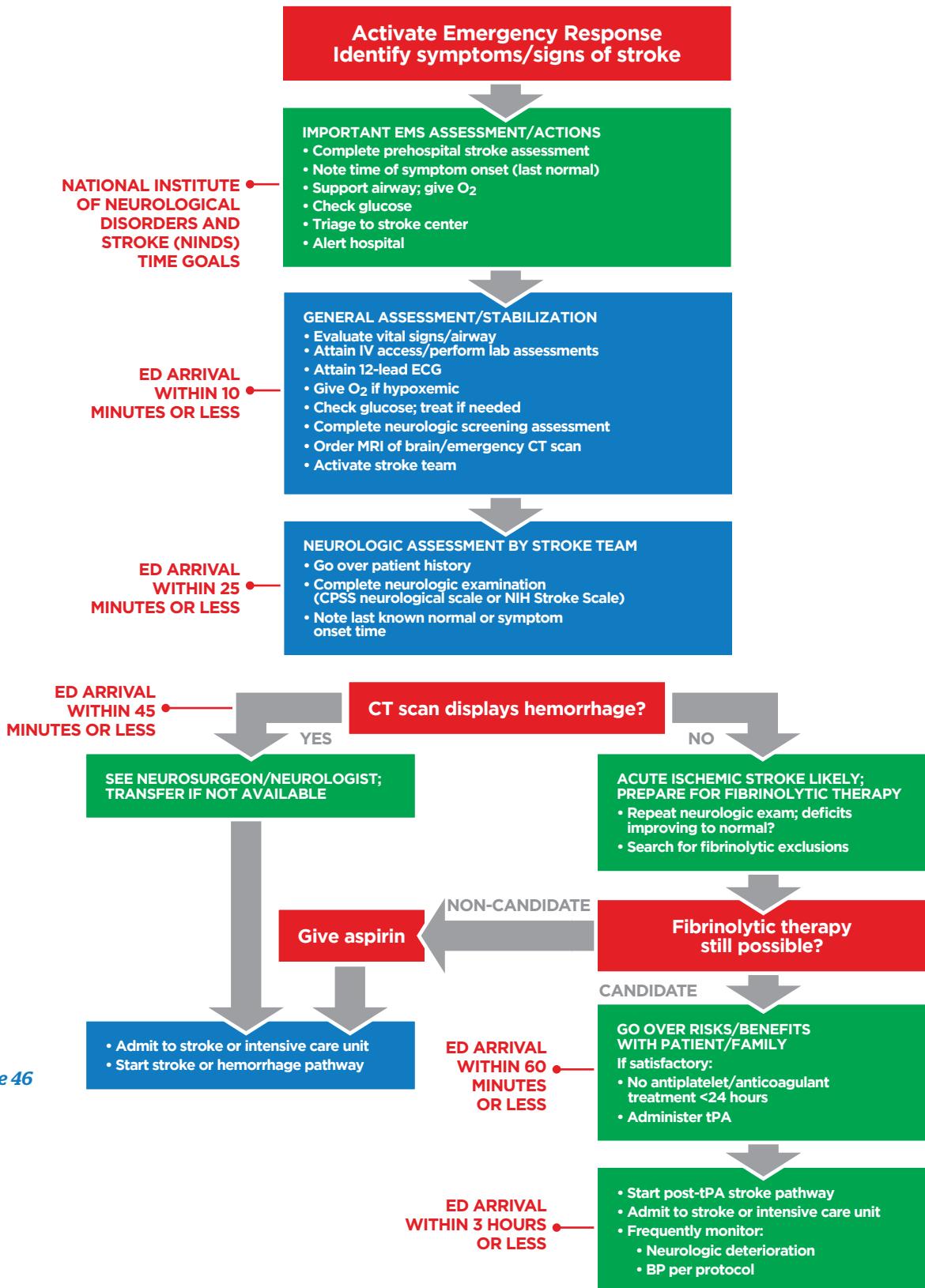


Figure 45



Acute Stroke Algorithm





SELF-ASSESSMENT FOR ACLS CASES

1. Which of the following is the correct next step in management after delivery of a shock?
 - a. Check pulse.
 - b. Ventilate only.
 - c. Do chest compressions.
 - d. Shock again.
2. Where does the electrical impulse for normal cardiac activity originate?
 - a. Unknown
 - b. SA node
 - c. AV node
 - d. Purkinje fibers
3. Choose the correct sequence of electrical activity in the heart for normal sinus rhythm?
 - a. SA node, Purkinje, AV node, Bundle of His
 - b. Purkinje, Bundle of His, AV node, SA node
 - c. SA node, AV node, Bundle of His, Purkinje fibers
 - d. AV node, SA node, Bundle of Hers, Purkinje fibers
4. What does the QRS complex on an ECG represent?
 - a. Ventricular contraction
 - b. AV valve closure
 - c. Atrial contraction
 - d. Septum relaxation
5. What is the recommended method to monitor breathing during ACLS care?
 - a. Look, listen, and feel
 - b. Capnography
 - c. Venous blood gas
 - d. Monitoring chest rise
6. You are transporting an individual who goes into cardiac arrest during transport. IV access is unsuccessful. What is the next step?
 - a. Terminate resuscitation.
 - b. Obtain intraosseous access.
 - c. Place a central line.
 - d. Administer all medications through ET tube.
7. An individual has been ill, and the monitor reveals sinus tachycardia with a heart rate of 135. What is the primary goal in treating this individual?
 - a. Determine the underlying cause.
 - b. Prepare for synchronized cardioversion.
 - c. Transfuse packed red blood cells.
 - d. Administer Adenosine.



8. A 79-year-old individual is in SVT. BP is 80/50, and he is complaining of chest discomfort and feels like passing out. What is the next appropriate step?
 - a. Carotid massage
 - b. Synchronized cardioversion
 - c. Amiodarone
 - d. Lidocaine
9. You are treating an individual who presented in ventricular fibrillation. After CPR and one attempt at defibrillation, his new rhythm is third-degree AV block. What is the next step in management?
 - a. Repeat defibrillation
 - b. Vasopressin
 - c. Transcutaneous pacing
 - d. High dose epinephrine
10. A 55-year-old male has stroke symptoms, and the CT scan shows multilobar infarction (more than one-third of the cerebral hemisphere). What therapy is contraindicated?
 - a. Oxygen
 - b. Monitoring glucose
 - c. Thrombolytic therapy
 - d. Blood pressure monitoring
11. What piece of data is critical to obtain in all stroke individuals?
 - a. Date of birth
 - b. Hemoglobin A1c
 - c. Bilateral arm blood pressure
 - d. Time last seen normal
12. True or False: The goal of stroke care is to complete the ED initial evaluation within 10 minutes, the neurologic evaluation within 25 minutes of arrival, and have the head CT read within 45 minutes of arrival.



ANSWERS

1. C
CPR is resumed for two minutes before any reassessment is performed. Begin with compression followed by ventilation in a 30:2 ratio for adults.
2. B
The SA node generates electrical impulse in normal cardiac activity. The impulse then travels to the rest of the conduction system and facilitates contraction of the atria and ventricles.
3. C
Normal cardiac electrical impulse travels in a consistent pattern producing normal sinus rhythm.
4. A
The QRS represents ventricular contraction. The T wave represents repolarization of the ventricles.
5. B
Quantitative waveform capnography is the recommended method to assess breathing/ventilation during ACLS. In addition, pulse oximetry should be assessed, and clinical assessment plays a role as well.
6. B
An intraosseous line can be placed rapidly and is the next best route for drug delivery. Absorption after ET tube delivery is unreliable.
7. A
The primary objective of treating sinus tachycardia is to determine the underlying cause. Appropriate treatment decisions can then be made.
8. B
This individual is symptomatic with hypotension and chest pain. Adenosine could be considered if IV access is already in place, while preparation is made for cardioversion. Carotid massage may cause complications in elderly individuals.
9. C
Transcutaneous pacing is indicated for Mobitz Type II second degree AV block, third-degree AV block, and bradycardia with symptomatic ventricular escape rhythm.
10. C
Thrombolytic therapy is contraindicated in large strokes that involve more than one-third of a cerebral hemisphere.
11. D
Eligibility for thrombolytic therapy hinges on the time of onset of symptoms. Current guidelines support administering tPA for eligible individuals with symptom onset of three hours or fewer. Selected individuals may be eligible for up to 4.5 hours from onset.
12. True
Stroke is a neurologic emergency and rapid evaluation and treatment may improve outcomes. The mantra “Time is Brain” should be used here.



ACLS ESSENTIALS

- Prompt recognition and intervention with high-quality CPR is critical in any arrest situation.
- Mentally prepare for resuscitation as you approach the scene and the individual.
- Scene safety is critical; do not get injured yourself.
- BLS focus is early CPR and early defibrillation.
- Do not attempt to place an oropharyngeal airway in an awake individual.
- Pull the jaw up into the mask; do not push the mask onto the face as it may close the airway.
- IV or IO is the preferred routes for drug delivery; ET tube absorption is unpredictable.
- The dose of amiodarone is different for VF and VT with a pulse.
- Resume chest compressions immediately after delivering a shock.
- Therapeutic hypothermia is utilized after return of spontaneous circulation.
- Learn specific cardiac rhythms: sinus tachycardia, SVT, atrial fibrillation/flutter, VF, VT, torsades de pointes, and asystole.
- Confirm asystole in two separate leads.
- VF and pulseless VT are treated the same: deliver a shock.
- Remember the causes of PEA: the H's and the T's.
- Capnography is a valuable tool in resuscitation. If PETCO₂ is greater than 10, attempt to improve CPR quality.
- Use nitroglycerin with caution in individuals with inferior myocardial infarction; avoid if systolic blood pressure (SBP) is less than 90 mmHg, or if taking erectile dysfunction medications (phosphodiesterase inhibitors) within 24 hours.
- Confusion may be a presenting sign of a stroke.



ADDITIONAL TOOLS

MEDICODE

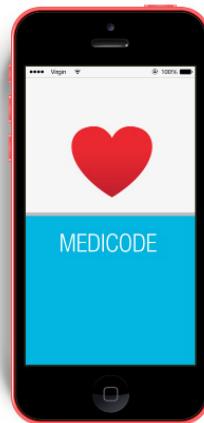


With MediCode, you no longer will have to carry a set of expandable cards with you at all times while at work. You will never have to waste valuable time in an emergency situation searching through multiple algorithms until you find the right one. All of the algorithms are now accessible from the palm of your hand, and you will be selecting your desired algorithm by memory in no time. Choose between multiple viewing options and easily share algorithms with co-workers and friends through email and social media.

To improve functionality and speed in obtaining your desired algorithm as quickly as possible in an emergency, they have been divided between BLS, ACLS, PALS, and CPR. All are accessible from the home screen.

The individual algorithms included in this app are:

- Basic Life Support (BLS)
- Advanced Cardiac Life Support (ACLS)
- Pediatric Advanced Life Support (PALS)
- Cardiopulmonary Resuscitation (CPR) AED, and First Aid



CERTALERT+



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ACLS REVIEW QUESTIONS

1. The following are included in the ACLS Survey:
 - a. Airway, Breathing, Circulation, Differential Diagnosis
 - b. Airway, Breathing, Circulation, Defibrillation
 - c. Assessment, Breathing, Circulation, Defibrillation
 - d. Airway, Breathing, CPR, Differential Diagnosis
2. The primary focus of treating cardiac arrest is:
 - a. Effective CPR
 - b. Early defibrillation
 - c. Drug administration
 - d. Both A and B
3. Which of the following is not an example of an advanced airway?
 - a. Oropharyngeal airway
 - b. Esophageal-tracheal tube
 - c. Laryngeal mask airway
 - d. Combitube
4. The following are possible effects of hyperventilation:
 - a. Increased intrathoracic pressure
 - b. Decreased venous return to the heart
 - c. Both A and B
 - d. None of the above
5. The normal sinus rhythm of the heart starts in the:
 - a. Left ventricle
 - b. Atrioventricular node
 - c. Sinoatrial node
 - d. Right ventricle
6. What is high-quality CPR?
 - a. 80 compressions per minute at a depth of at least one-inch (2.5 cm)
 - b. 100 to 120 compressions per minute at a depth of 2 to 2.4 inches (5 to 6 cm)
 - c. 80 compressions per minute at a depth of at least two inches (5 cm)
 - d. 100 compressions per minute at a depth of at least one inch (2.5 cm)



7. Before placement of an advanced airway, the compression to ventilation ratio during adult CPR is:
 - a. 30:1
 - b. 30:2
 - c. 15:1
 - d. 20:2
8. You should _____ in an individual with ventricular fibrillation immediately following a shock.
 - a. Resume CPR
 - b. Check heart rate
 - c. Analyze rhythm
 - d. Give amiodarone
9. _____ joules (J) are delivered per shock when using a monophasic defibrillator.
 - a. 380
 - b. 320
 - c. 340
 - d. 360
10. The following medication(s) can be used to treat hypotension during the post-cardiac arrest phase:
 - a. Dopamine
 - b. Milrinone
 - c. Amiodarone
 - d. Both A and B
11. The following antiarrhythmic drug(s) can be used for persistent ventricular fibrillation or pulseless ventricular tachycardia, except:
 - a. Amiodarone
 - b. Lidocaine
 - c. Atropine
 - d. Epinephrine
12. Which of the following is not a potential cause of PEA?
 - a. Toxins
 - b. Hyperkalemia
 - c. Hyperventilation
 - d. Trauma
13. Which of the following is a shockable rhythm?
 - a. Ventricular fibrillation
 - b. Ventricular tachycardia (pulseless)
 - c. Torsades de Pointes
 - d. All of the above



14. The following drug(s) may be used in an ACS individual for cardiac reperfusion:
 - a. Fibrinolytic therapy
 - b. Epinephrine
 - c. Atropine
 - d. Both A and C
15. All of the following are bradycardic rhythms except:
 - a. Atrial fibrillation
 - b. First-degree heart block
 - c. Mobitz Type I
 - d. Third-degree heart block
16. _____ access is preferred in arrest due to easy access and no interruption in CPR.
 - a. Central
 - b. Peripheral
 - c. Intraosseous
 - d. Endotracheal
17. Which of the following is first-line treatment for ACS?
 - a. Morphine
 - b. Aspirin
 - c. Nitroglycerin
 - d. All of the above
18. The following are classic signs of an acute stroke except:
 - a. Facial droop
 - b. Arm drift
 - c. Abnormal speech
 - d. Seizure
19. Which of the following is not found within the 8 D's of stroke care?
 - a. Detection
 - b. Dispatch
 - c. Delivery
 - d. Defibrillate



ANSWERS

1. A
Airway, Breathing, Circulation, Differential Diagnosis
2. D
Both A and B
3. A
Oropharyngeal airway
4. C
Both A and B
5. C
Sinoatrial node
6. B
100 to 120 compressions per minute at a depth of 2 to 2.4 inches (5 to 6 cm)
7. B
30:2
8. A
Resume CPR
9. D
360
10. A
Dopamine
11. C
Atropine
12. C
Hyperventilation
13. D
All of the above
14. A
Fibrinolytic therapy
15. A
Atrial fibrillation
16. B
Peripheral
17. D
All of the above
18. D.
Seizure
19. D
Defibrillate



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