Summary

2015 AHA Advanced Cardiac Life Support Changes

Assessment Sequence

- Healthcare providers (HCPs) must call for nearby help upon finding the victim unresponsive, but it would be practical for an HCP to continue to assess the breathing and pulse simultaneously before fully activating the emergency response system (or calling for backup).

- Trained rescuers are encouraged to simultaneously perform some steps (ie, checking for breathing and pulse at the same time), in an effort to reduce the time to first chest compression.

Compression Rate

- In adult victims of cardiac arrest, it is reasonable for rescuers to perform chest compressions at a rate of 100 to 120/min.

Chest Compression Depth

- Perform chest compressions to a depth of at least 2 inches/5 cm for an average adult. Avoid excessive chest compression depths of more than 2.4 inches/6 cm when a feedback device is available.

Advanced airway ventilation rate

- It may be reasonable for the provider to deliver 1 breath every 6 seconds (10 breaths per minute) while continuous chest compressions are being performed (ie,during CPR with an advanced airway).

Targeted temperature management

- All comatose (ie, lacking meaningful response to verbal commands) adult patients with return of spontaneous circulation (ROSC) after cardiac arrest should have targeted temperature management (TTM), with a target temperature between 32°C and 36°C selected and achieved, and least 24 hours.

Out-of-hospital cooling

- The routine prehospital cooling of patients with rapid infusion of cold intravenous (IV) fluids after ROSC is not recommended.

Vasopressors for resuscitation: vasopressin

- Vasopressin in combination with epinephrine offers no advantage as a substitute for standard-dose epinephrine in cardiac arrest.

Vasopressors for resuscitation: epinephrine

- It may be reasonable to administer epinephrine as soon as feasible after the onset of cardiac arrest due to an initial nonshockable rhythm.

Cardiac arrest in patients with known or suspected opioid overdose

- Patients with no definite pulse may be in cardiac arrest or may have an undetected weak or slow pulse. These patients should be managed as cardiac arrest patients. Standard resuscitative measures should take priority over naloxone administration, with a focus on high-quality CPR (compressions plus ventilation). It may be reasonable to administer intramuscular (IM) or intranasal (IN) naloxone based on the possibility that the patient is in respiratory arrest, not in cardiac arrest. Responders should not delay access to more-advanced medical services while awaiting the patient’s response to naloxone or other interventions.

Cardiac arrest in pregnancy: provision of CPR

- Priorities for the pregnant woman in cardiac arrest are provision of high-quality CPR and relief of aortocaval compression. If the fundus height is at or above the level of the umbilicus, manual left uterine displacement can be beneficial in relieving aortocaval compression during chest compressions.