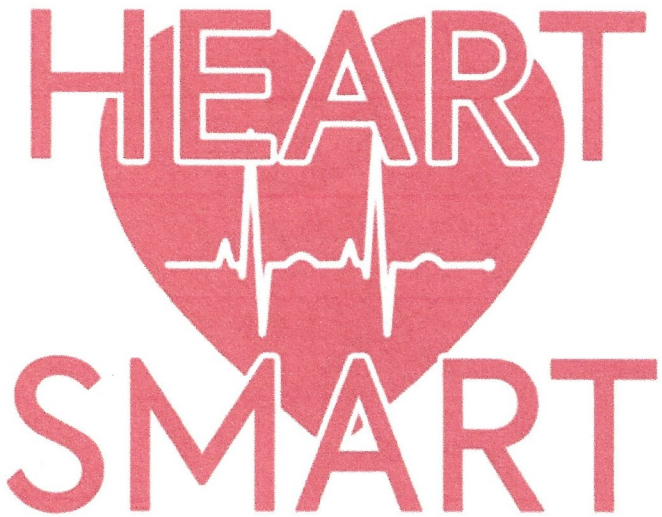


ACLS STUDY GUIDE

HeartSmartACLS.com

Summary of High-Quality CPR Components for BLS Providers

American Heart Association.

Component	Adults and adolescents	Children (age 1 year to puberty)	Infants (age less than 1 year, excluding newborns)
Verifying scene safety	Make sure the environment is safe for rescuers and victim		
Recognizing cardiac arrest	Check for responsiveness No breathing or only gasping (ie, no normal breathing) No definite pulse felt within 10 seconds (Breathing and pulse check can be performed simultaneously in less than 10 seconds)		
Activating emergency response system	***If a mobile device is available, phone emergency services (9-1-1)***		
	If you are alone with no mobile phone, leave the victim to activate the emergency response system and get the AED before beginning CPR Otherwise, send someone and begin CPR immediately; use the AED as soon as it is available	***Witnessed collapse*** Follow steps for adults and adolescents on the left ***Unwitnessed collapse*** Give 2 minutes of CPR Leave the victim to activate the emergency response system and get the AED Return to the child or infant and resume CPR; use the AED as soon as it is available	
Compression-ventilation ratio *without advanced airway*	***1 or 2 rescuers*** 30:2	***1 rescuer*** 30:2 ***2 or more rescuers*** 15:2	
Compression-ventilation ratio *with advanced airway*	Continuous compressions at a rate of 100-120/min Give 1 breath every 6 seconds (10 breaths/min)	Continuous compressions at a rate of 100-120/min Give 1 breath every 2-3 seconds (20-30 breaths/min)	
Compression rate	100-120/min		
Compression depth	At least 2 inches (5 cm)*	At least one third AP diameter of chest Approximately 2 inches (5 cm)	At least one third AP diameter of chest Approximately 1½ inches (4 cm)
Hand placement	2 hands on the lower half of the breastbone (sternum)	2 hands or 1 hand (optional for very small child) on the lower half of the breastbone (sternum)	***1 rescuer*** 2 fingers or 2 thumbs in the center of the chest, just below the nipple line ***2 or more rescuers*** 2 thumb–encircling hands in the center of the chest, just below the nipple line If the rescuer is unable to achieve the recommended depth, it may be reasonable to use the heel of one hand
Chest recoil	Allow complete recoil of chest after each compression; do not lean on the chest after each compression		
Minimizing interruptions	Limit interruptions in chest compressions to less than 10 seconds with a CCF goal of 80%		

*Compression depth should be no more than 2.4 inches (6 cm).
Abbreviations: AED, automated external defibrillator; AP, anteroposterior; CCF, chest compression fraction; CPR, cardiopulmonary resuscitation.

Respiratory

BLS Agonal/Gasping breaths may indicate cardiac arrest

Open airway with head tilt-chin lift

Airway Adjunct – NPA/OPA

Rescue Breathing (with pulse) - 10 x minute

Suction no longer than 10 seconds

Excessive ventilation causes decreased cardiac output

ALS Advanced Airway - LMA/ETT

Uninterrupted chest compressions 100-120 pm

Breaths 10x per minute

Continuous Waveform Capnography

Measures the quality of compressions for CPR

During Cardiac Arrest should at least 10

Goal after ROSC is 35-45 mmHg

Transition to ALS

Follow M.O.V.E on all stable patients prior to treatment

M – Monitor	get the vital signs
O – Oxygen	titrate to 94-99%
V – Veinous Access	peripheral IV
E – EKG 12lead	identify STEMIs

Peripheral IV (AC) is the preferred route for medications

I.O. is next, use it the same as an IV...push medications

Rapid Response Teams for early clinical deterioration

Team Dynamics

Clearly designated tasks for efficiently including a CPR Coach

Know your limitations

Use clear messages to the team

Verbalize completion of a task for a Closed Loop Communication

Constructive Intervention is good for quality CPR/ACLS

A.C.S.

Treat CP with M.O.N.A.

M – Morphine 2-4mg

O – Oxygen 90-99%

N – Nitro 3x SL

A – Aspirin 162 - 325mg

Nitro Contraindications

Right sided ischemia or infarction

Hypotension – Syst <90

Viagra/Cialis <36 hours

Preparation for ALS

Goal for PCI <90 min

EMS transport and notification to PCI Hospital

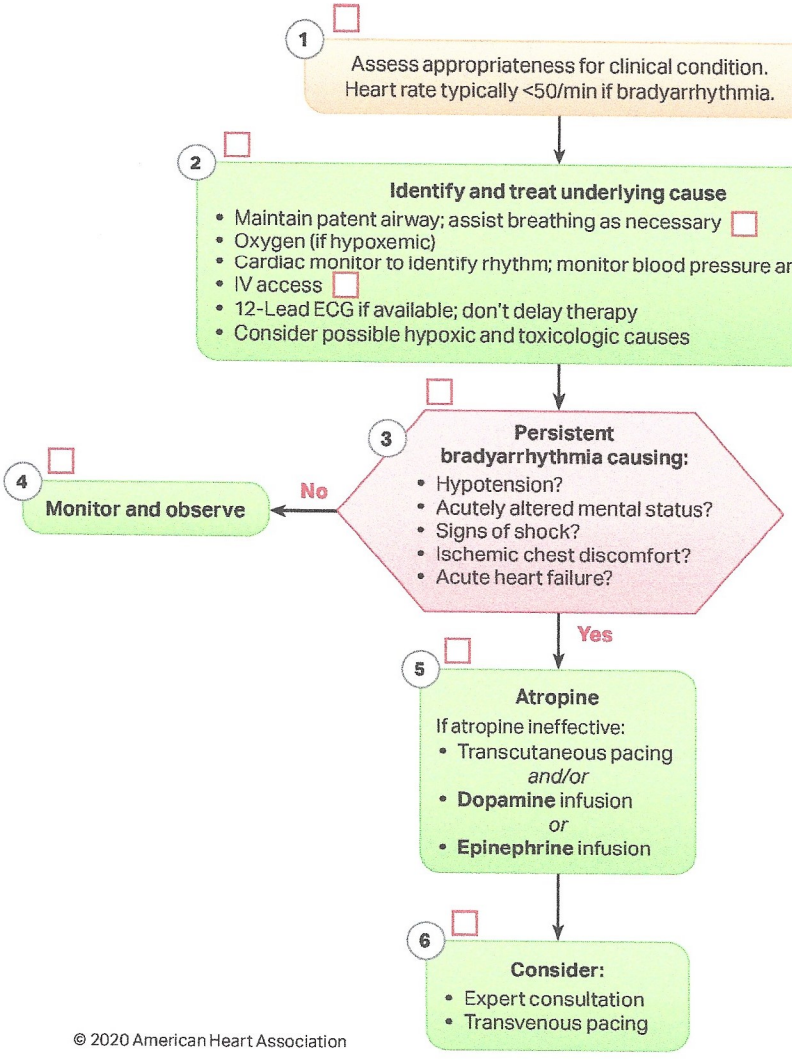
IV Fluids

Suction On

Code Cart in the room / Board under PT

Adult Bradycardia Learning Station Checklist

Adult Bradycardia Algorithm



Doses/Details

Atropine IV dose:
First dose: 1 mg bolus.
Repeat every 3-5 minutes.
Maximum: 3 mg.

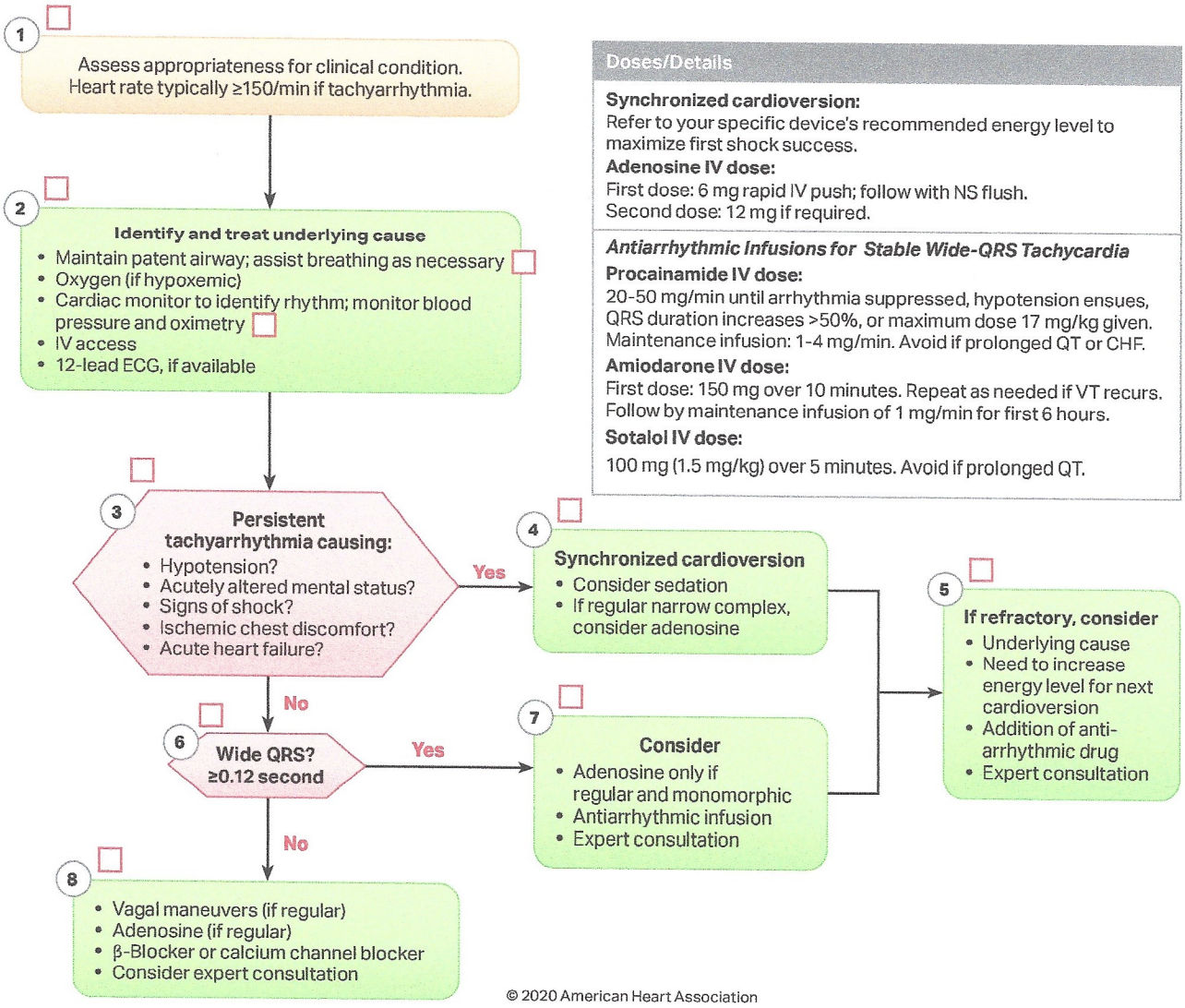
Dopamine IV infusion:
Usual infusion rate is 5-20 mcg/kg per minute.
Titrate to patient response; taper slowly.

Epinephrine IV infusion:
2-10 mcg per minute infusion.
Titrate to patient response.

Causes:
- Myocardial ischemia/infarction
- Drugs/toxicologic (eg, calcium-channel blockers, beta blockers, digoxin)
- Hypoxia
- Electrolyte abnormality (eg, hyperkalemia)

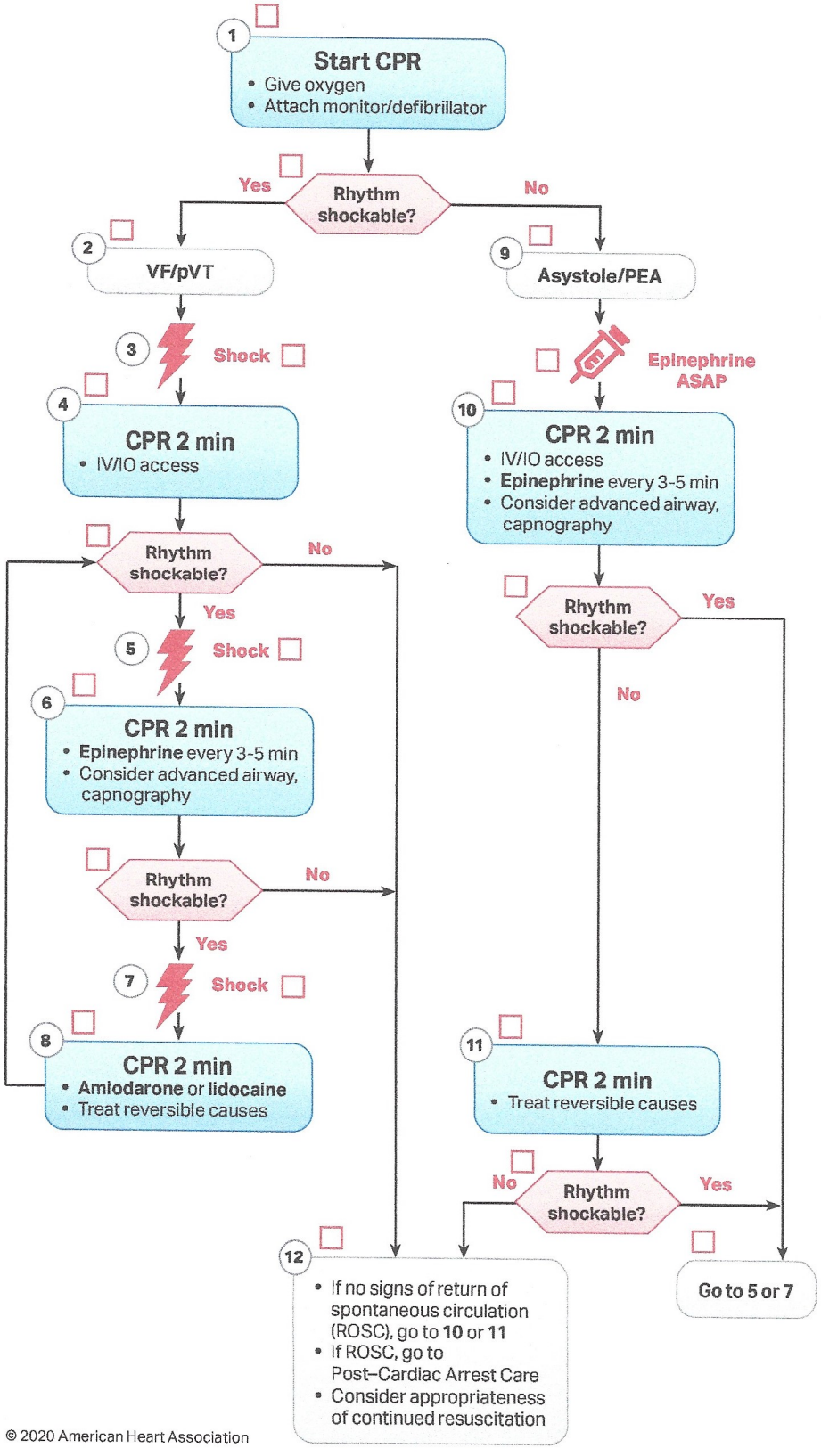
Adult Tachycardia With a Pulse Learning Station Checklist

Adult Tachycardia With a Pulse Algorithm



Adult Cardiac Arrest Learning Station Checklist (VF/pVT/Asystole/PEA)

Adult Cardiac Arrest Algorithm (VF/pVT/Asystole/PEA)



CPR Quality

- Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.
- Minimize interruptions in compressions.
- Avoid excessive ventilation.
- Change compressor every 2 minutes, or sooner if fatigued.
- If no advanced airway, 30:2 compression-ventilation ratio.
- Quantitative waveform capnography
  - If P_{ETCO_2} is low or decreasing, reassess CPR quality.

Shock Energy for Defibrillation

- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- **Monophasic:** 360 J

Drug Therapy

- **Epinephrine IV/IO dose:** 1 mg every 3-5 minutes
- **Amiodarone IV/IO dose:** First dose: 300 mg bolus. Second dose: 150 mg.
  or
  Lidocaine IV/IO dose: First dose: 1-1.5 mg/kg. Second dose: 0.5-0.75 mg/kg.

Advanced Airway

- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement
- Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions

Return of Spontaneous Circulation (ROSC)

- Pulse and blood pressure
- Abrupt sustained increase in P_{ETCO_2} (typically ≥40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

Cardiac Arrest

Have defibrillator charged 15 sec prior to 2 min switch

Resume CPR – Push medications

Advanced Airway with Capnography

Mechanical Compression Device

Think of underlying causes and reversals

Recap interventions, any team member have ideas?

Return of Spontaneous Circulation (ROSC)

M.O.V.E.

M – Monitor Vital Signs

O – oxygen Sp02 92-98 PETC02 35-45

V – IV fluids KVO or Bolus

E – EKG 12 lead - STEMI?

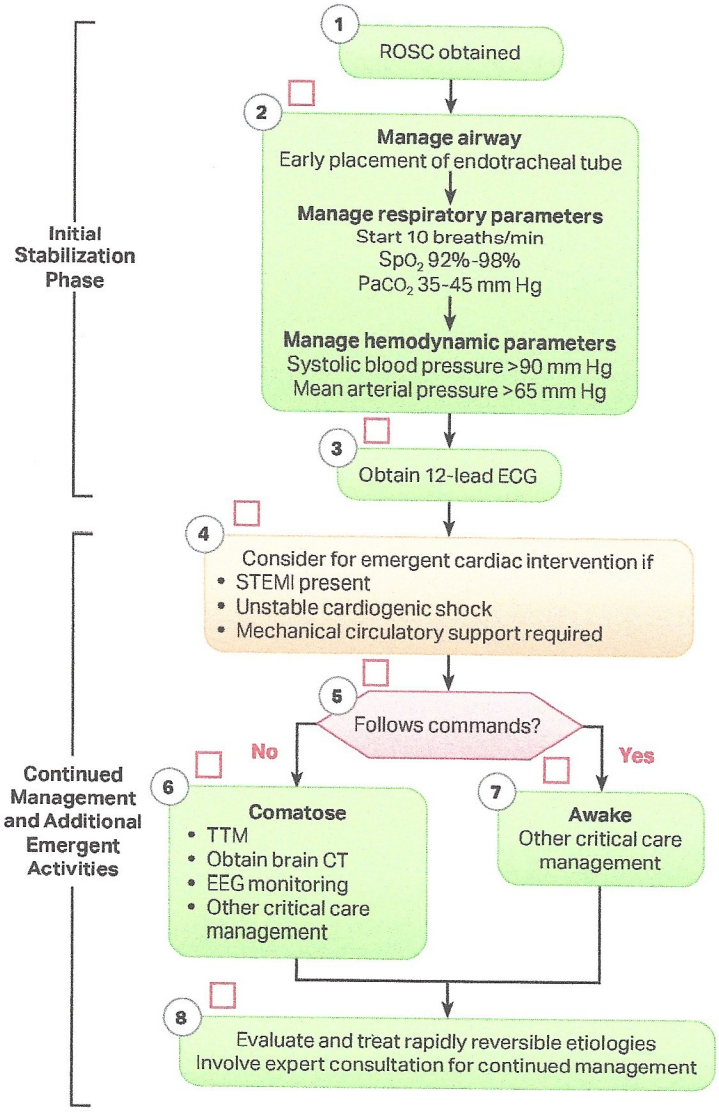
Prehospital transport to PCI capable hospital

Hypotension (<90s) 1-2 Liter Bolus and/or Vasopressor

Targeted Temperature is 32-36c for min of 24 hours

Adult Post–Cardiac Arrest Care Learning Station Checklist

Adult Post–Cardiac Arrest Care Algorithm



Initial Stabilization Phase

Resuscitation is ongoing during the post-ROSC phase, and many of these activities can occur concurrently. However, if prioritization is necessary, follow these steps:

- Airway management: Waveform capnography or capnometry to confirm and monitor endotracheal tube placement
- Manage respiratory parameters: Titrate FIO_2 for SpO_2 92%-98%; start at 10 breaths/min; titrate to $PaCO_2$ of 35-45 mm Hg
- Manage hemodynamic parameters: Administer crystalloid and/or vasopressor or inotrope for goal systolic blood pressure >90 mm Hg or mean arterial pressure >65 mm Hg

Continued Management and Additional Emergent Activities

These evaluations should be done concurrently so that decisions on targeted temperature management (TTM) receive high priority as cardiac interventions.

- Emergent cardiac intervention: Early evaluation of 12-lead electrocardiogram (ECG); consider hemodynamics for decision on cardiac intervention
- TTM: If patient is not following commands, start TTM as soon as possible; begin at 32-36°C for 24 hours by using a cooling device with feedback loop
- Other critical care management
  - Continuously monitor core temperature (esophageal, rectal, bladder)
  - Maintain normoxia, normocapnia, euglycemia
  - Provide continuous or intermittent electroencephalogram (EEG) monitoring
  - Provide lung-protective ventilation

H's and T's

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypokalemia/**h**yperkalemia
Hypothermia
Tension pneumothorax
Tamponade, cardiac
Toxins
Thrombosis, pulmonary
Thrombosis, coronary

Figure 21. Adult Suspected Stroke Algorithm.