

2025 Guidelines: Systems & Team Updates

Systems of Care: Community & Dispatch

Community
Inter



Naloxone Access: Public policies for access and immunity now recommended alongside AEDs.

Dispatch
Inter



No consciousness

+

No breathing

→ Go

Telecommunicators: “No-No-Go” Framework confirmed.
No consciousness + No breathing = Go.

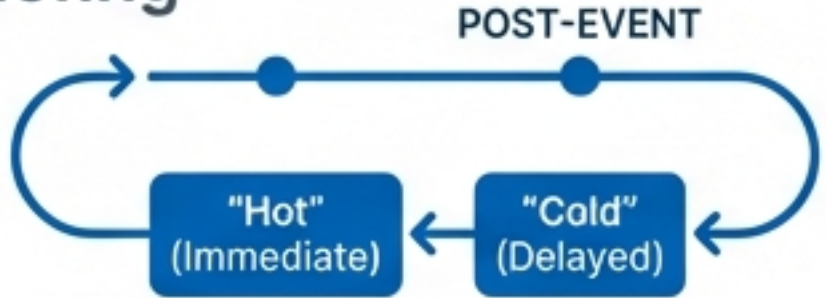
In-Hospital & Team Dynamics

Prevention
Inter



Safety Huddles: Implementation required for high-risk patients to mitigate deterioration.

Debriefing
Inter



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graph LR; A[POST-EVENT] --> B["Cold (Delayed)"]; B --> C["Hot (Immediate)"]; C --> A;
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Debriefing: Recommendation for both immediate ‘Hot’ and delayed ‘Cold’ debriefing.

Team
Inter



Team Composition: OHCA and IHCA teams must include members with ALS-level training.

2025 CLINICAL INTERVENTIONS: WHAT CHANGED?

CAUTION / UNCERTAIN BENEFIT



Double Sequential & Vector Change Defibrillation:

Usefulness not established for refractory VF/pVT.



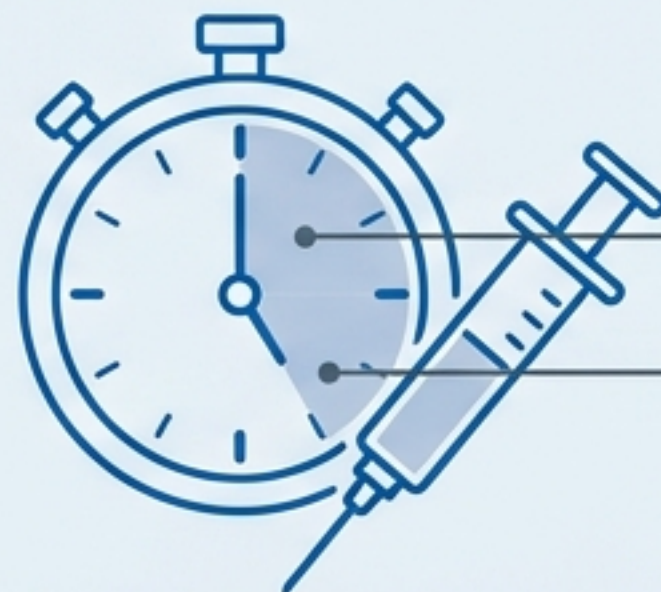
Antiarrhythmics:

Beta-blockers, bretylium, procainamide, or sotalol for VF/pVT are of uncertain benefit.

ACTION / RECOMMENDED



Vascular Access: IV access is preferred (Class 1). IO is reasonable only if IV fails (Class 2a).



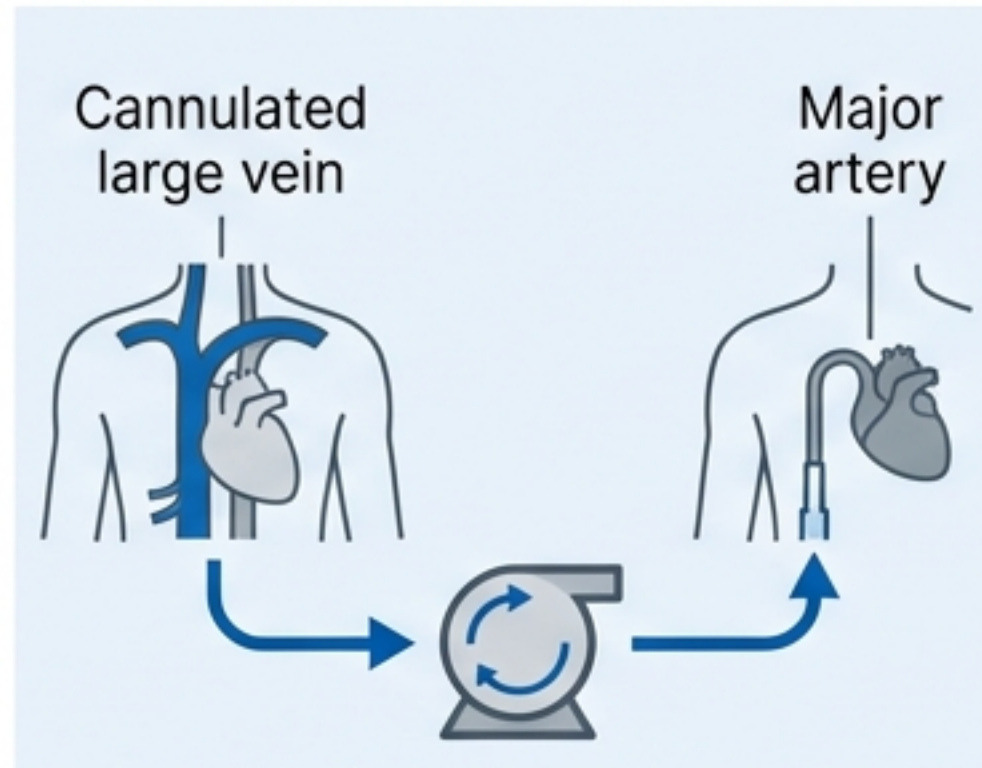
Epinephrine Timing:

Non-shockable: ASAP.

Shockable: After initial defibrillation attempts fail.

ADVANCED CARE & SPECIAL CIRCUMSTANCES

ECPR (Extracorporeal CPR)



Regionalized approach recommended. Rapid intra-arrest transport considered for highly selected patients.

Maternal Cardiac Arrest



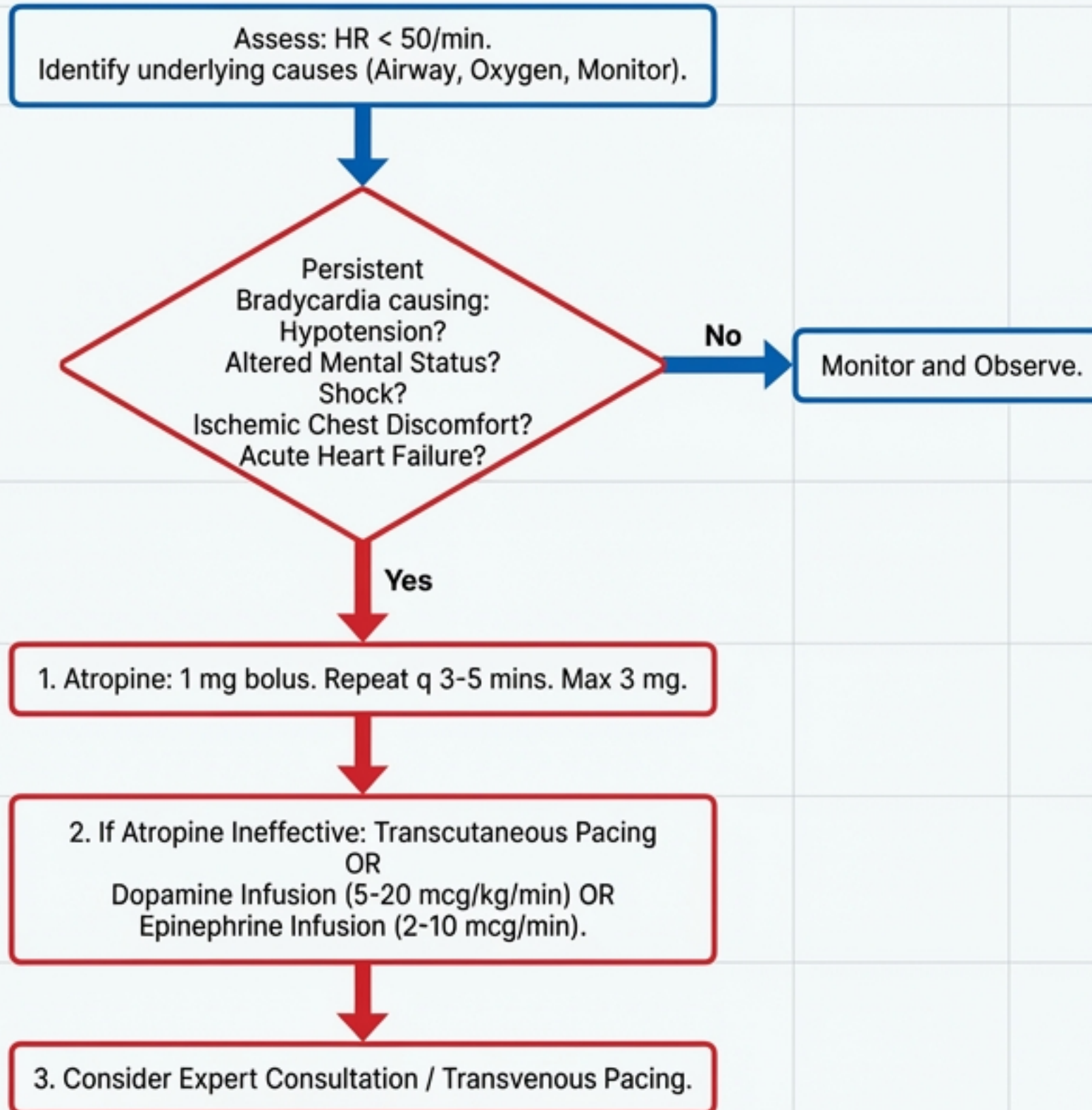
Term updated to 'Resuscitative Delivery'. Goal: Delivery by 5 minutes if no ROSC. Priority: **Left lateral uterine displacement.**

Prognostication

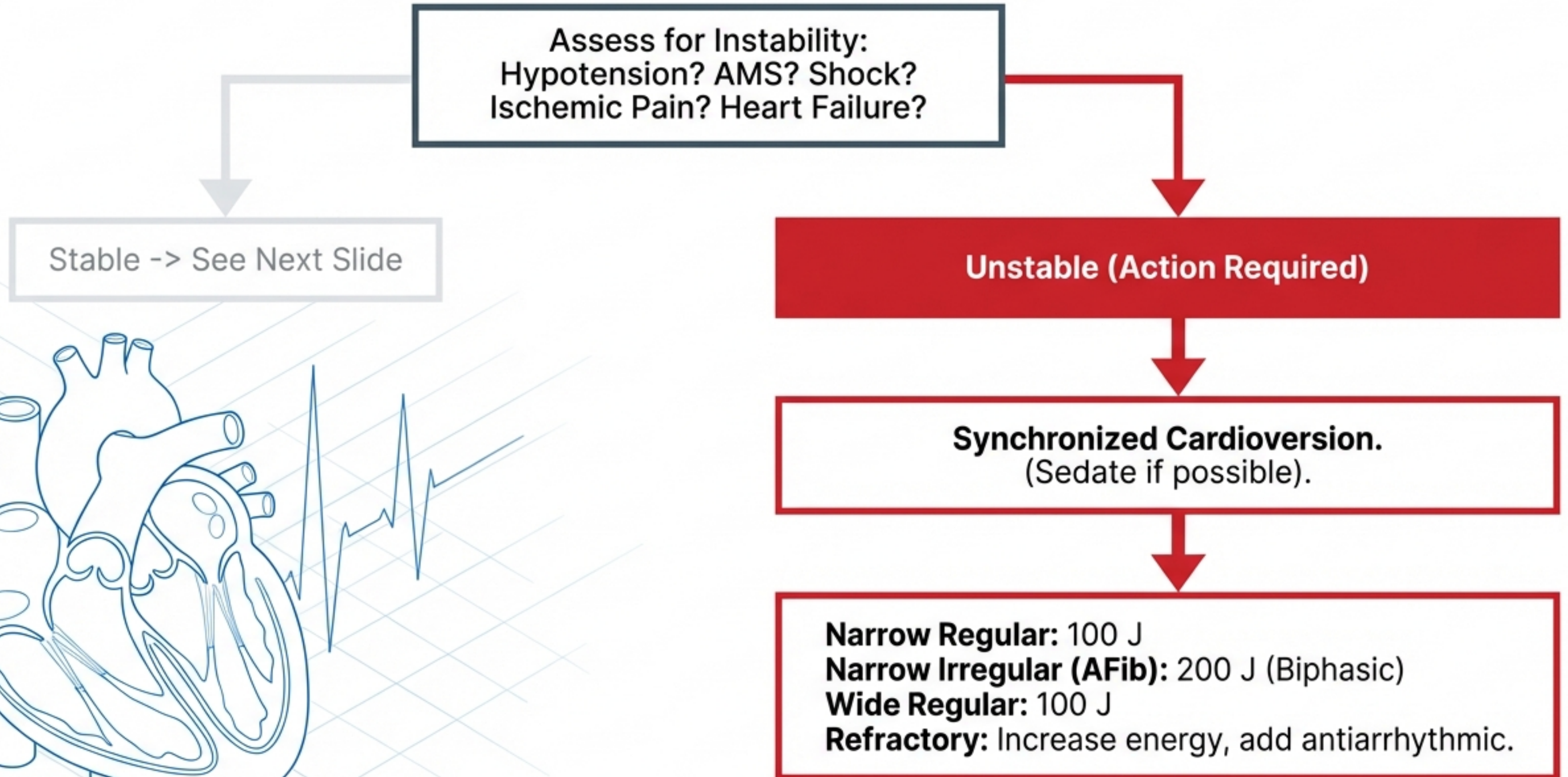


Do **NOT use cough/gag reflex alone** to predict outcome. Use multimodal approach. **EEG reasonable up to 72 hours** post-arrest.

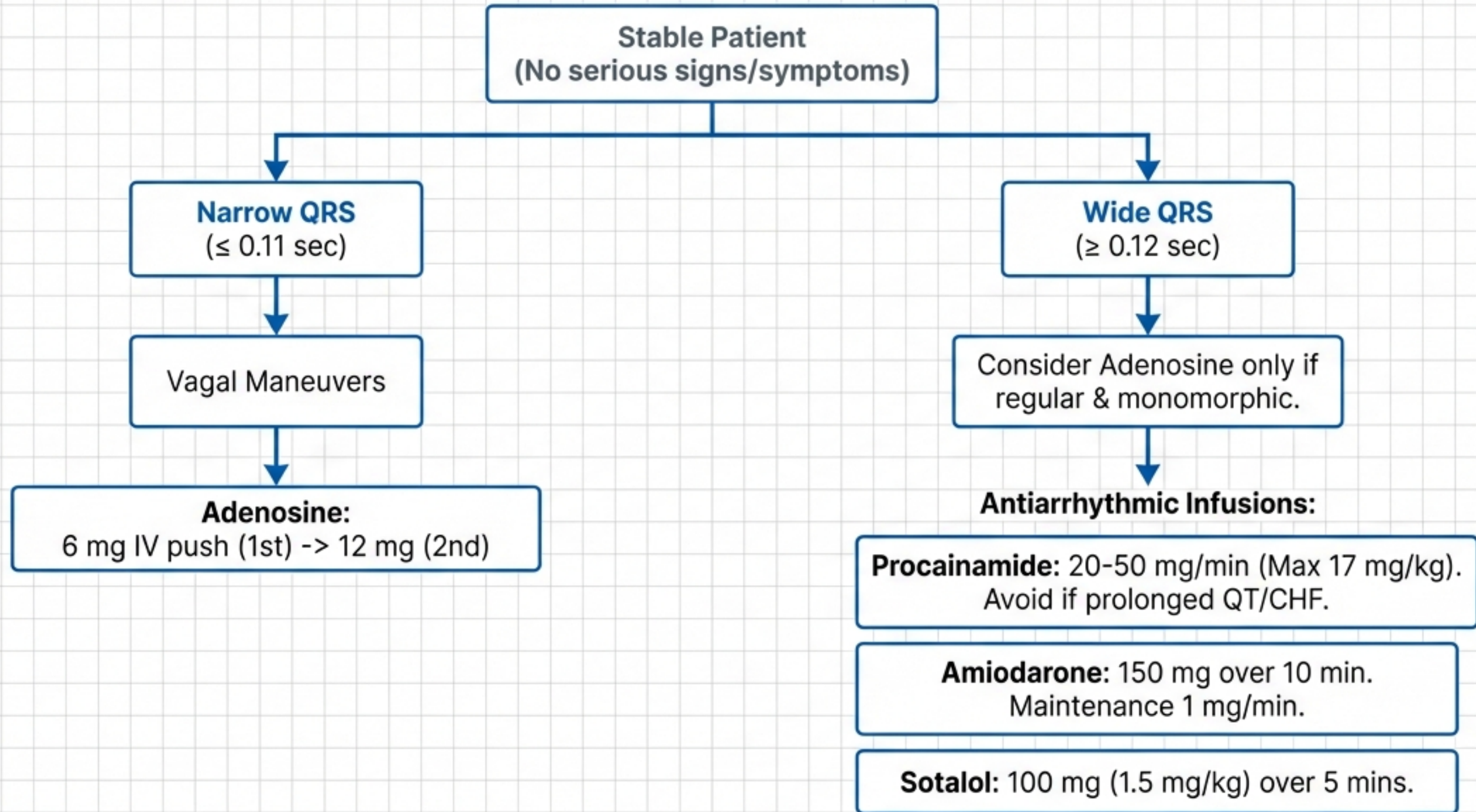
BRADYCARDIA PATHWAY (PULSE PRESENT)



TACHYCARDIA: THE STABILITY DECISION (HR $\geq$ 150/MIN)

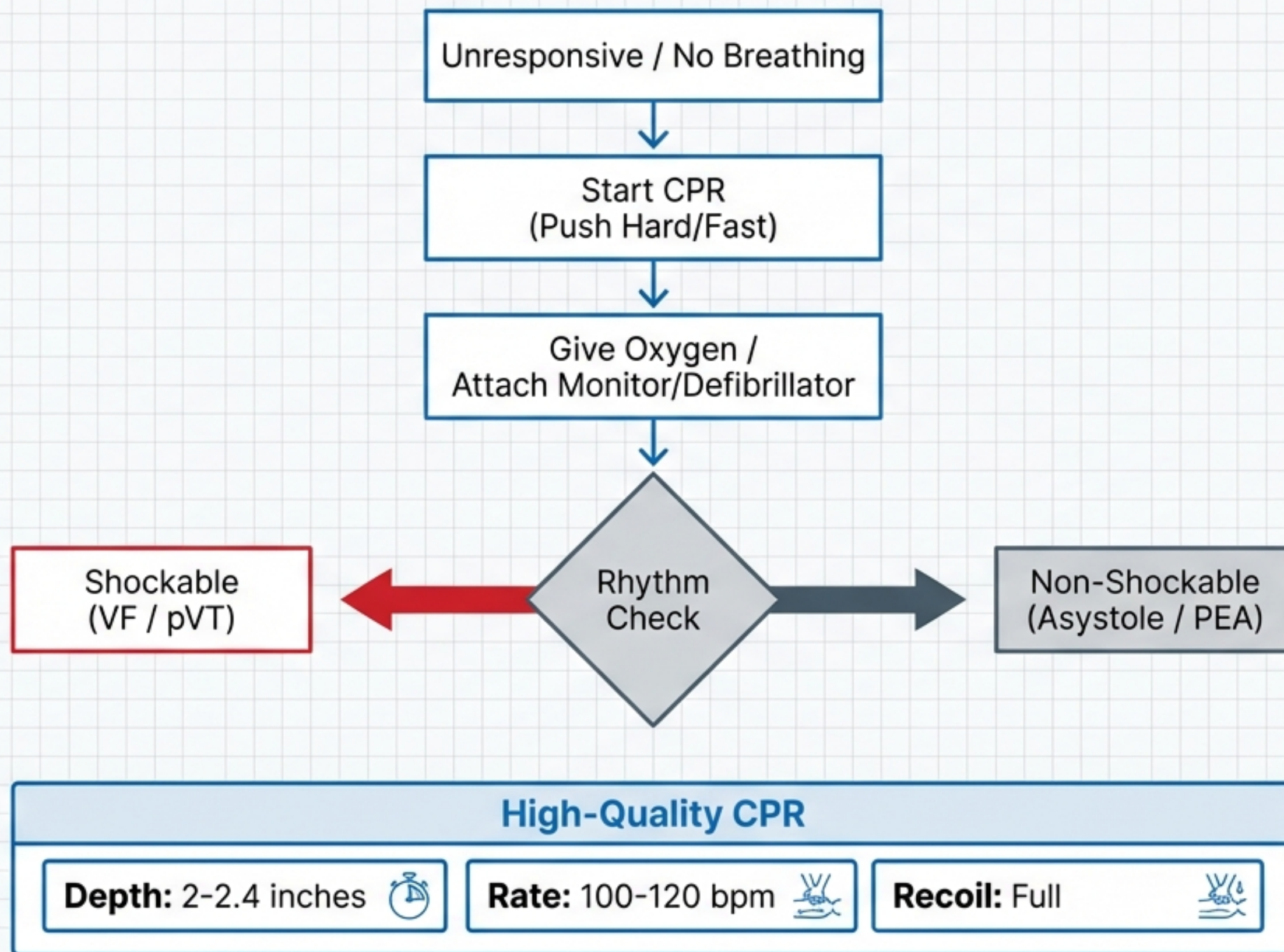


STABLE TACHYCARDIA MANAGEMENT

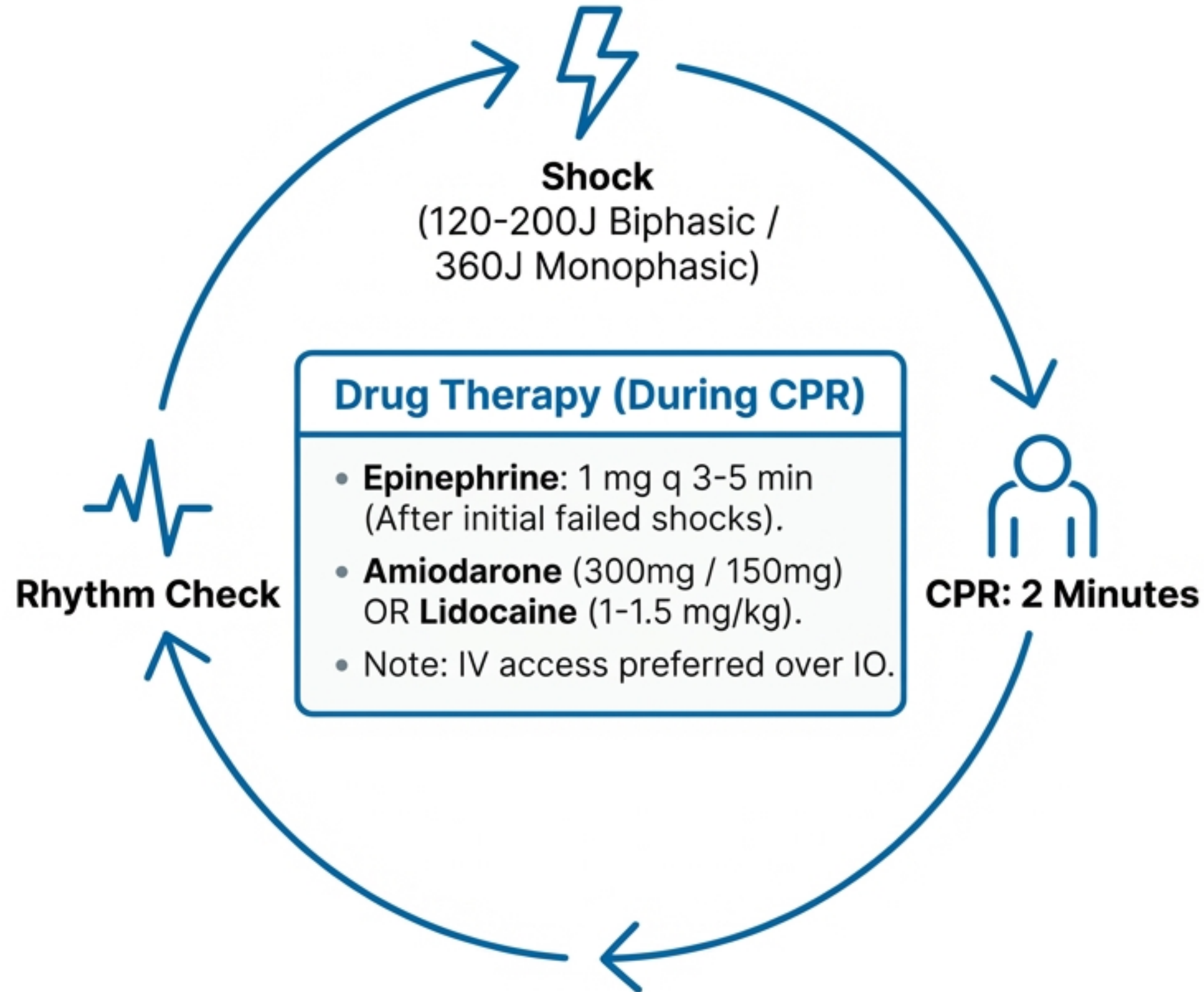


IF PATIENT BECOMES UNSTABLE AT ANY POINT -> IMMEDIATE SYNCHRONIZED CARディオVERSION

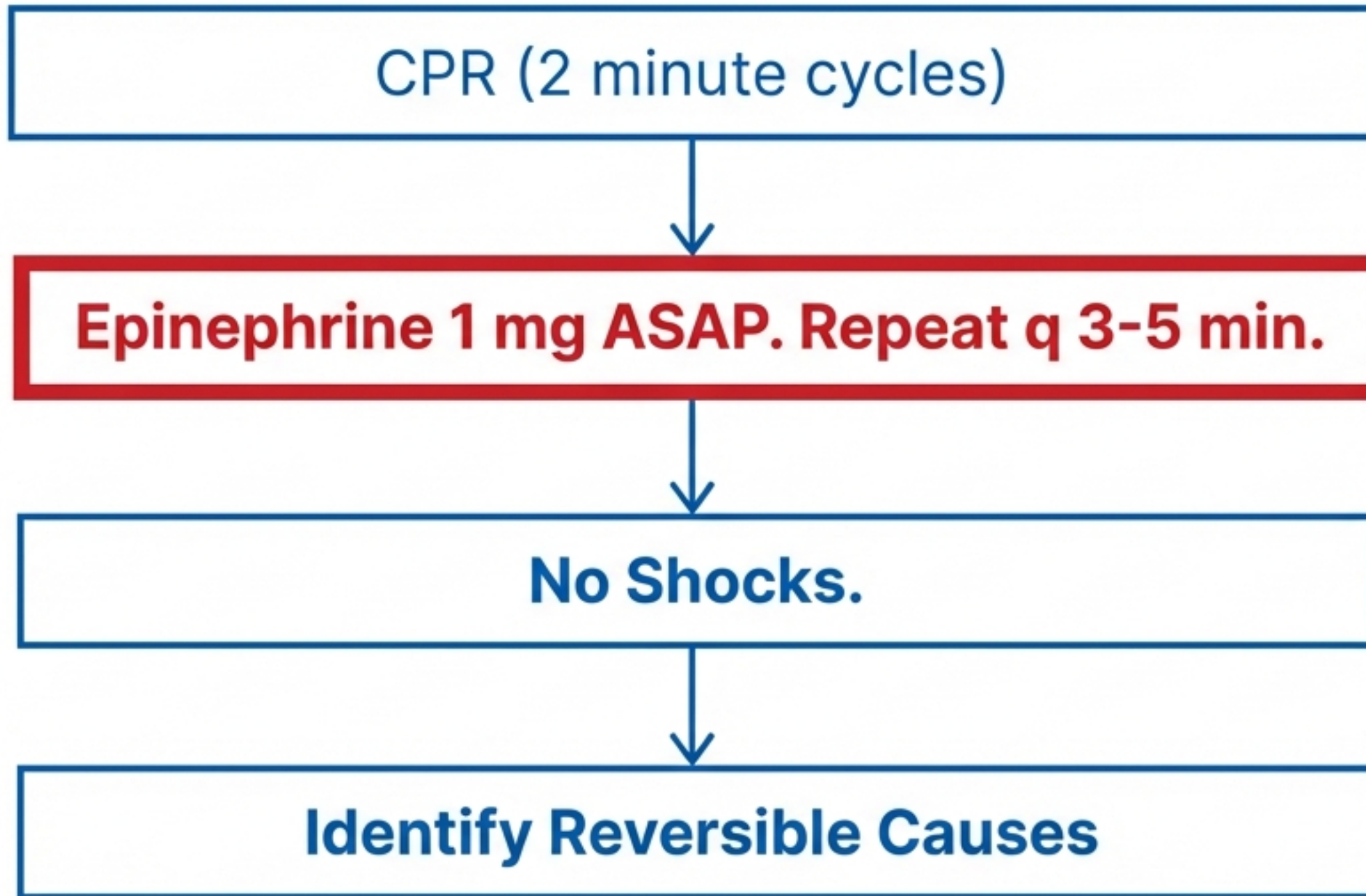
CARDIAC ARREST: THE FIRST 2 MINUTES



THE SHOCKABLE LOOP (VF/pVT)



THE NON-SHOCKABLE PATH (ASYSTOLE/PEA)



H's and T's

H's:

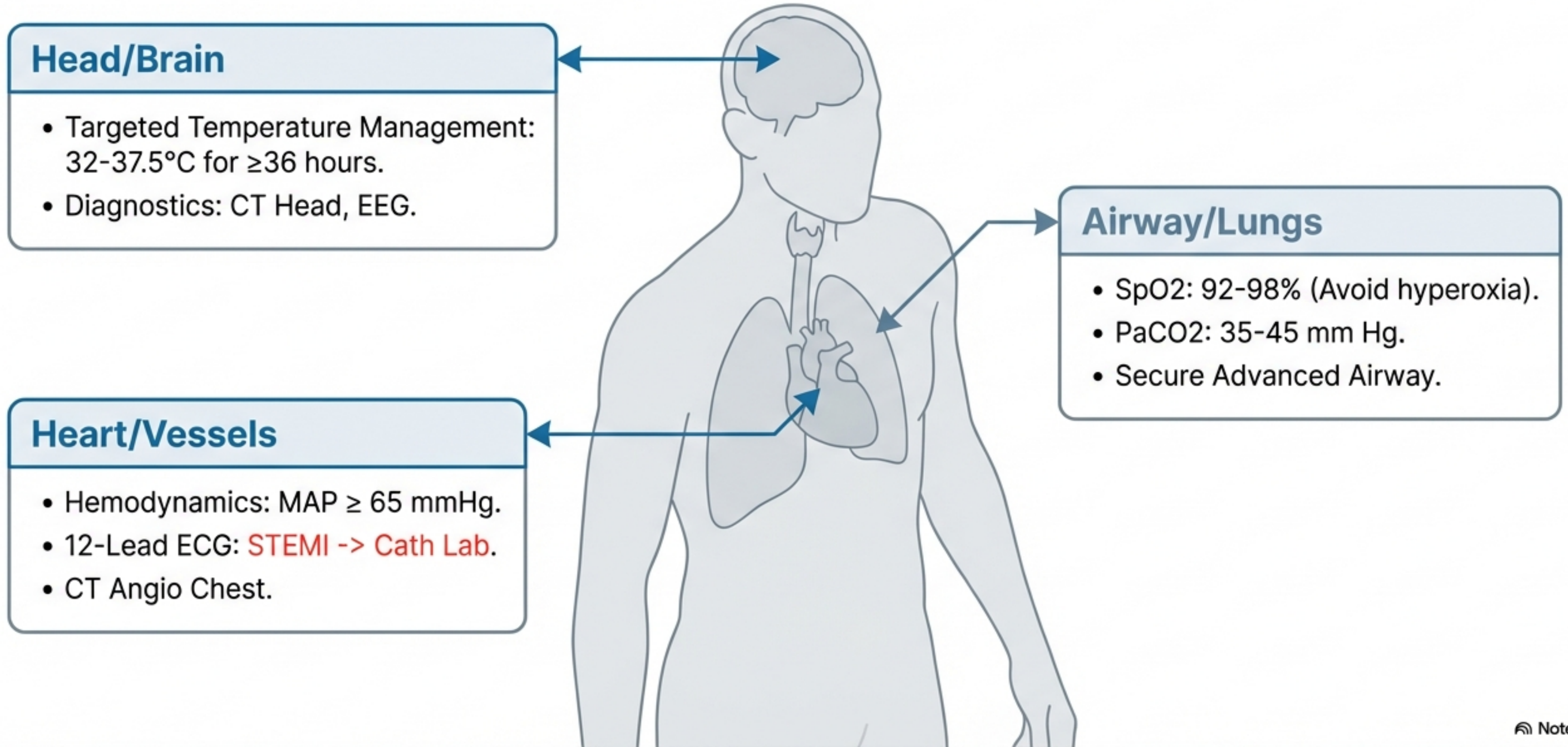
- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia

T's:

- Tension pneumothorax
- Tamponade
- Toxins
- Thrombosis (pulmonary/coronary)

If no ROSC + unwitnessed → Consider Termination of Resuscitation.

Post-ROSC: Optimizing Survival



THE MECHANICS OF HIGH-QUALITY CPR

Chest Compression
Fraction (CCF)

> 80%



Compression
Rate



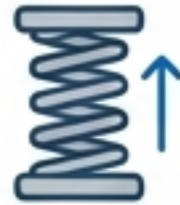
**100-120
/ min**

Depth

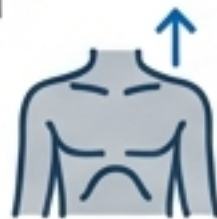


**> 2 inches
(5 cm)**

Recoil



Allow Full Recoil
(Don't lean)



Ventilation



1 breath every 6
sec (10/min) with
advanced airway.

Interruptions



**< 10
seconds**



Common Pitfalls & Team Dynamics



Clinical Errors



Hyperventilation: Reduces cerebral perfusion.



Prolonged Pauses: During rhythm checks or airway placement.



Tunnel Vision: Treating the monitor in PEA, neglecting H's & T's.



Team Failures



No Closed-Loop Communication.



Role Ambiguity: Lack of clear Team Leader.



Cognitive Overload: Failure to use checklists/aids.

High-performance teams save lives through preparation, not just reaction.