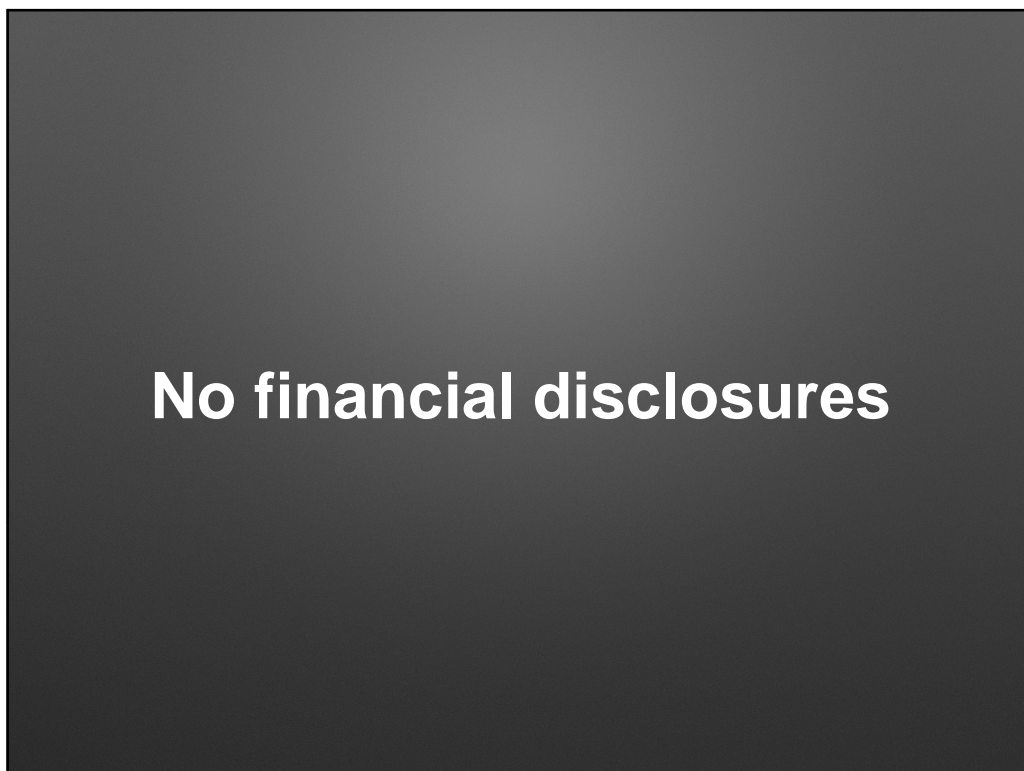




1



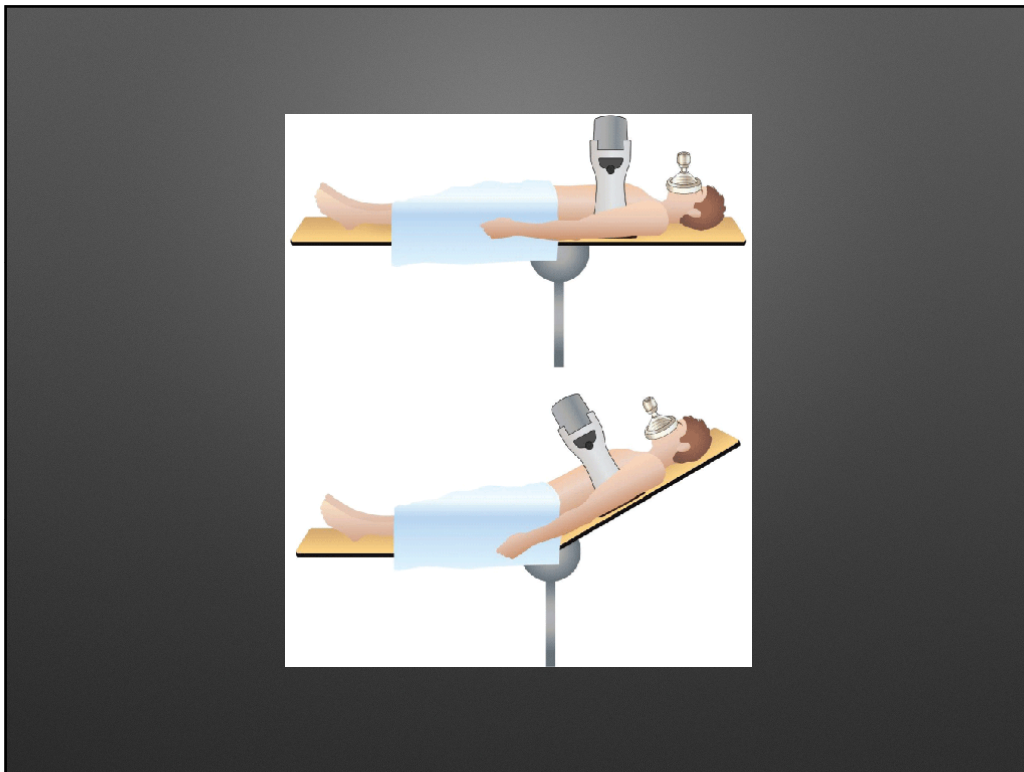
2



3



4



5



6

1. Fix your compressions

7



8

100-120 cpm

2.0-2.4"

9

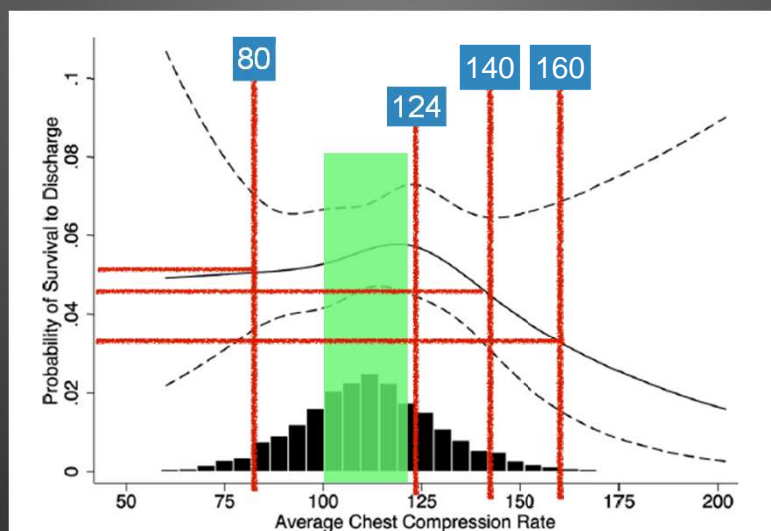
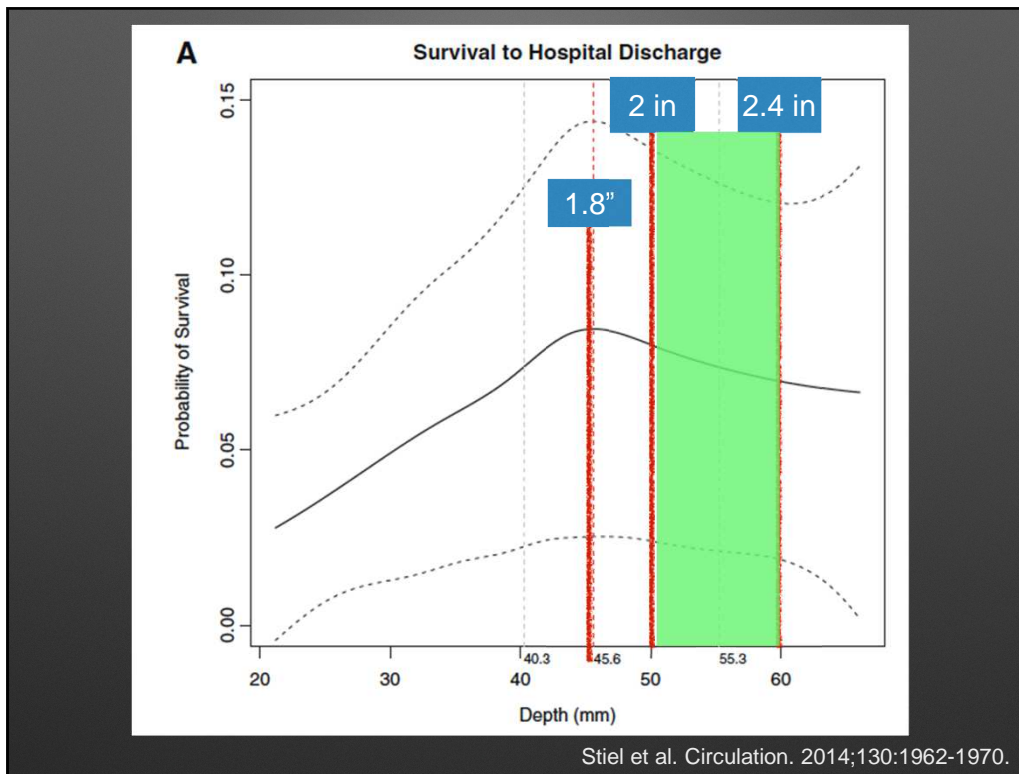


Figure 4. Adjusted cubic spline of the relationship between chest compression rates and the probability of survival to hospital discharge. The adjusted model includes sex, age, bystander-

Idris et al, *Circulation*. 2012;125:3004-3012.

10



11

PEB is in Oklahoma
Don't push fast

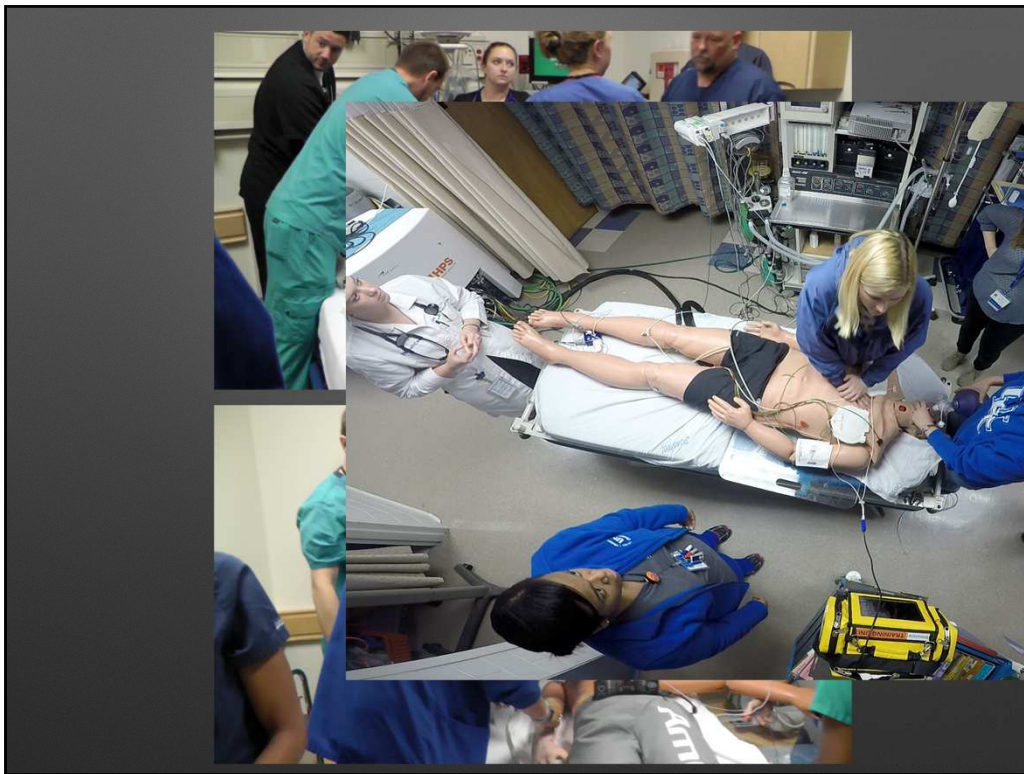
12

ARE YOU DOING THAT?

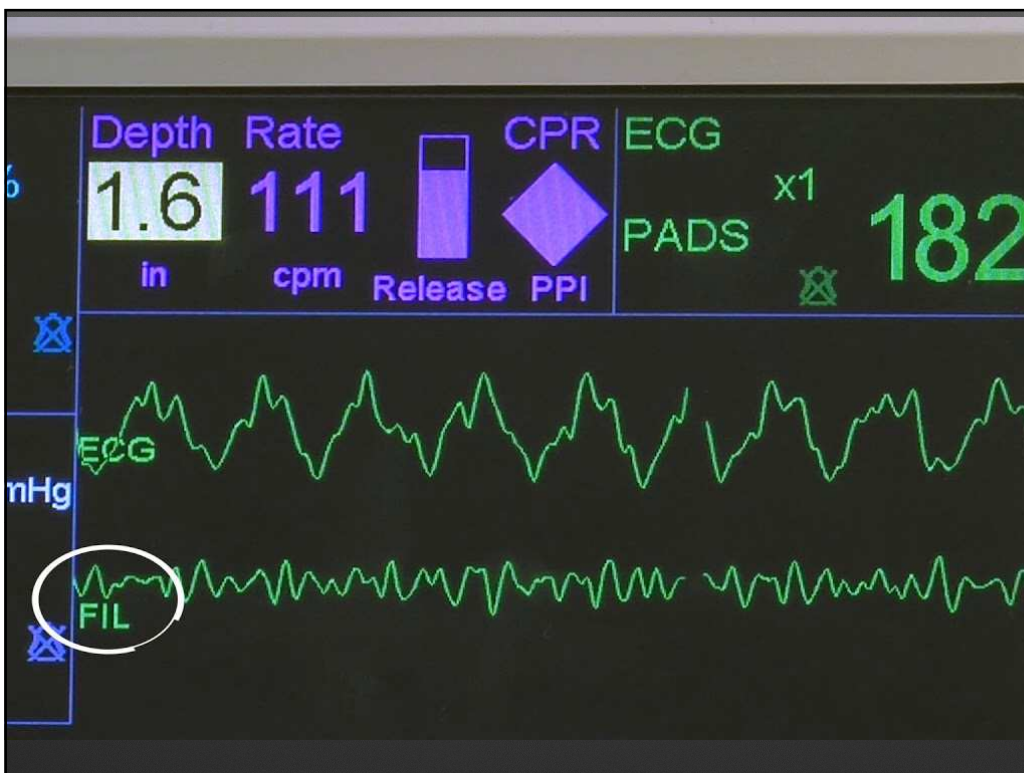
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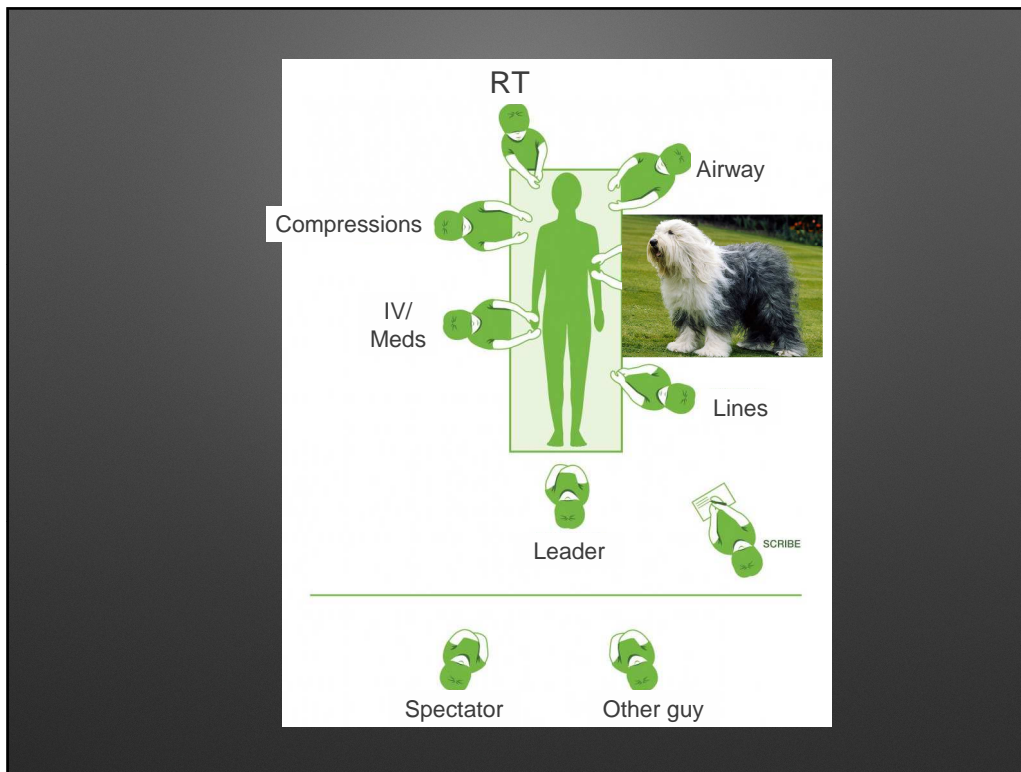
14



15



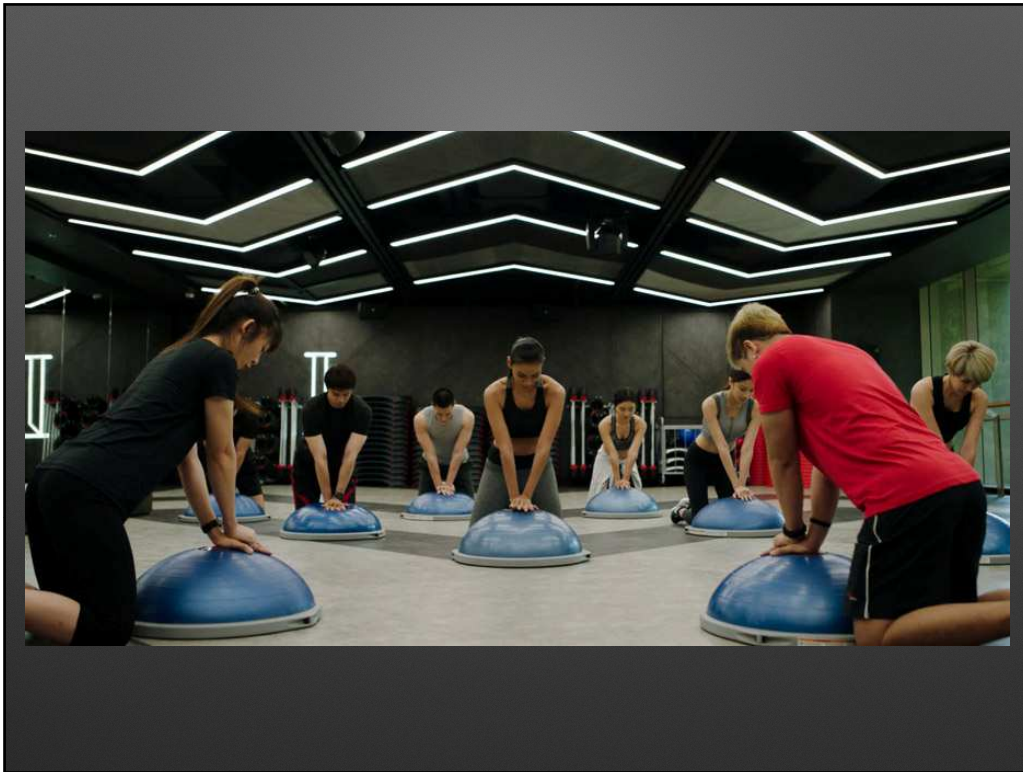
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17



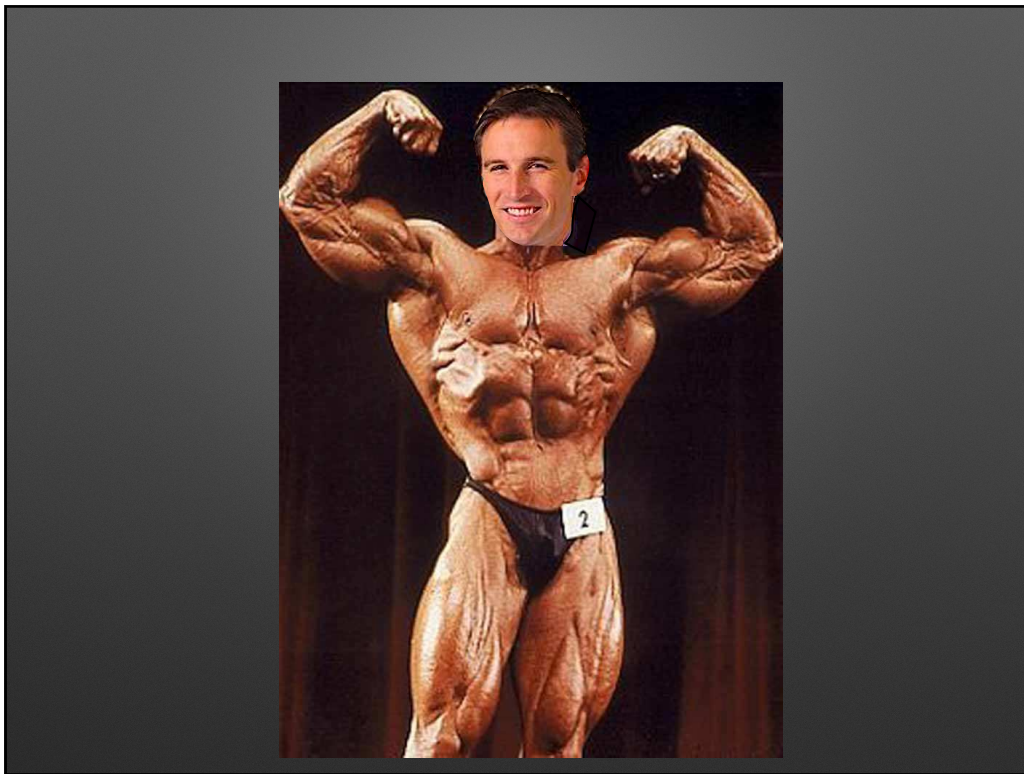
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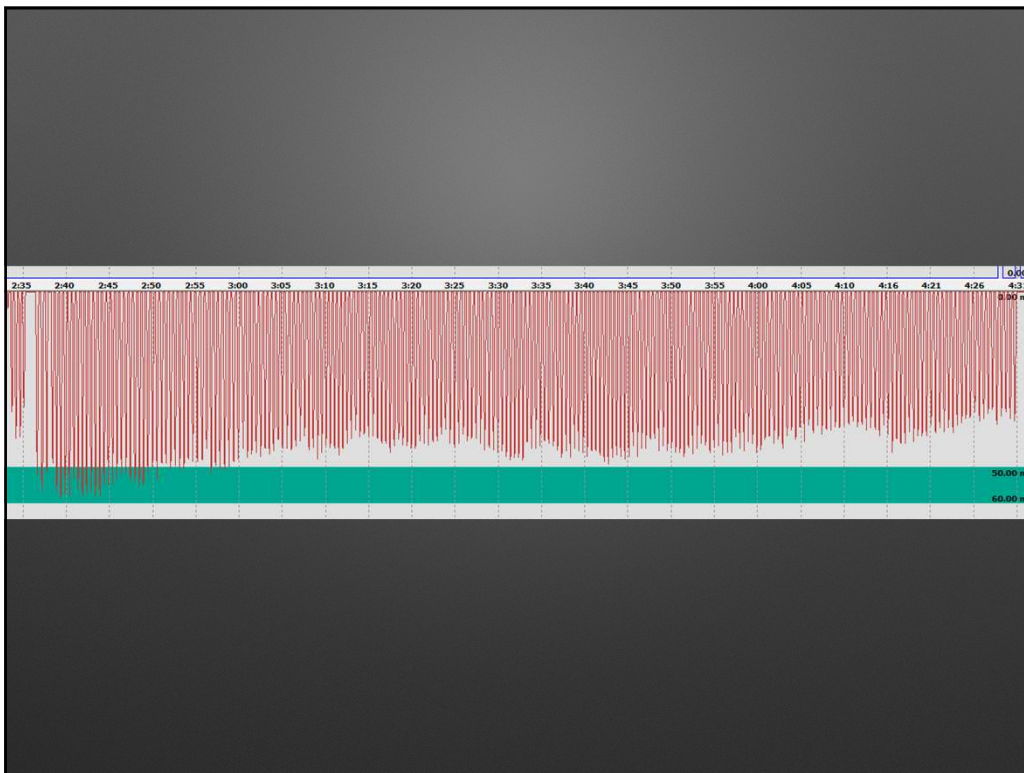
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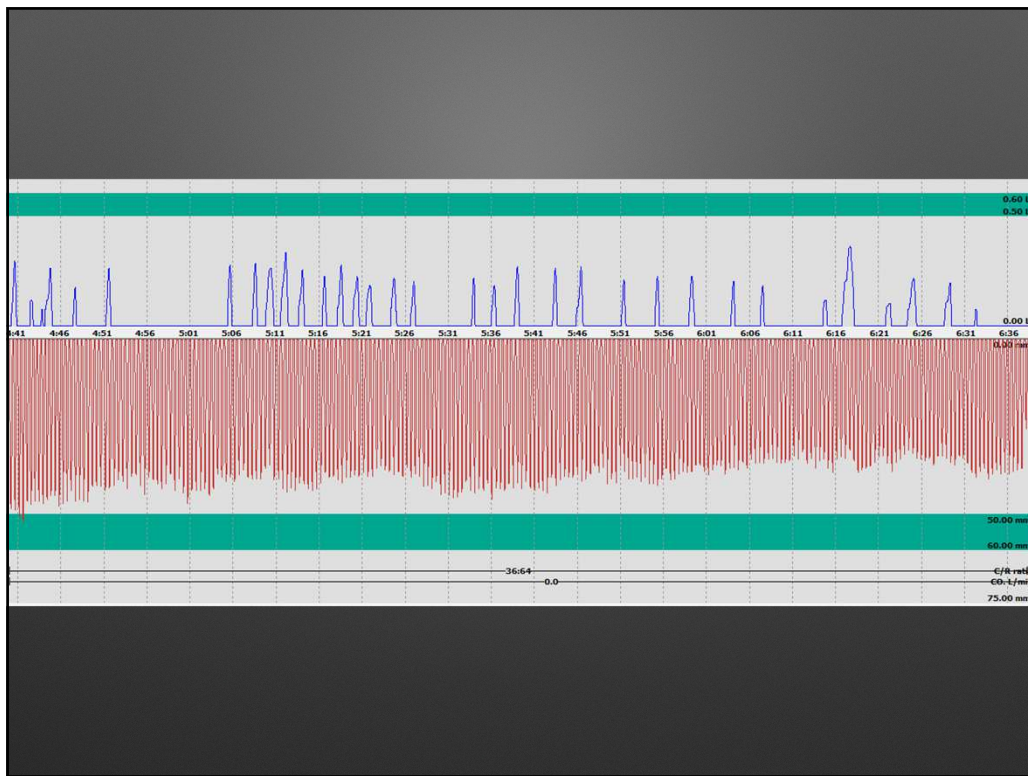
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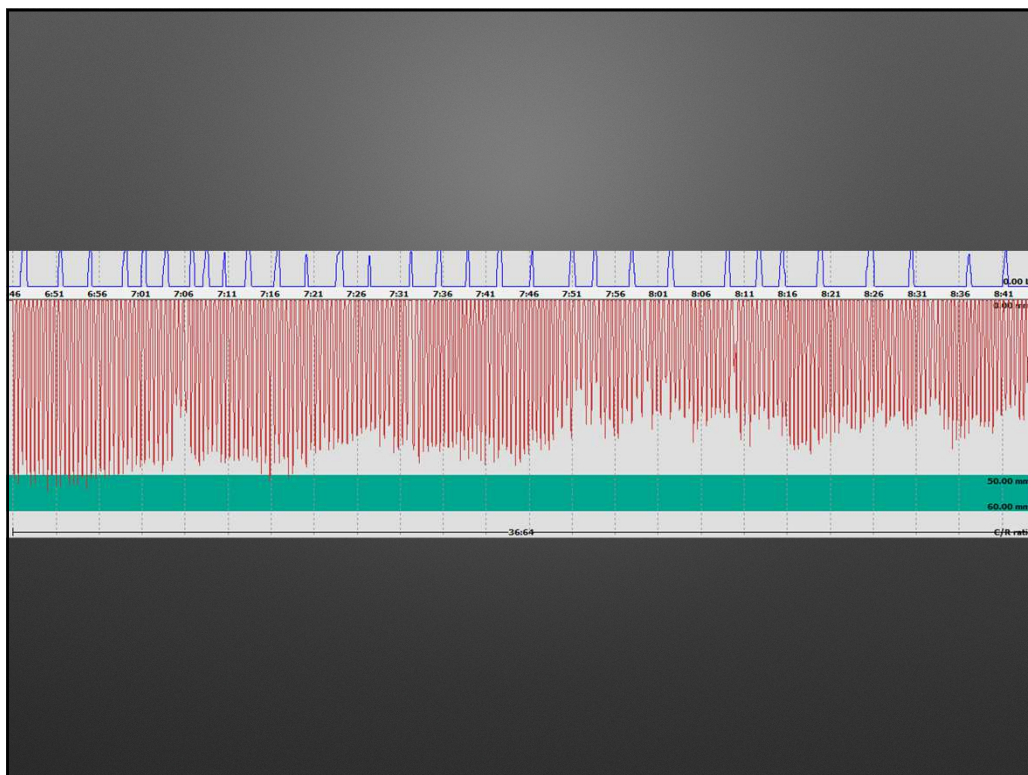
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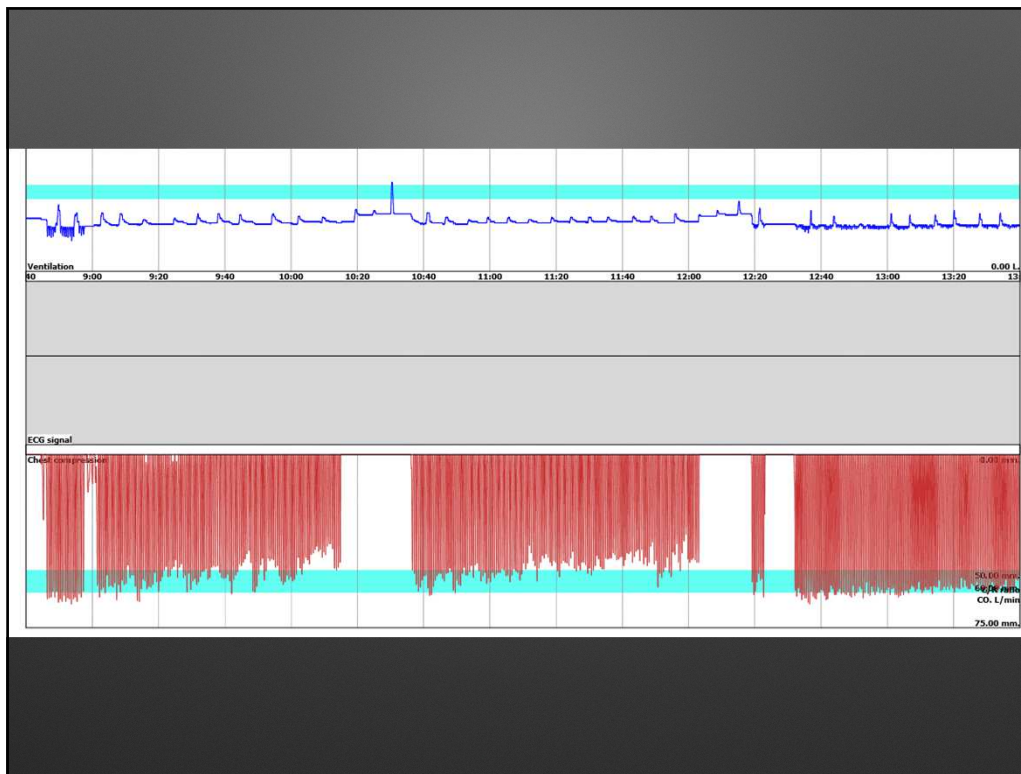
22



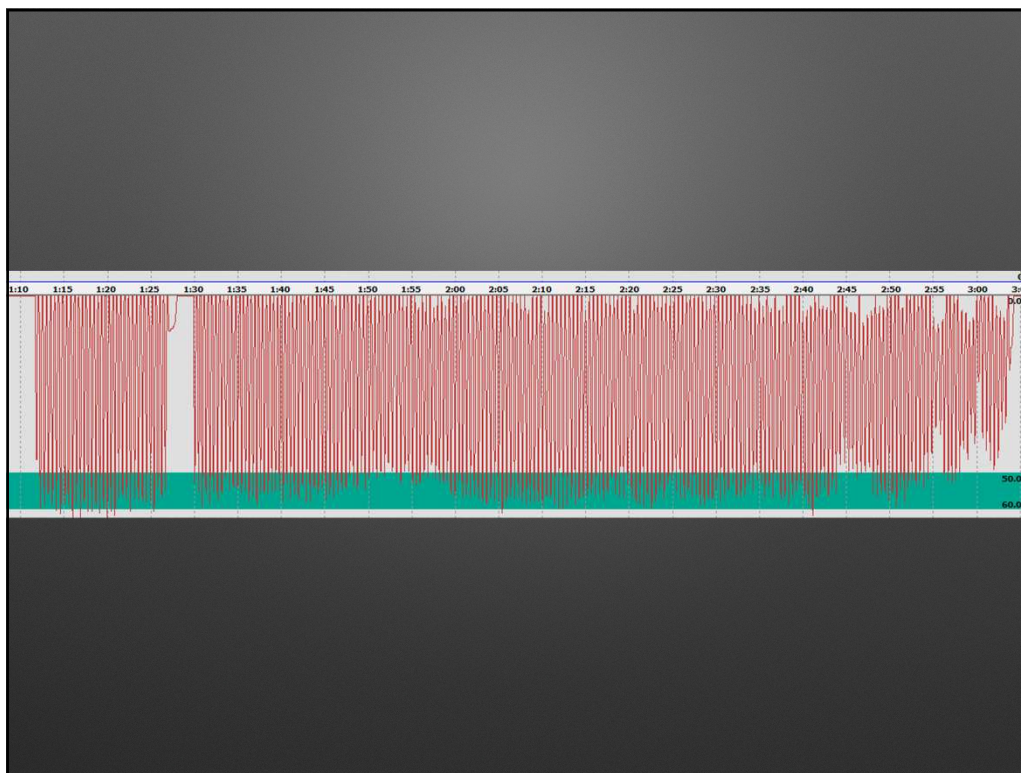
23



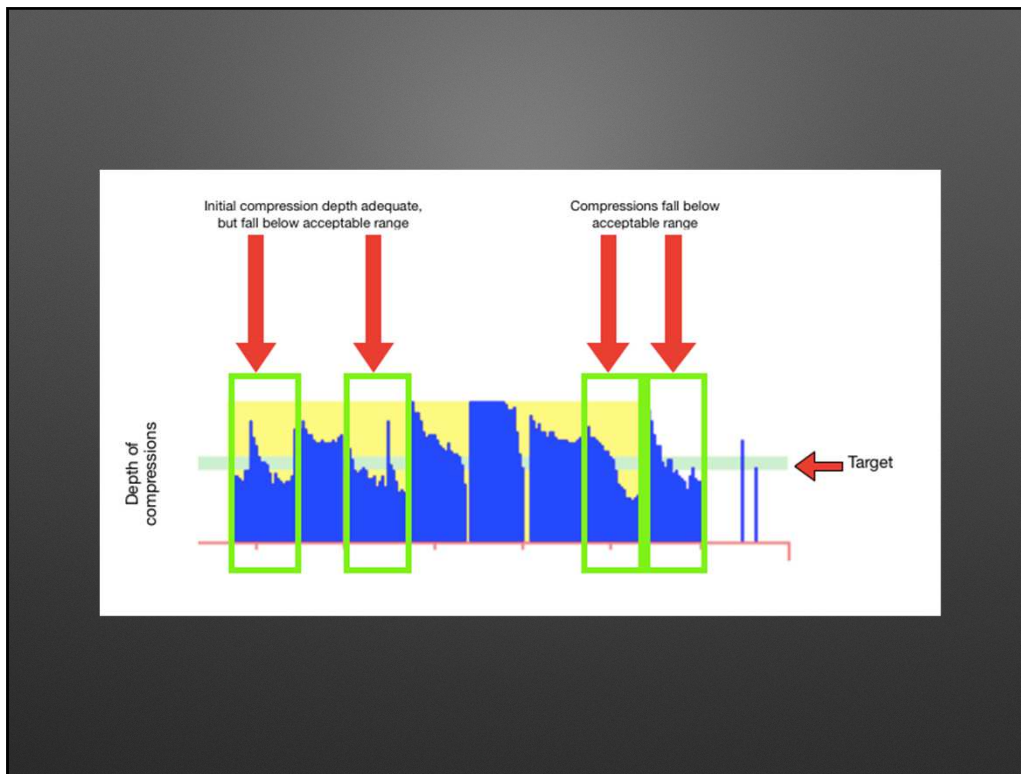
24



25



26



27

60 Seconds

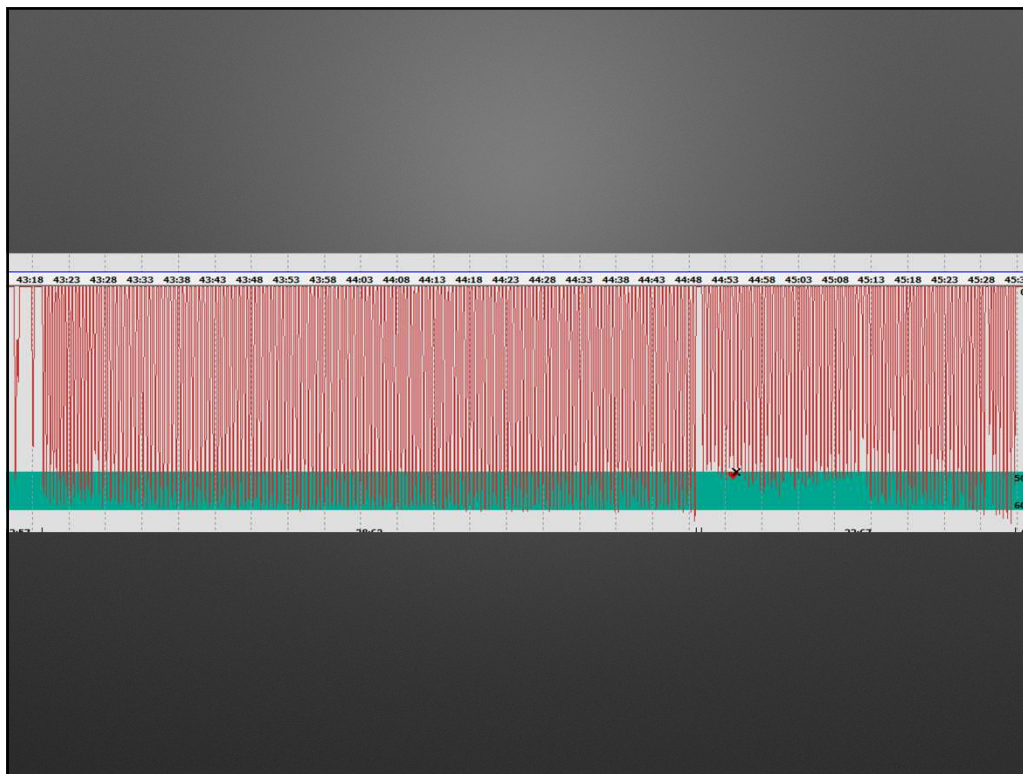
28



29

Identify the need
Put the pieces together
Make a controlled stop
Fill in the gap

30



31

**Rate
Depth
Release
Ventilations
Pauses**

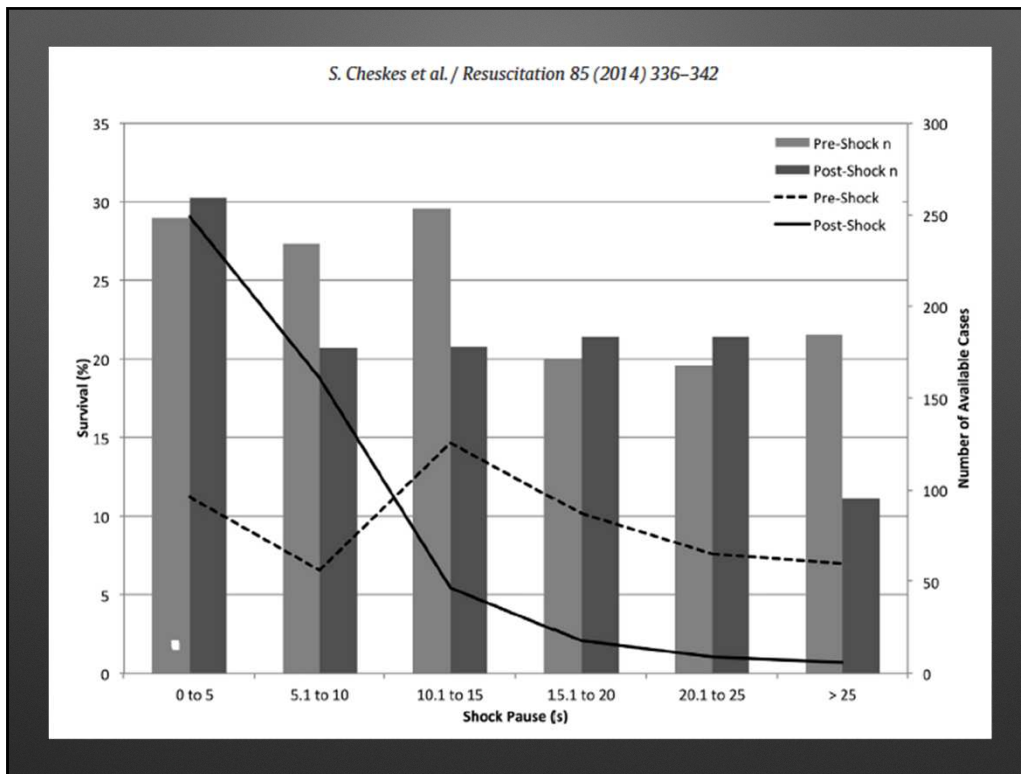
32

Chest compressions: a 2 person job

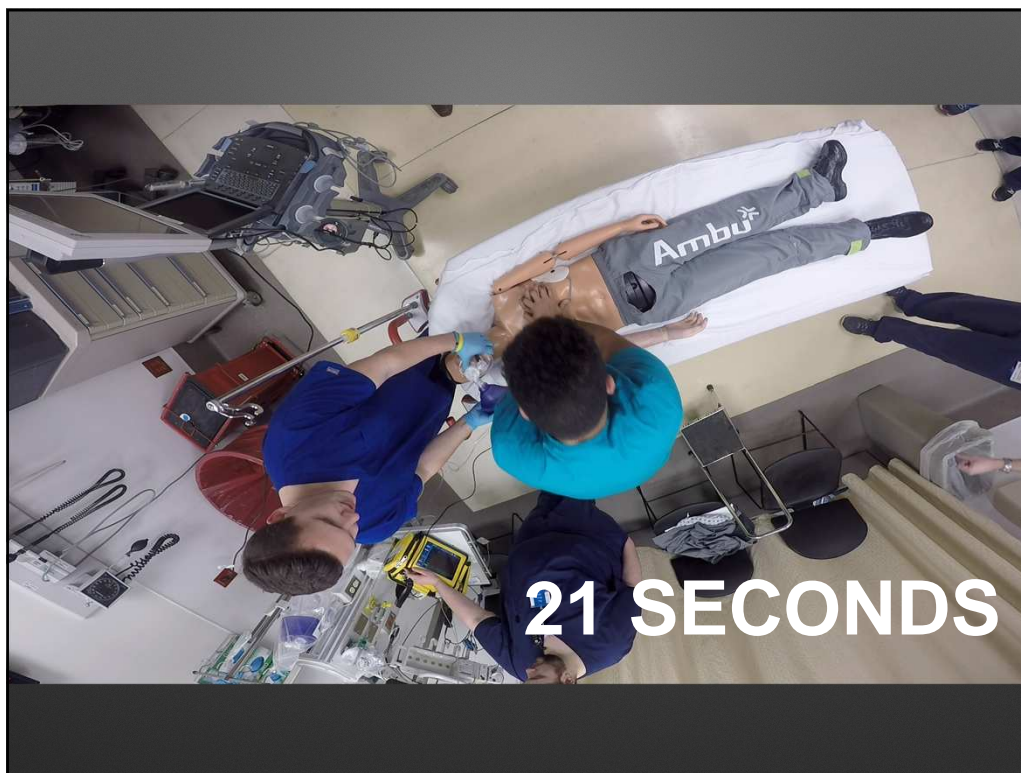
33

**2.
Your pulse check is too long**

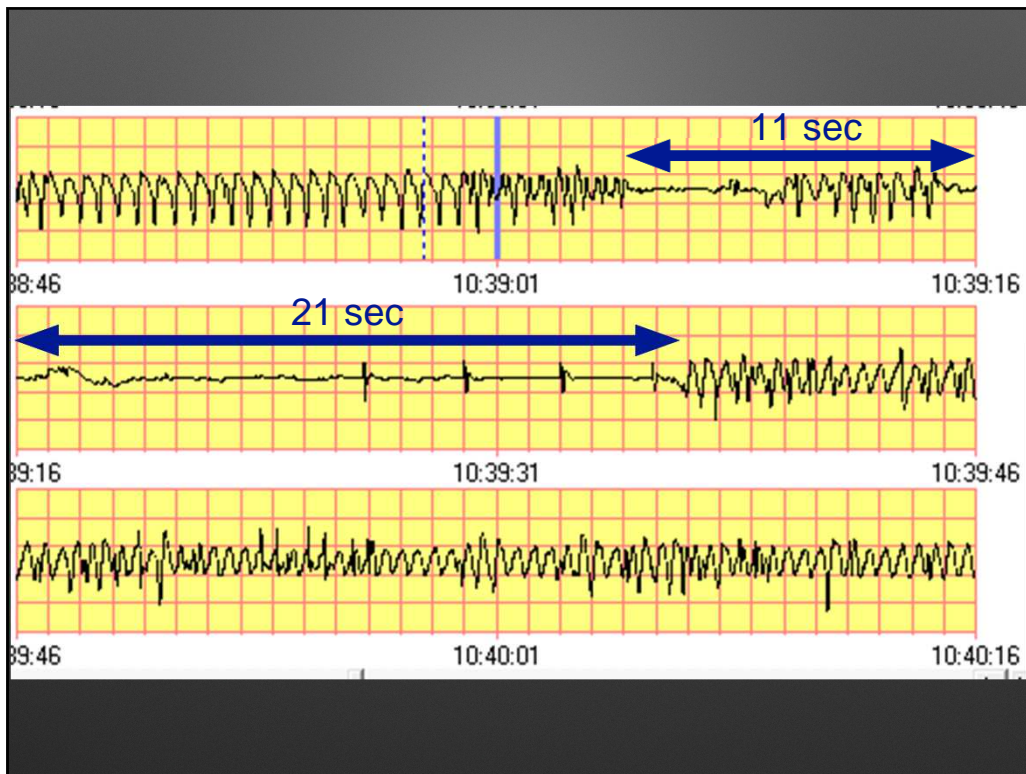
34



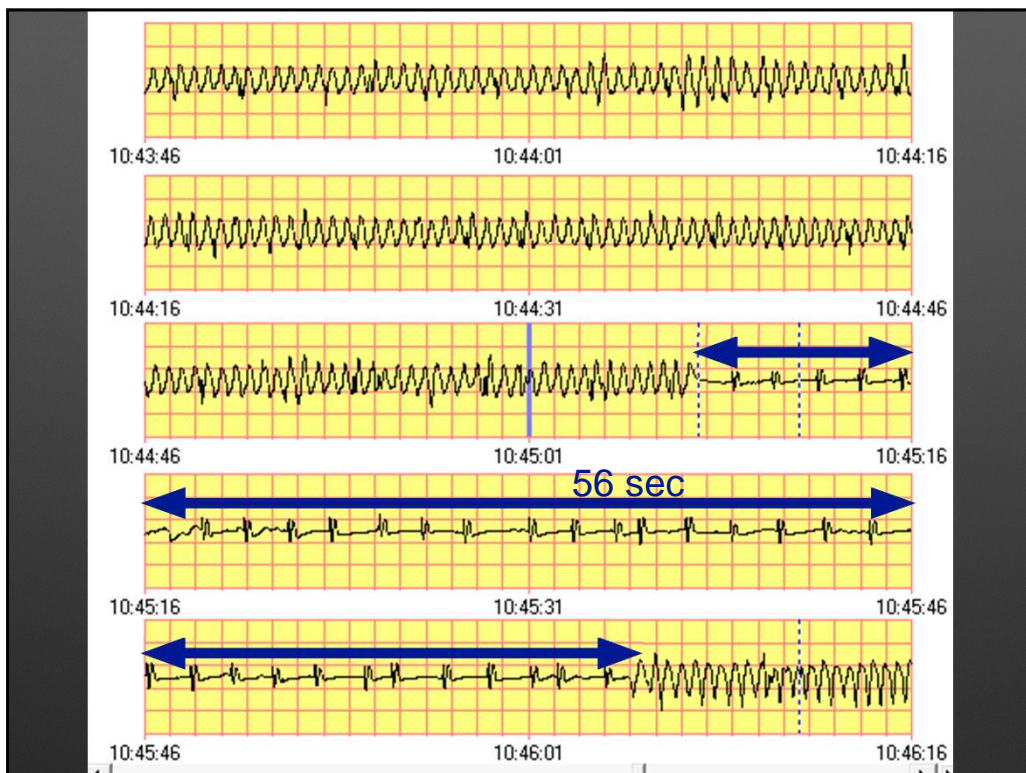
35



36



37



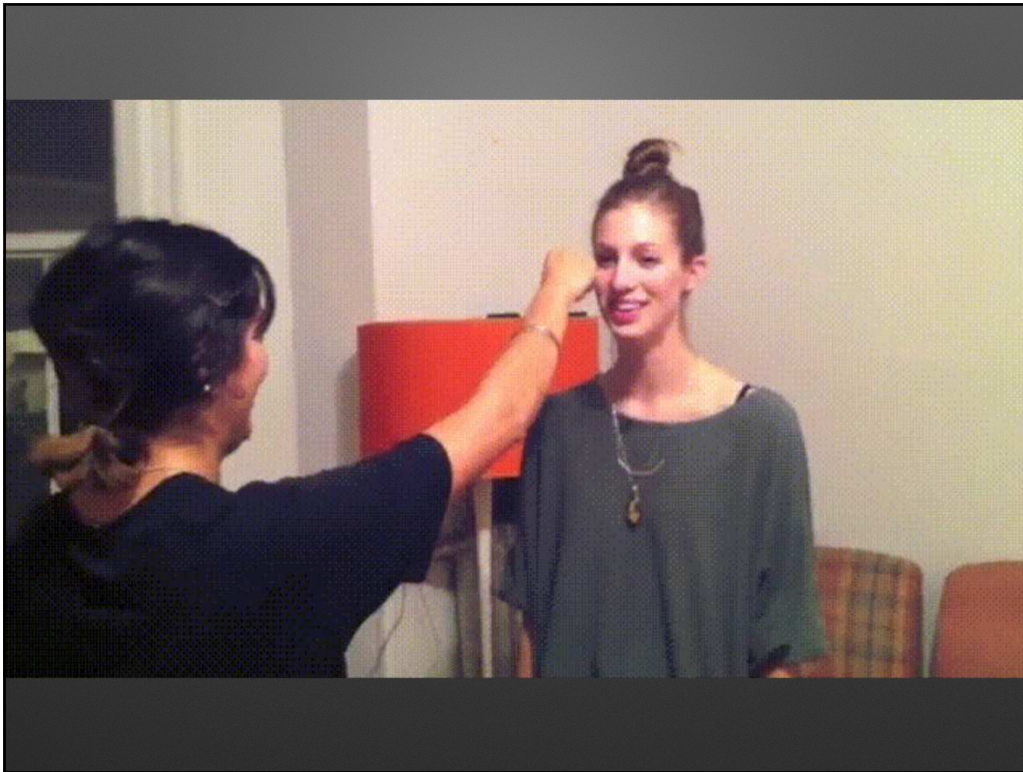
38

Forget about 2 minutes

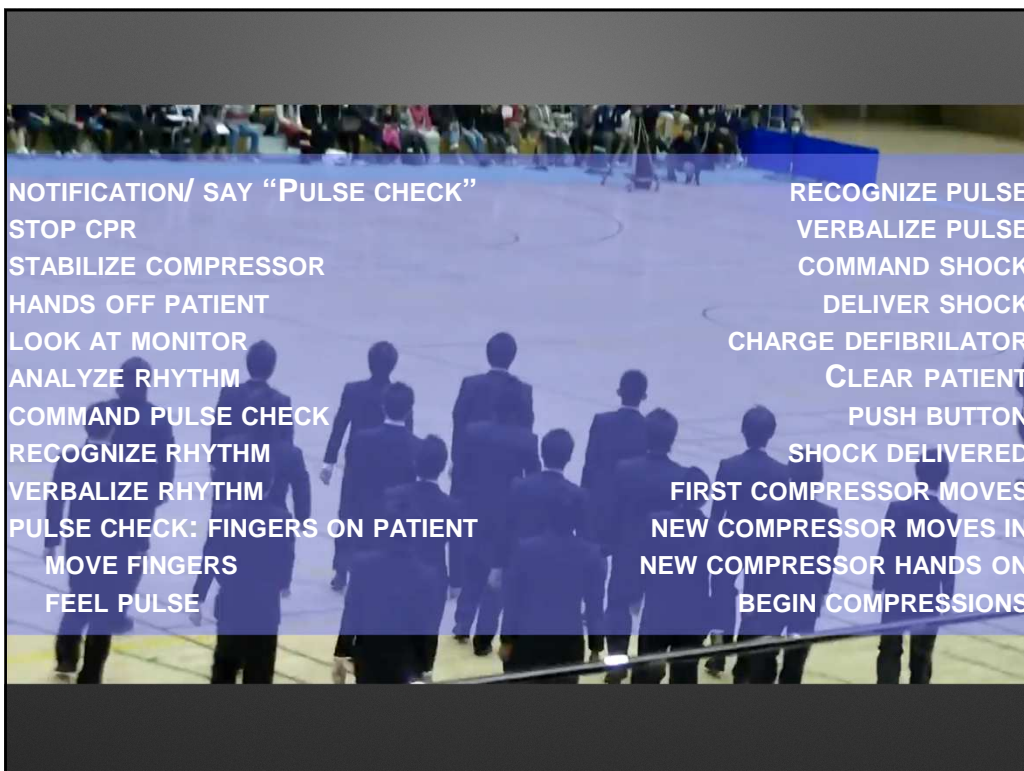
39

**Don't stop until you are
ready**

40



41



42

NOTIFICATION/ SAY "PULSE CHECK"	RECOGNIZE PULSE
STOP CPR	VERBALIZE PULSE
STABILIZE COMPRESSOR	COMMAND SHOCK
HANDS OFF PATIENT	DELIVER SHOCK
LOOK AT MONITOR	CHARGE DEFIBRILATOR
ANALYZE RHYTHM	CLEAR PATIENT
COMMAND PULSE CHECK	PUSH BUTTON
RECOGNIZE RHYTHM	SHOCK DELIVERED
VERBALIZE RHYTHM	FIRST COMPRESSOR MOVES
PULSE CHECK: FINGERS ON PATIENT	NEW COMPRESSOR MOVES IN
MOVE FINGERS	NEW COMPRESSOR HANDS ON
FEEL PULSE	BEGIN COMPRESSIONS

43

Precharge defibrillator

Have next compressor ready

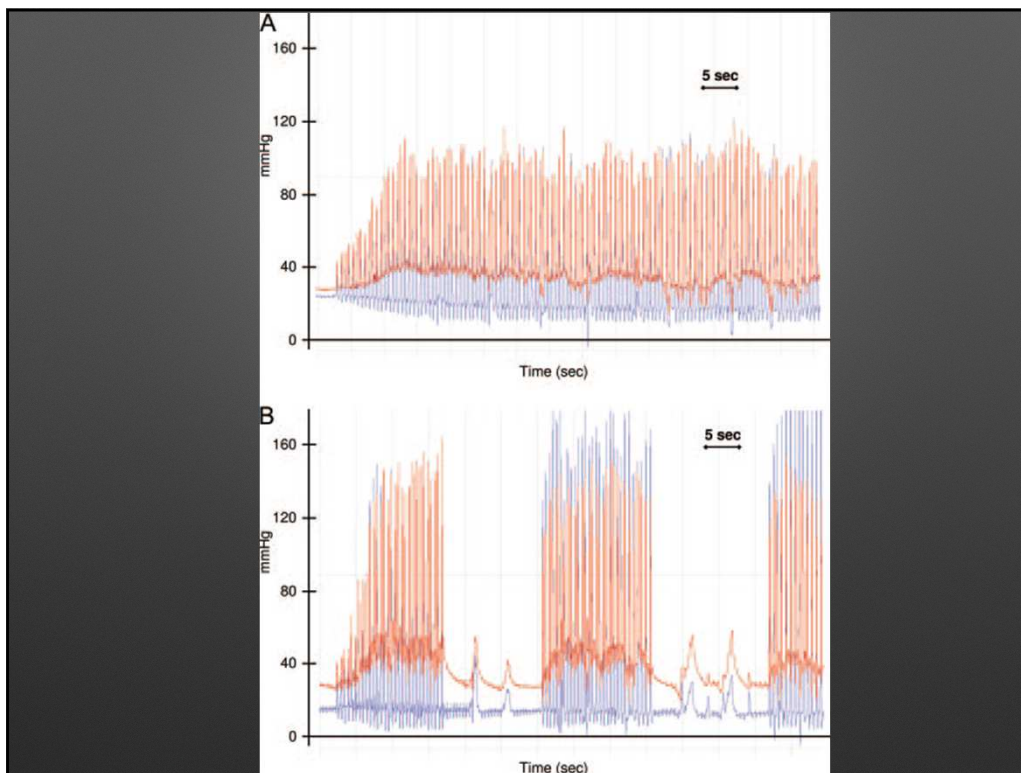
Be looking at the monitor

Never just stop

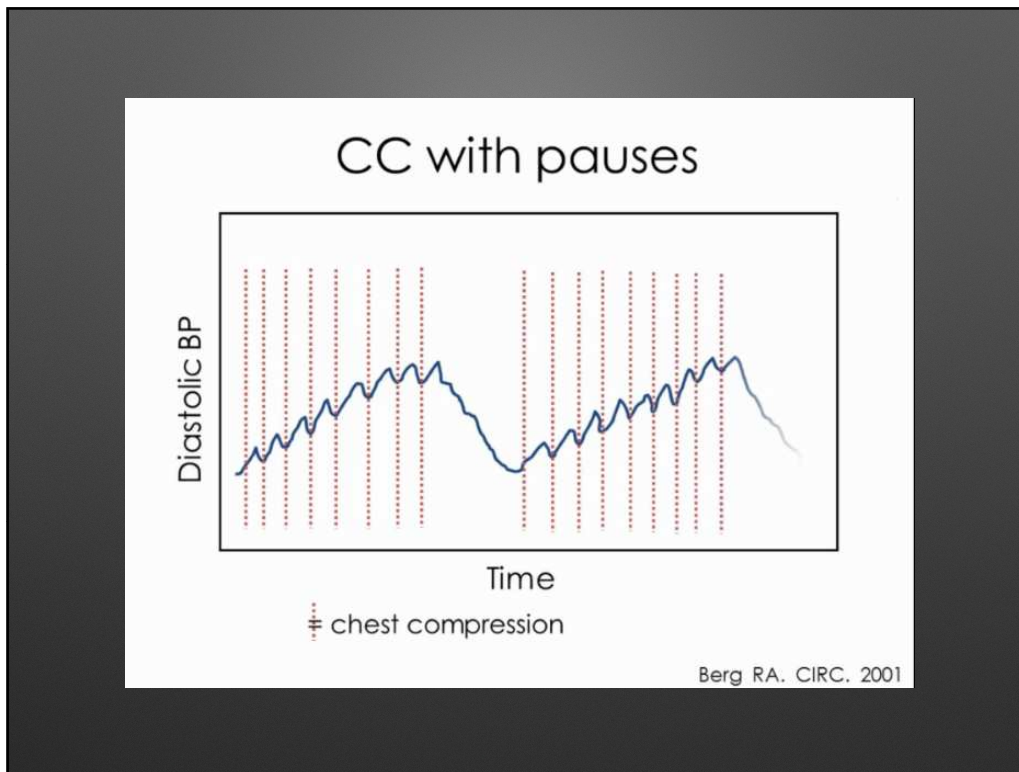
44

3. You're bagging to fast... or maybe too slow

45



46



47

The **NEW ENGLAND**
JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 3, 2015 VOL. 373 NO. 23

Trial of Continuous or Interrupted Chest Compressions during CPR

Graham Nichol, M.D., M.P.H., Brian Leroux, Ph.D., Henry Wang, M.D., Clifton W. Callaway, M.D., Ph.D., George Sopko, M.D., Myron Weisfeldt, M.D., Ian Stiell, M.D., Laurie J. Morrison, M.D., Tom P. Aufderheide, M.D., Sheldon Cheskes, M.D., Jim Christenson, M.D., Peter Kudenchuk, M.D., Christian Vaillancourt, M.D., Thomas D. Rea, M.D., Ahamed H. Idris, M.D., Riccardo Colella, D.O., M.P.H., Marshal Isaacs, M.D., Ron Straight, Shannon Stephens, Joe Richardson, Joe Condle, Robert H. Schmicker, M.S., Debra Egan, M.P.H., B.S.N., Susanne May, Ph.D., and Joseph P. Ornato, M.D., for the ROC Investigators*

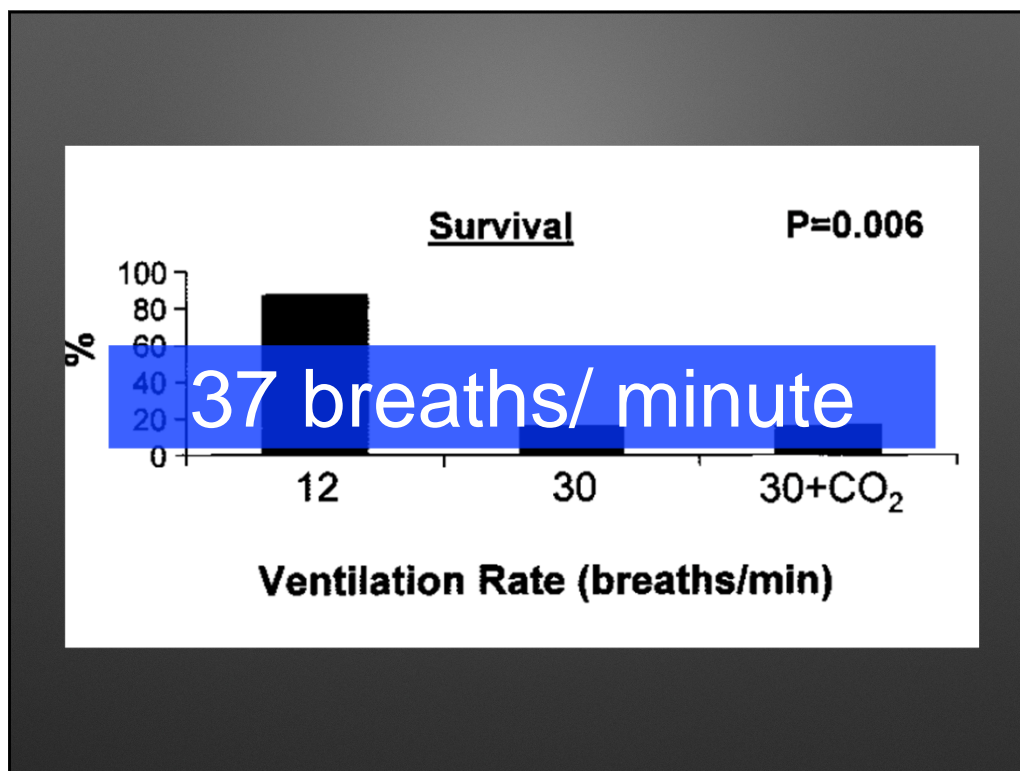
	Continuous	Interrupted
ROSC		
Survival		
Neuro intact		

SAME!

48

	Continuous	Interrupted
CCF	SAME!	
Pauses > 2 sec	REALLY LOW!	
Pre-shock pause	SAME!	
Post-shock pause	SAME!	
Intubated	SAME!	

49



50

Synchronous Asynchronous Compressions

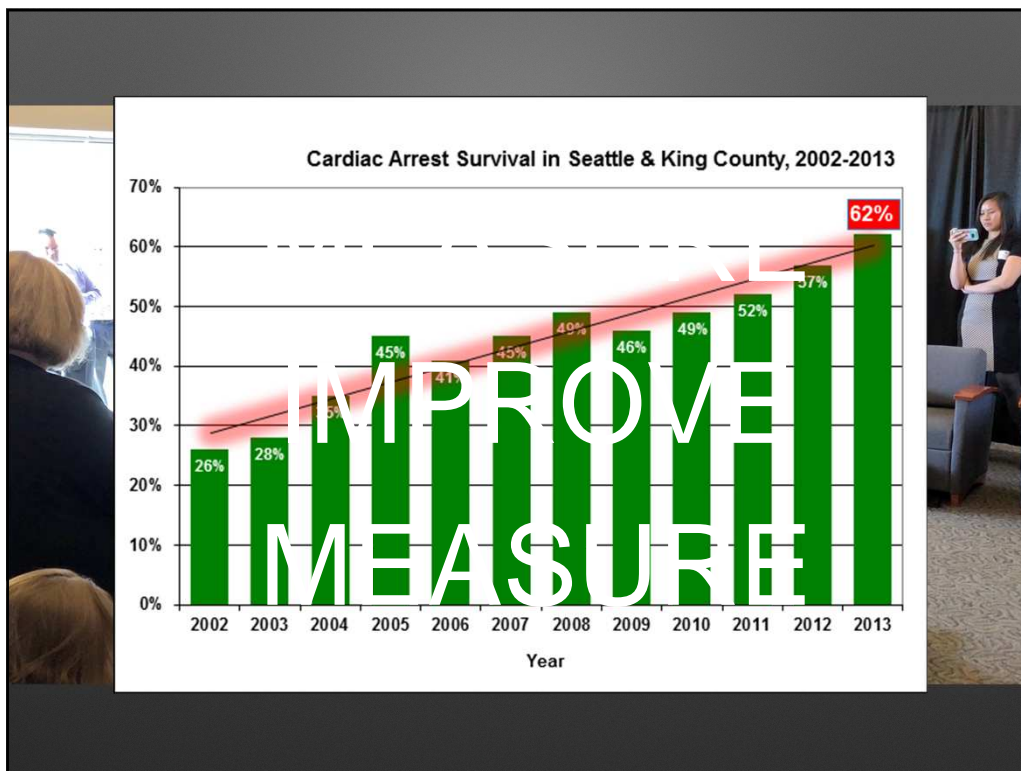
51

What is your survival?

52

What's your Utstein survival?

53



54

4. Data drives your improvements

55



56

Improve Family Presence Improve ETCO₂ use

57



58



59

Was Defibrillation shock provided for Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia?

Yes

No/Not Documented

No, Per Advance Directive

If CPR mechanics device (e.g. accelerometer, force transducer, TFI device) used:

Average compression rate: _____ (per minute) Not Documented

Average compression depth: _____ mm cm inches Not Documented

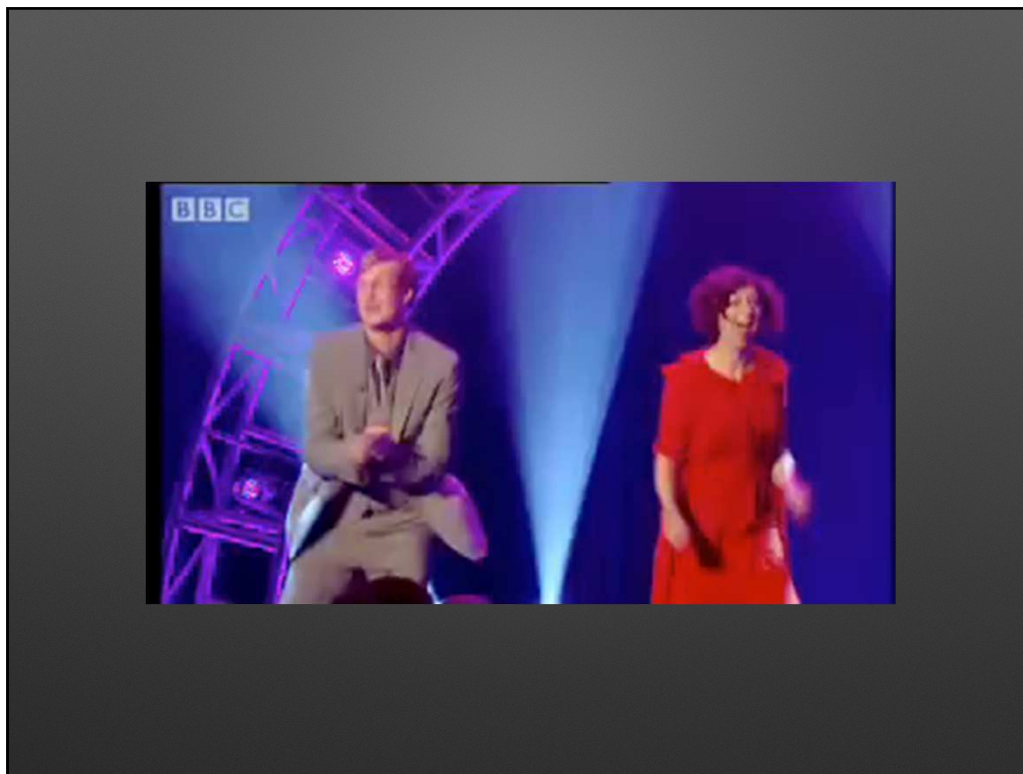
Compression fraction: _____ (enter number between 0 and 1) Not Documented

Percent of Chest Compressions with complete release: _____ (%) Not Documented

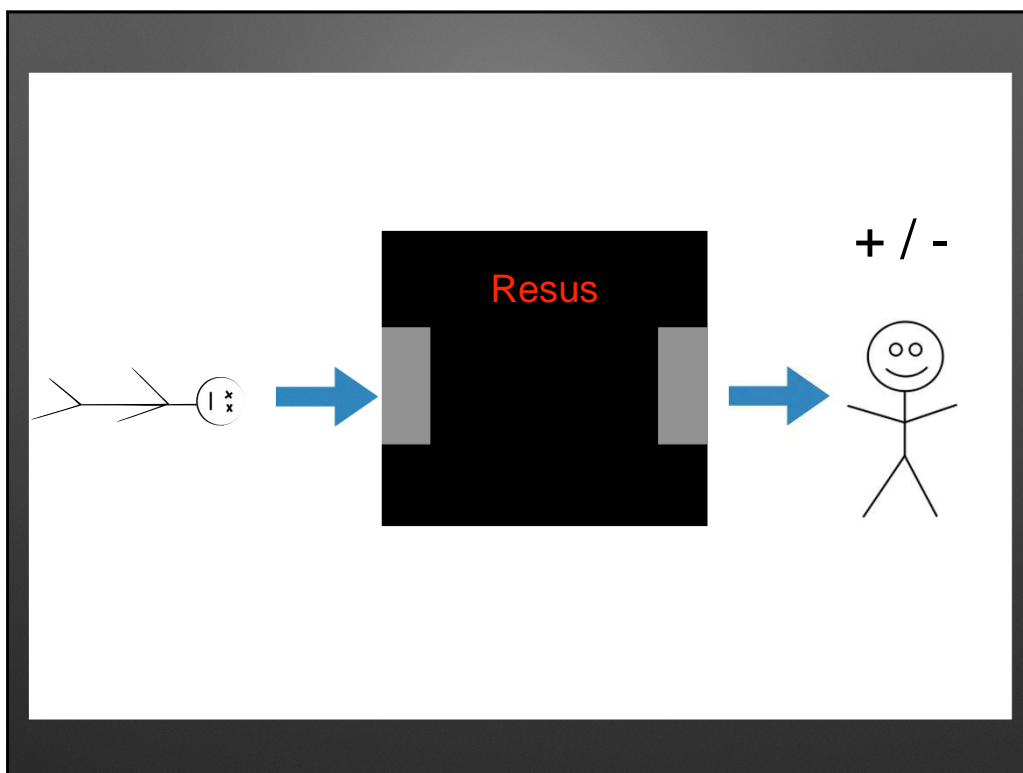
Average Ventilation Rate: _____ (per minute) Not Documented

Longest Pre-shock pause _____ (seconds) Not Documented

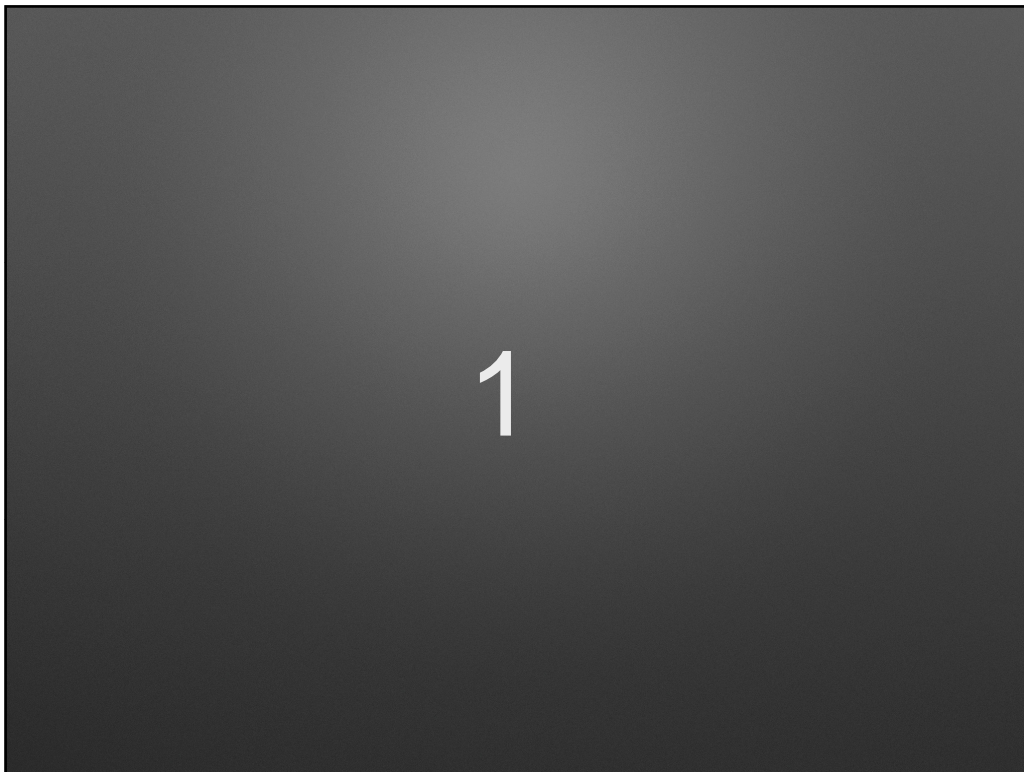
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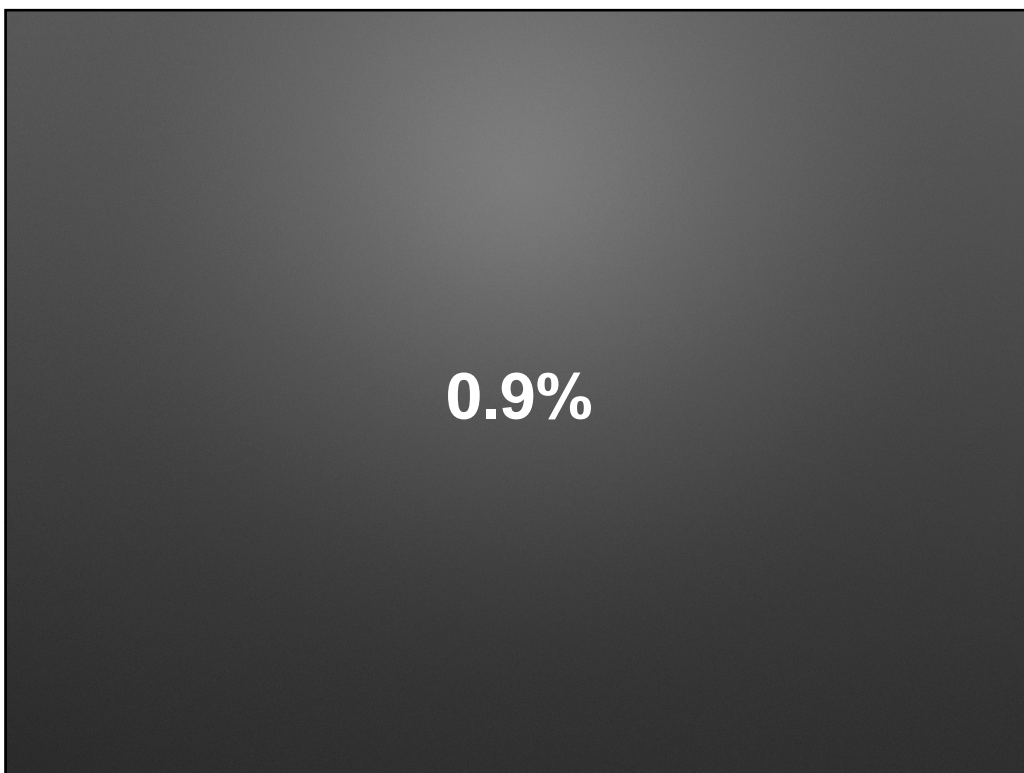
61



62



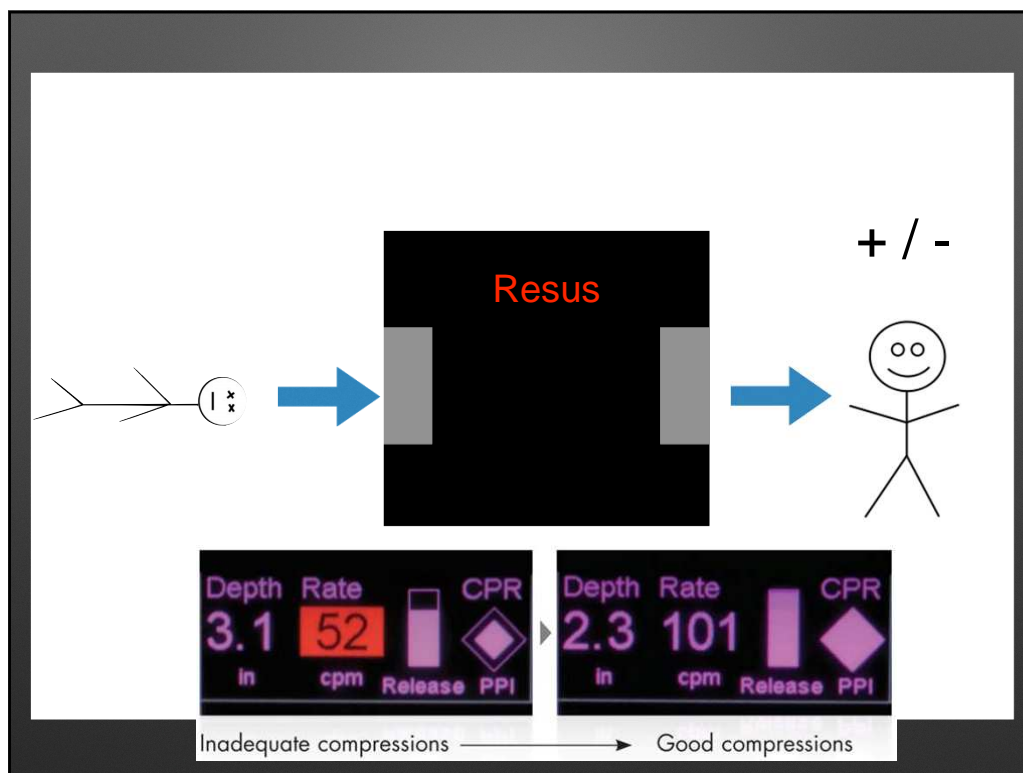
63



64

Rate
Depth
Recoil
Ventilation
CCF
Peri-shock interval

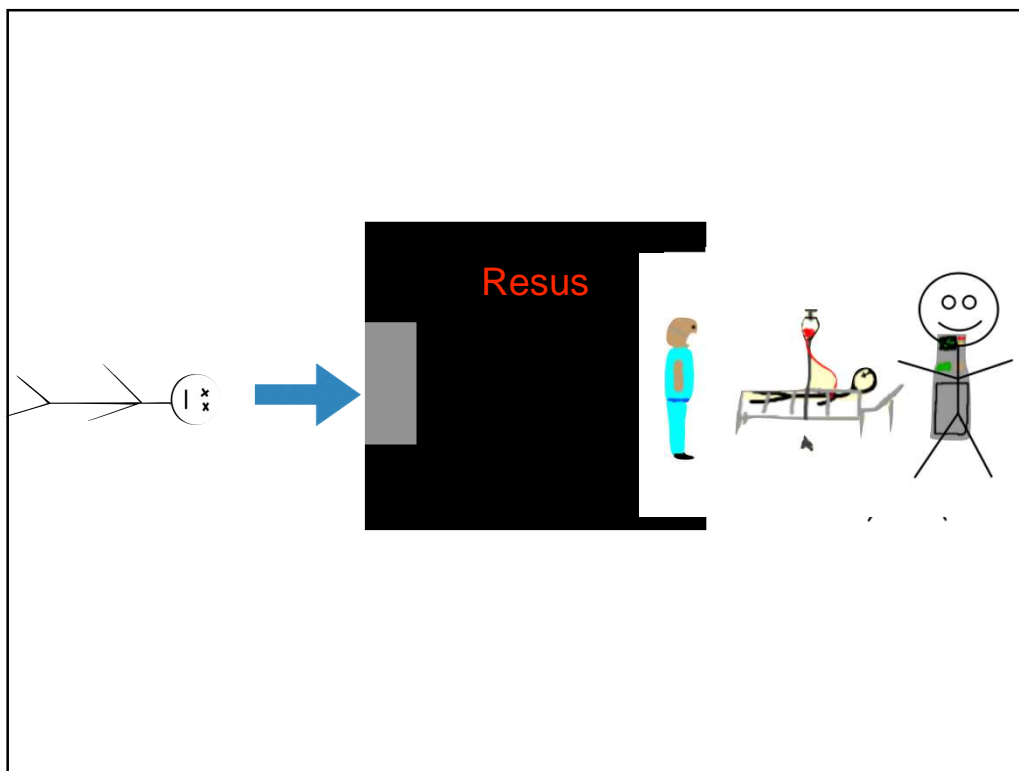
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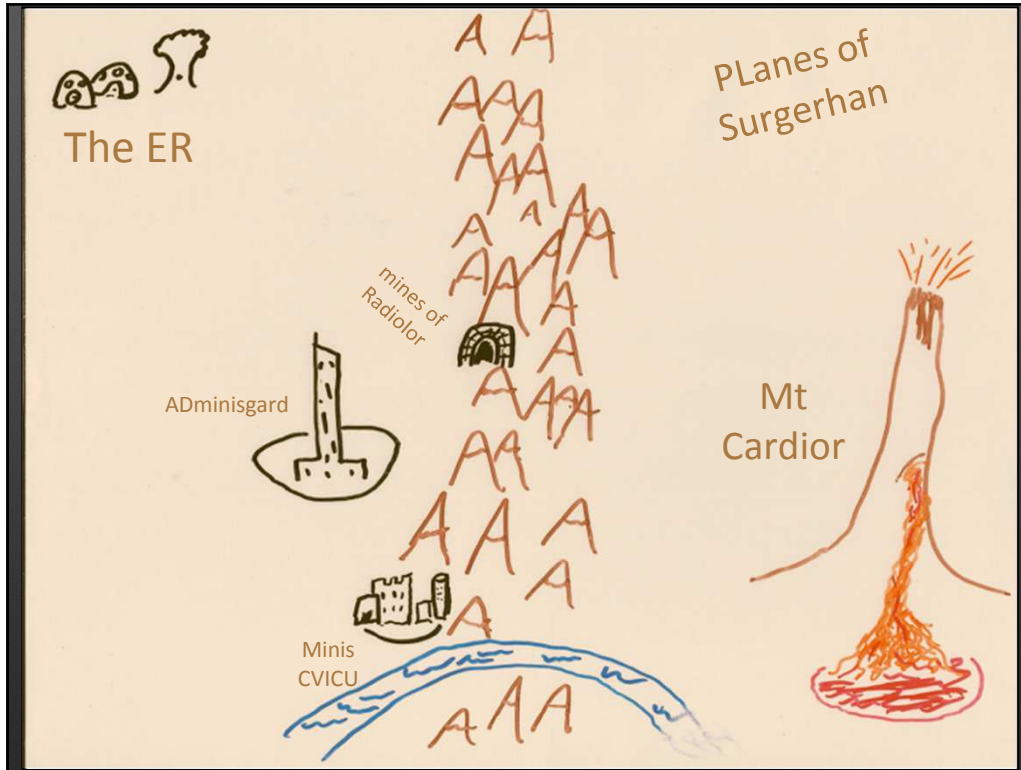
66



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Circulation

AHA SCIENTIFIC STATEMENT

The Evolving Role of the Cardiac Catheterization Laboratory in the Management of Patients With Out-of-Hospital Cardiac Arrest

A Scientific Statement From the American Heart Association

Conversely, among patients resuscitated from VF/pVT OHCA **without ST-segment elevation** on their postresuscitation ECG, the prevalence of coronary artery disease has been shown to be 25% to 50%. For these patients, early **access to the cardiac catheterization laboratory is associated with a 10% to 15% absolute higher functionally favorable**

70

5.
**A change in survival takes more
than a single department**

71



72



73