Regarding chest compressions:
- Agonal respirations is an indicator of cardiac arrest
- If equipment does not function properly – begin chest compressions
- Prolonged interruptions in chest compression is a fatal mistake
- Stop compressions only when told to do so by the AED, for no more than 10 secs to check a pulse and to administer a shock
- High quality chest compressions at 100-120/minute, 2 inches in depth, allowing for adequate chest recoil, 30:2 ratio without ET tube
- Switch providers every 2 minutes or 5 cycles

Regarding respirations:
- With ET tube and in cardiopulmonary arrest squeeze bag every 6-8 seconds to equal 8-10 respirations/minute
- In respiratory arrest with a pulse use rate of compressions every 5-6 seconds to equal 10-12 respirations/minute
- Excessive ventilations will result in a decrease in cardiac output
- Do not allow oxygen to blow in the direction of the defibrillating pads/paddles
- To suction airway – insert Yankauer, suction on withdrawal, perform in less than 10 seconds
- No more cricoid pressure as it may impede ventilations or tube placement
- OPA (oropharyngeal airways) should be measured from the corner of the mouth to the angle of the mandible

Regarding CO₂ monitoring:
- A CO₂ detector offers qualitative assessment
- Waveform capnography offers a quantitative assessment and allows for monitoring CPR quality and correct ET tube placement
- Normal range is 35-40 mmHg
- Once a Return of Spontaneous Circulation (ROSC) is achieved, the target range for PETCO₂ is 35-40 mmHg
- During CPR, the goal is to maintain a PETCO₂ ≥10 mmHg
- A low value signifies the need to improve the quality of chest compress
Regarding a ROSC and MI:
- Atropine increases rate
- 1 – 2 L of NS or LR increases pressure
- The systolic BP target is 90 mmHg
- STEMI = ST elevation myocardial infarction
- PCI = percutaneous coronary interventions such as stent placement or thrombolytics
- Door to balloon inflation should be within 90 minutes
- Therapeutic hypothermia post-arrest should only be performed on comatose patients with a target range of 32-36°C
- Once hypothermia target has been reached, maintain for 24 hours
- Recommended ASA dose is 160-325 mg

Order of preferred vascular access sites – peripheral, IO, ET, central venous

You need a negative non-contrast CT within 25 mins of hospital arrival before treating stroke with tpa

Cincinnati Prehospital Stroke Scale – facial drooping, pronator drift, abnl speech