

The following 3 figures are excerpted from the Winter 2005-2006 issue of *Currents*, Vol. 16 No 4. All rights reserved.
 © 2006 American Heart Association, Inc.

TABLE 1. Summary of Lay Rescuer CPR for Adults, Children, and Infants
 (Newborn/Neonatal information not included)

Step/Action	Adult: 8 years and older	Child: 1 to 8 years	Infant: Under 1 year
Airway	Head tilt–chin lift		
Breaths Initial	2 breaths at 1 second/breath		
Foreign-body airway obstruction	Abdominal thrust		Back slaps and chest thrusts
Compressions			
Compression landmarks	In the center of the chest, between nipples		Just below nipple line
Compression method Push hard and fast Allow complete recoil	2 Hands: Heel of 1 hand, second hand on top	2 Hands: Heel of 1 hand with second on top or 1 Hand: Heel of 1 hand only	2 fingers
Compression depth	1½ to 2 inches	About ⅓ to ½ the depth of the chest	
Compression rate	About 100/min		
Compression-ventilation ratio	30:2		
Defibrillation			
AED	Use adult pads. Do not use child pads/child system.	Use after 5 cycles of CPR. Use child pads/system for child 1 to 8 years if available. If not, use adult AED and pads.	No recommendation for infants <1 year of age

© 2006 American Heart Association, Inc. Reproduction permitted only for American Heart Association Instructor Updates and Provider Course Bridge Materials. All other uses are prohibited.

Excerpted from the Winter 2005-2006 issue of *Currents*, Vol. 16 No 4.
All rights reserved.

TABLE 2. Summary of BLS ABCD Maneuvers for Infants, Children, and Adults
(Newborn/Neonatal Information Not Included) *Note:* Maneuvers used only by healthcare providers are indicated by “HCP”

MANEUVER	ADULT	CHILD	INFANT
	Lay rescuer: ≥8 years HCP: Adolescent and older	Lay rescuers: 1 to 8 years HCP: 1 year to adolescent	Under 1 year of age
ACTIVATE Emergency Response Number (lone rescuer)	Activate when victim found unresponsive HCP: if asphyxial arrest likely, call after 5 cycles (2 minutes) of CPR	Activate after performing 5 cycles of CPR For sudden, witnessed collapse, activate after verifying that victim unresponsive	
AIRWAY	Head tilt–chin lift (HCP: suspected trauma, use jaw thrust)		
BREATHS Initial	2 breaths at 1 second/breath	2 effective breaths at 1 second/breath	
HCP: Rescue breathing without chest compressions	10 to 12 breaths/min (approximately 1 breath every 5 to 6 seconds)	12 to 20 breaths/min (approximately 1 breath every 3 to 5 seconds)	
HCP: Rescue breaths for CPR with advanced airway	8 to 10 breaths/min (approximately 1 breath every 6 to 8 seconds)		
Foreign-body airway obstruction	Abdominal thrusts		Back slaps and chest thrusts
CIRCULATION HCP: Pulse check (≤10 sec)	Carotid (HCP can use femoral in child)		Brachial or femoral
Compression landmarks	Center of chest, between nipples		Just below nipple line
Compression method Push hard and fast Allow complete recoil	2 Hands: Heel of 1 hand, other hand on top	2 Hands: Heel of 1 hand with second on top or 1 Hand: Heel of 1 hand only	1 rescuer: 2 fingers HCP, 2 rescuers: 2 thumb–encircling hands
Compression depth	1½ to 2 inches	Approximately ⅓ to ½ the depth of the chest	
Compression rate	Approximately 100/min		
Compression-ventilation ratio	30:2 (1 or 2 rescuers)	30:2 (single rescuer) HCP: 15:2 (2 rescuers)	
DEFIBRILLATION			
AED	Use adult pads. Do not use child pads/child system. HCP: For out-of-hospital response may provide 5 cycles/2 minutes of CPR before shock if response > 4 to 5 minutes and arrest not witnessed.	HCP: Use AED as soon as available for sudden collapse and in-hospital. All: After 5 cycles of CPR (out-of-hospital). Use child pads/child system for child 1 to 8 years if available. If child pads/system not available, use adult AED and pads.	No recommendation for infants <1 year of age

© 2006 American Heart Association, Inc. Reproduction permitted only for American Heart Association Instructor Updates and Provider Course Bridge Materials. All other uses are prohibited.

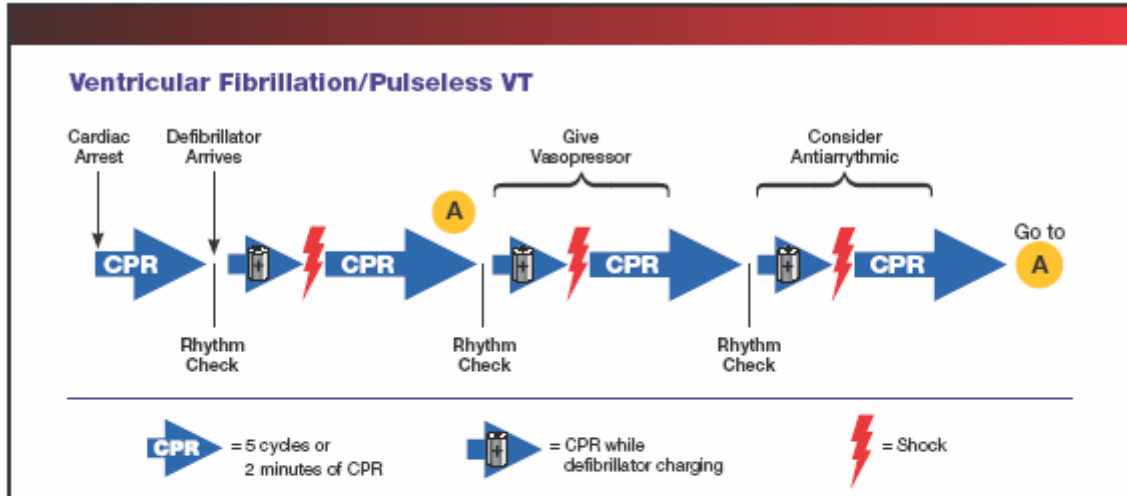


Figure 2: Ventricular Fibrillation and Pulseless VT: Treatment Sequences for ACLS and PALS. This illustrates suggested timing of CPR, rhythm checks, attempted defibrillation (shock delivery), and drug delivery for persistent VF/pulseless VT. Drug doses should be prepared *prior* to rhythm check. Drugs should be administered during CPR, as soon after a rhythm check as possible. Ideally CPR (particularly chest compressions) is interrupted only for rhythm check and shock delivery. If possible, rescuers should perform chest compressions while the defibrillator is charging. Rescuers should resume chest compressions immediately after a shock is delivered. In in-hospital settings with continuous (eg, electrocardiographic, hemodynamic) monitoring in place, this sequence may be modified by the physician. If PEA or asystole develops after a shock (and CPR), rescuers should follow the Asystole/PEA branch of the ACLS or PALS Pulseless Arrest Algorithms.

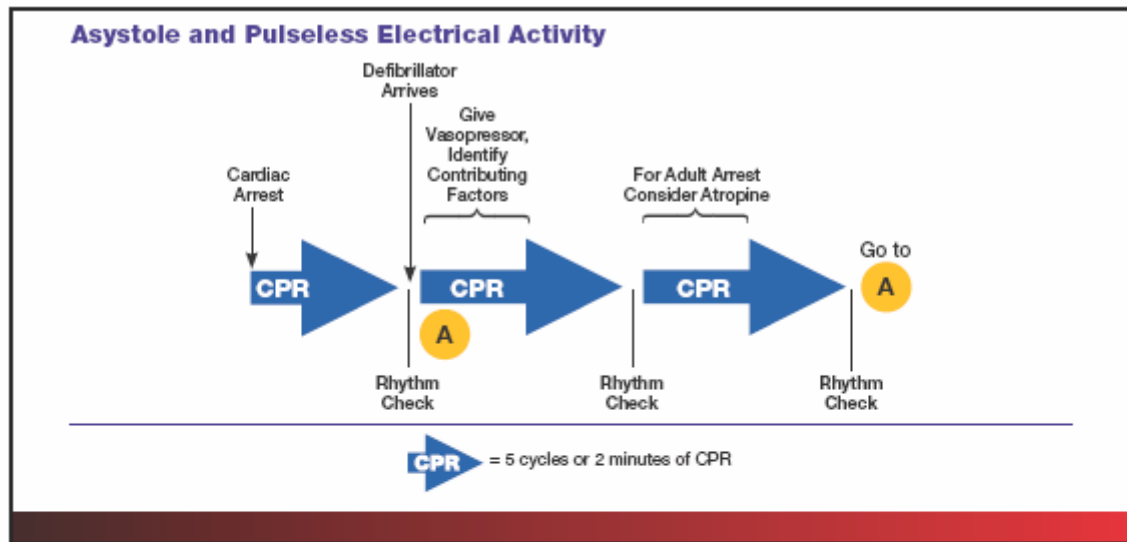


Figure 3: Asystole and Pulseless Electrical Activity: Treatment Sequence for ACLS and PALS. This illustrates the suggested timing of CPR, rhythm checks, and drug delivery for pulseless electrical activity (PEA) or asystole. Drug doses should be prepared *prior* to rhythm check. Drugs should be administered during CPR, as soon after a rhythm check as possible. Rescuers should search for and treat any contributing factors. Ideally CPR (particularly chest compressions) is interrupted only for rhythm check and shock delivery. If possible, rescuers should perform chest compressions while the defibrillator is charging. Rescuers should resume chest compressions immediately after a shock is delivered, without checking the rhythm. In in-hospital settings with continuous (eg, electrocardiographic, hemodynamic) monitoring in place, this sequence may be modified by the physician. If VF/pulseless VT develops, rescuers should follow the VF/Pulseless VT branch of the ACLS or PALS Pulseless Arrest Algorithm.