



Circular 32:03:07

To: District Officers Assessors
 Chief Instructors Trainers

Cc:

From: Stuart Wall – Assessment Development Officer

Date: 28 February 2007

Subject: Australian Resuscitation Council latest FAQ

Action:

Dear Assessors and Trainers

The following is an adapted version (Sequence of events, ALS flowchart, has been removed) of the latest Frequently Asked Questions (FAQ) as produced by the Australian Resuscitation Council. This reproduction is aimed at Trainers and Assessors of CPR within Lifesaving Victoria.

If there is further interest with the relation to the Practice, Training or Assessment of CPR or other first aid within Lifesaving Victoria please do not hesitate to contact Rob O'Brien, as below.

I hope this is helpful.

Stuart Wall
State Assessment Development Officer

For additional detail on this Circular contact:
Rob O'Brien Support Officer – Lifesaving Training
Email rob.obrien@lifesavingvictoria.com.au or by phone 9676 6954
Circulars are also available at www.lifesavingvictoria.com.au
Address: PO Box 353 South Melbourne DC 3205



AUSTRALIAN RESUSCITATION COUNCIL

CHAIRMAN:
Assoc. Professor I G Jacobs BAppSc, DipEd, PhD, RN, FRCNA, FACAP
DEPUTY CHAIRMAN:
Dr P Morley MB BS, FRACP, FANZCA, FJFICM

SPONSORED BY
Royal Australasian College of Surgeons
Australian and New Zealand College
of Anaesthetists

FREQUENTLY ASKED QUESTIONS (FAQ) FOLLOWING THE RELEASE OF THE “NEW” ARC GUIDELINES (MARCH 2006)

- FAQ 1:** The guidelines now recommend that full CPR be given to all those requiring resuscitation. What about victims who may not be breathing but have a pulse?
- FAQ 2:** Guideline 5 says we should check for signs of life after giving 2 initial rescue breaths, but this does not appear on the basic life support flow chart. Which is correct?
- FAQ 3:** If unconscious and unresponsive are the same then why not just use “Unconscious, no movement, not breathing normally”?
- FAQ 4:** How many hands should be placed on the chest when given chest compressions to a child? One or two?
- FAQ 5:** Choking
- FAQ 6:** Should CPR be done by one or two rescuers?
- FAQ 7:** Should you use cold/ice packs or hot water for relieving the pain after bluebottle stings?
- FAQ 8:** ‘Best Interests’ of Collapsed Victims

FAQ 1

The guidelines now recommend that full CPR be given to all those requiring resuscitation. What about victims who may not be breathing but have a pulse?

To determine the need for only rescue breathing you would need to be able to check for a pulse. There is reasonable evidence that rescuers are no more likely to be able to correctly determine if a pulse is present than simply tossing a coin. Accordingly Resuscitation councils all around the world removed the pulse check in 2000. Epidemiological data would suggest that the vast majority of victims requiring resuscitation will be in cardiac arrest – thus requiring full CPR. Furthermore only about half of the victims requiring CPR get any resuscitation before and ambulance arrives. Thus it was considered of greater benefit overall that anyone who has no signs of life be given CPR rather than not receiving any compressions because the rescuer thought the victim had a pulse. This is very much the case as there is no reliable way of for the rescuer to detect a pulse. **COMPRESSIONS ARE VITAL.**

Will I do harm if I give chest compressions to someone with a beating heart?

There is very little data in this area however you are highly unlikely to do harm. One study has shown that patients who were defibrillated and had immediate CPR for 2 minutes after the shock, regardless of whether a pulse was present or not, were no more likely to have complications. In addition, it is recommended in paediatric resuscitation and common practice in critical care settings for CPR to be given to patients who have a slow heart rate. NO adverse effects have been reported. Based on the available evidence, it appears that the fear of doing harm by giving chest compressions to some who has no signs of life, but has a beating heart, is unfounded.

FAQ 2

Guideline 5 says we should check for signs of life after giving 2 initial rescue breaths, but this does not appear on the basic life support flow chat. Which is correct?

They are both correct. The flow chart outlines the general steps (DRABCD) of providing CPR with the specific details in the guideline. Once the rescuer has made the decision to start CPR, the initial rescue breaths are intended to inflate the lungs with oxygen and confirm that the airway is patent. After giving 2 initial rescue breaths, one should quickly move to commence compressions but review the patient's condition if any signs of life have returned (eg coughing, movement, normal breathing). The important thing here is not to delay commencing compressions while you look for signs of life.

FAQ 3

If unconscious and unresponsive are the same then why not just use “Unconscious, no movement, not breathing normally”?

The term “unconscious” means different things to different people and given that the rescuer is checking for response it was felt that the addition of the term “unresponsive” helps clarify the intent and need for CPR.

FAQ 4

How many hands should be placed on the chest when given chest compressions to a child? One or two?

Guideline 6 recommends that two fingers should be used to give chest compressions to an infant. (less than 1 year of age) In children where the size of the child and that of the rescuer can vary greatly it is impossible to make a clear recommendation. Guideline 6 recommends two hands for simplicity of BLS training in that one hand may not always be sufficient whereas two hands will always be. The important focus here is to ensure that the depth of chest compressions is adequate (ie about 1/3 of the chest depth). For some people that will require two hands, for others one hand will be sufficient. Furthermore, when using two hands the full weight of the rescuer may not need to be applied to achieve adequate depth of compressions. Training should focus on achieving adequate compression depth rather than when to use one or two hands for chest compressions in children. Providing adequate depth of chest compression is achieved the use of one hand is acceptable.

FAQ 5

Choking

Guideline 4 outlines the recommended procedure for choking. This is a controversial area mainly as there is a lack of any scientific evidence for making strong clinical guideline recommendations. The Consensus of Resuscitation Science identified that the combination of back blows, chest thrusts and abdominal thrusts could be used to relieve complete foreign body airway obstruction. Where the patient is unconscious then CPR should be used.

It is the use of the chest thrust which appears to be causing some confusion. Chest thrusts are applied:

- At the same point on the chest that is used when providing chest compressions during CPR.
- They are delivered sharper and slower than chest compressions during CPR.

In order to do chest thrusts you need to have the back of the patient supported. This can be achieved by either:

- Placing your other hand on the patients back.
- If the patient is sitting use your other hand to support the back of the chair.
- Have someone stand behind to provide support.
- Stand against a firm surface like a wall.
- Lie the patient down.

It is very hard to state categorically on how to achieve back support when using chest thrusts but the overall principle remains the same. Support the back any way you can.

Remember if chest thrusts cannot be applied continue with back blows. If the patient becomes unconscious commence CPR. The ARC does not recommend the use of abdominal thrusts as there is considerable evidence of harm caused by this procedure. For those interested there are two evidence based worksheets under Basic Life Support on the website www.c2005.org

The ARC has been made aware of a recent successful outcome in choking victim following the use of the chest thrust.

FAQ 6

Should CPR be done by one or two rescuers?

CPR should be performed by a single rescuer until other rescuers are available, then it may be performed by two rescuers (one performing chest compressions and one performing rescue breaths). There is less interruption to chest compressions if the work is shared between the two rescuers, rather than one person doing it all until tired. Frequent rotation of rescuers (especially the rescuer performing chest compressions) should be undertaken to reduce fatigue.

FAQ 7

Should you use cold/ice packs or hot water for relieving the pain after bluebottle stings?

Recently the results of a randomised trial comparing hot water with ice packs for relieving pain after a Bluebottle sting was published in the Medical Journal of Australia ¹. The overall conclusion of the study was that hot water (45 degrees C) provided better pain relief than ice. As this study supports a treatment not currently recommended, the ARC is now undertaking a review of its current guideline (8.9.6 Jellyfish stings) in light of this new data. Until the guideline review for Jellyfish stings is completed the ARC continues to recommend ice packs for Bluebottle stings.

1. Loten C, Stokes B, Worsley D, Seymour JE, Jiang S, Isbister GK. A randomised controlled trial of hot water (45 degrees C) immersion versus ice packs for pain relief in bluebottle stings. Med J Aust 2006;184(7):329-33.

FAQ 8

'BEST INTERESTS' OF COLLAPSED VICTIMS

First-aiders and professionals endeavouring to render assistance to an incompetent person (eg: child, comatose adult) in need of assistance are sometimes faced with requests by family or others to refrain on the grounds that the person would not have wanted assistance or that the treatment proposed is burdensome.

When the situation applies to an incompetent adult (unable to communicate rationally) who has previously stated in writing their intention, the situation is quite clear and the person's desires must be followed. Of importance, is that spouses and relatives of incompetent adults do not normally have authority to decline treatment of their loved one unless this has been given force by an appropriate legal directive.

If a competent adult states that treatment is not wanted, this request should be followed since to do otherwise is ethically and legally wrong.

However, when the situation pertains to a child (an incompetent legal person), the child's parents or legal guardian have the right to refuse such treatment provided that this is in the 'best interests' of the child. However, medical practitioners, and presumably other professional healthcare personnel, also have a duty of care to always act in the 'best interests' of the child.

When conflict arises, the question arises: what is meant by ‘best interests’?

Although used freely in medical and legal contexts, the term ‘best interests’ is a nebulous term. With respect to children, legally, Courts are directed to act in the ‘best interests’ of a child in section 68F of the Family Law Act 1975 (Clth). In determining what these might be, consideration must be given to current wishes of the child, relationships with parents and others, any changeable circumstances, the child’s maturity, protection from physical and psychological harm and any other matters that the Court considers relevant.

From a practical viewpoint, ‘best interests’ may be defined from an examination of common law cases involving incompetent adults and children ¹.

Essentially, ‘best interests’ may be defined as:

1. **Avoidance of futile treatment.** This is somewhat facile. It leads to the question of: What is futility? What may seem futile to one person is not to another, but from a legal common law perspective, it may be stated as actions that only serve to prolong death rather than save life.
2. A consideration of the **burden versus benefit** of treatment. This requires a consideration of the results of withholding treatment versus its application.
3. Consideration of the **quality of life** if treatment is given and survival ensues.

When faced with a situation in which it is unclear whether treatment should be given or withheld in the incompetent adult’s ‘best interests’, it is justifiable to give treatment, otherwise a possible benefit may be foregone. If it so happens that treatment is later considered to not be beneficial, it can be withdrawn since both ethically and legally, withholding and withdrawing treatment are identical.

1. Tibballs J. The legal basis for ethical withholding and withdrawing of life-sustaining medical treatment in children. (2006) 14 Journal of Law and Medicine 244.