

MODE: **CODE BLUE** · BLS + ACLS · NGN NCLEX-RN

HR — SpO₂ — RHY **SINUS**

CODE BLUE

CPR · CARDIAC ARREST · BLS & ACLS ALGORITHMS — **HIGH-YIELD MUST-KNOW REVIEW**

FLASHCARDS

REFERENCE TABLES

INFOGRAPHIC

BLS BY AGE — THE CORE NUMBERS

The single most-tested table. Note: only the **pediatric** ratio changes with a second rescuer.

PARAMETER	ADULT (≥PUBERTY)	CHILD (1 YR-PUBERTY)	INFANT (<1 YR)
Compression rate	100–120/min	100–120/min	100–120/min
Depth	≥2 in (5 cm), max 2.4 in	~2 in (≥½ AP)	~1.5 in (≥½ AP)
Ratio — 1 rescuer	30:2	30:2	30:2
Ratio — 2 rescuers	30:2	15:2	15:2
Hand / technique	2 hands, lower sternum	1 or 2 hands	2 fingers (1) / 2 thumbs (2)
Pulse site	Carotid	Carotid / femoral	Brachial
Lone-rescuer call	Phone first	CPR first* (unless witnessed sudden collapse)	CPR first*

VENTILATION RATES

Same rates apply to **rescue breathing** (pulse present) and to ventilation with an **advanced airway** during CPR.

SITUATION	ADULT	CHILD / INFANT
Rescue breathing (has pulse)	1 breath / 6 sec — 10/min	1 breath / 2–3 sec — 20–30/min
Advanced airway during CPR	1 breath / 6 sec — 10/min + continuous compressions	1 breath / 2–3 sec — 20–30/min + continuous compressions
Each breath	Given over ~1 sec, just enough for visible chest rise. Avoid over-ventilation.	

SHOCKABLE VS. NON-SHOCKABLE

RHYTHM	SHOCK?	KEY MANAGEMENT
Ventricular fibrillation (VF)	YES — defibrillate	CPR + shock; epi after 2nd shock; amiodarone after 3rd
Pulseless VT (pVT)	YES — defibrillate	Same as VF pathway
Asystole	NO	CPR + epi ASAP, q3–5 min; treat H's & T's; confirm not fine VF/lead artifact
PEA	NO	CPR + epi ASAP; find & fix the cause (H's & T's)
Unstable rhythm WITH a pulse	Synchronized cardioversion	Not defibrillation — sync to the R wave

ACLS ARREST DRUGS

DRUG	DOSE	WHEN / WHY
Epinephrine	1 mg (1:10,000) IV/IO q3–5 min	ALL arrest rhythms. ASAP in asystole/PEA; after 2nd shock in VF/pVT. Vasoconstriction → coronary/cerebral perfusion.
Amiodarone	300 mg, then 150 mg	SHOCKABLE only (VF/pVT) after defibrillation fails (≈3rd shock).
Lidocaine (alt.)	1–1.5 mg/kg, then 0.5–0.75	Alternative antiarrhythmic for VF/pVT.
Defibrillation energy	Biphasic 120–200 J · Monophasic 360 J	Subsequent shocks equal or higher.

REVERSIBLE CAUSES — H'S & T'S

H'S	T'S
Hypovolemia	Tension pneumothorax
Hypoxia	Tamponade (cardiac)
Hydrogen ion (acidosis)	Toxins (overdose)
Hypo-/Hyperkalemia	Thrombosis — pulmonary (PE)
Hypothermia	Thrombosis — coronary (MI)

MNEMONICS & MEMORY HOOKS

C-A-B

Compressions → **A**irway → **B**reathing. Circulation first for cardiac arrest.

NUMBERS

100–120/min for everyone · **30:2** adults always · kids get **15:2** with help.

SHOCK THE V'S

Defibrillate **VF** & pulseless **VT**. Don't shock the flat (asystole) or the pulseless-organized (PEA).

DEFIB VS. SYNC

No pulse → defibrillate (unsynchronized).
Pulse + unstable → synchronized cardioversion.

DRUGS

Epi everywhere, q3–5 min. **Amio** 300→150 only after shocks.

POST-SHOCK

Shock → CPR, never Shock → check pulse. Resume compressions immediately for 2 min.

INFANT CHOKING

5 & 5: 5 back slaps + 5 chest thrusts. NEVER abdominal thrusts under 1 yr.

CLOSED LOOP

Call it → Confirm it → Complete it → Confirm done. Orders to a named person.

*Lone-rescuer pediatric: do ~2 min of CPR first, then call — unless the collapse was sudden and witnessed (treat like an adult and phone first).

CODE BLUE · CPR / BLS / ACLS — NGN NCLEX-RN review deck

Built for active recall & clinical-judgment practice. Faithful to current AHA BLS/ACLS standards.
Always defer to your program's protocols and the most current AHA guidelines. Educational use only.