

**2015 American Heart Association and American Red Cross
Guidelines Update for First Aid
Comparison Chart of Key Changes**

**EMBARGOED FOR RELEASE
Oct. 15, 2015, 12:01, a.m., CST**

2015 Recommendation	2010 Recommendation	Explanation
First Aid		
<p>The use of a stroke assessment system by first aid providers is recommended. Compared with stroke assessment systems that do not require glucose measurement, assessment systems that include glucose measurement have similar sensitivity but higher specificity for recognition of stroke. The Face, Arm, Speech, Time (FAST) or Cincinnati Prehospital Stroke Scale (CPSS) stroke assessment systems are the simplest of these tools for use by first aid providers, with high sensitivity for the identification of stroke.</p>	<p>New for 2015</p>	<p>Evidence shows that the early recognition of stroke with the use of a stroke assessment system decreases the interval between the time of stroke onset and arrival at a hospital and definitive treatment. In 1 study, more than 94% of lay providers trained in a stroke assessment system were able to recognize signs and symptoms of a stroke, and this ability persisted at 3 months after training.</p>
<p>A healthcare provider (HCP) should evaluate any person with a head injury that has resulted in a change in level of consciousness, progressive development of signs or symptoms of concussion, or other causes for concern to the first aid provider. The evaluation should occur as soon as possible.</p>	<p>New for 2015</p>	<p>First aid providers often encounter individuals with minor head injury and possible concussion (mild traumatic brain injury). The myriad of signs and symptoms of concussion can make recognition of this injury a challenge. In addition, the long-term consequences of unrecognized concussion can be significant. Although a simple validated single-stage concussion scoring system could possibly help first aid providers with the recognition of concussion, no such assessment system has been identified. Sport concussion assessment tools used by HCPs that require a 2-stage assessment (before competition and after concussion) are not appropriate as a single assessment tool for first aid providers.</p>
<p>The recommended recovery position has changed from supine to a lateral side-lying position for patients without suspected spine, hip, or pelvis injury. There is little evidence to suggest that any alternative recovery position is of greater benefit for an individual who is unresponsive and breathing normally.</p>	<p>If the victim is facedown and is unresponsive, turn the victim faceup. If the victim has difficulty breathing because of copious secretions or vomiting, or if you are alone and have to leave an unresponsive victim to get help, place the victim in a modified HAINES recovery position.</p>	<p>Studies showing some improvement to respiratory indices when the victim is in a lateral position compared with a supine position has led to a change in the recommendation for patients without suspected spine, hip, or pelvis injury. The HAINES position is no longer recommended, due to the paucity and very low quality of evidence to support this position.</p>

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<p>While waiting for EMS to arrive, the first aid provider may encourage a person with chest pain to chew 1 adult or 2 low-dose aspirins if the signs and symptoms suggest that the person is having a myocardial infarction, and if the person has no allergy or other contraindication to aspirin. If a person has chest pain that does not suggest a cardiac source, or if the first aid provider is uncertain of the cause of chest pain or uncomfortable with administration of aspirin, then the first aid provider should not encourage the person to take aspirin and the decision to administer aspirin can be deferred to an EMS provider.</p>	<p>While waiting for EMS to arrive, the first aid provider may encourage the victim to chew and swallow 1 adult (non-enteric-coated) or 2 low-dose “baby” aspirins if the patient has no allergy to aspirin or other contraindication to aspirin, such as evidence of a stroke or recent bleeding.</p>	<p>The administration of aspirin significantly decreases mortality due to myocardial infarction, but there is no evidence to support the use of aspirin for undifferentiated chest pain. A reduction in mortality is also found when “early” administration of aspirin (i.e., in the first few hours after onset of symptoms from myocardial infarction) is compared with “later” (i.e., after hospital arrival) administration of aspirin for chest pain due to acute myocardial infarction. It remains unclear, however, whether first aid providers can recognize the signs and symptoms of myocardial infarction, and it is possible that use of aspirin for non-cardiac causes of chest pain could cause harm. Although the dose and form of aspirin used for chest pain was not specifically reviewed by the ILCOR First Aid Task Force, the bioavailability of entericcoated aspirin is similar to non-enteric-coated when chewed and swallowed.³⁶ Thus, there is no longer the restriction to use non-enteric-coated aspirin, as long as the aspirin is chewed before swallowing.</p>
<p>When a person with anaphylaxis does not respond to an initial dose of epinephrine, and arrival of advanced care will exceed 5 to 10 minutes, a repeat dose may be considered.</p>	<p>In unusual circumstances, when advanced medical assistance is not available, a second dose of epinephrine may be given if symptoms of anaphylaxis persist.</p>	<p>The 2010 Guidelines recommended that first aid providers assist with or administer (the victim’s own) epinephrine to persons with symptoms of anaphylaxis. Evidence supports the need for a second dose of epinephrine for acute anaphylaxis in persons not responding to a first dose; the guidelines revision provides clarification as to the timeframe for considering a second dose of epinephrine.</p>