EMERGENCY CARE NOW!

Clinical Update
November 2025

With the 15th edition of *Emergency Care*, we are committed to keeping the eText continuously updated to reflect the latest science and guidelines. We call this **EC NOW!** *Now* you will know the material you use in class is always the most up-to-date!

In addition to announcing our revolutionary approach to EMS texts, this provides an example of how we will keep you, the educator, up-to-date on EMS topics. We will:

- Inform you of clinical updates as they happen.
- Provide insight on how these changes affect you and your students.
- Relate these changes to the NREMT and practice.
- Update our eText on an ongoing basis to ensure you and your students have the most current content.

While we can't update the paper text as frequently as we can the eText, we remain committed to the entire *Emergency Care* line. Our print editions will still see regular updates incorporating changes.

The American Heart Association 2025 Update provides a great way to start this process–and we'll include some other recent updates here as well.

American Heart Association 2025 Guidelines

The 2025 AHA guidelines were released on October 22, 2025. The changes aren't dramatic, but they will affect teaching EMT courses in a few areas.

Change: Back Blows (slaps)

The AHA has reinstated back blows as part of the foreign body airway obstruction (FBAO) sequence for responsive adults and children. (These are already included for responsive infants.) Upon identifying severe or complete FBAO in a patient of any age, the EMT will perform five back blows (also known as back slaps) followed by five abdominal thrusts. This is repeated until the object is dislodged, or the patient becomes unresponsive. Guidelines for the unresponsive patient are unchanged.

Analysis: Back Blows (slaps)

The new AHA material is now available, and the change can be implemented immediately. Your classroom exams may need revision in this area. As far as the NREMT is concerned, this shouldn't be an issue at all. While the AHA didn't have back blows in their FBAO sequence for many years, the American Red Cross (ARC) never removed them. Due to these conflicting guidelines, we suspect the NREMT has avoided questions in this area.

Change: Use of Naloxone in Cardiac Arrest

The AHA now says that naloxone can be used in codes believed to be caused by opioid overdose. Routine use of naloxone in all codes is not recommended. Naloxone use should not be done before adequate compressions and ventilations have begun and been maintained. Naloxone use must not delay or reduce the effectiveness of CPR.

Analysis: Use of Naloxone in Cardiac arrest

As with back blows, we don't believe this will cause significant issues with NREMT questions. Teach naloxone use in codes the way we describe above (shouldn't delay or affect CPR). Evaluate your classroom exams. Consider adding questions that involve prioritizing steps in a code and include naloxone. A build-a-list TEI question would be ideal here, as it would give students additional exposure to that type of question.

Change: Death Notification and Debriefing After Cardiac Arrest

While some of this material is traditionally covered, the increased emphasis on death notification and debriefing after terminating resuscitation makes it a great time to enhance content in these areas.

Analysis: Death Notification and Debriefing After Cardiac Arrest

We don't expect significant changes to content at the national level, but we wouldn't be surprised to see additional questions begin to pop up in this area. This makes a bit more

emphasis on this in the introductory module reasonable as well as refreshing the content in the resuscitation chapter. Adding a notification and/or debriefing after a cardiac arrest management lab station would bring this content home nicely.

Change: Neonatal Resuscitation (multiple)

- The AHA continues to recommend delayed cord clamping and cutting (at least 60 seconds) for neonates who are vigorous and don't require resuscitation.
- Ventilations for neonates who require it are now recommended at **30 - 60/minute** (previously 40 - 60/minute)
- The two-thumb encircling method of chest compressions is now recommended for all neonates and infants. When the patient's size prohibits this, compress with the heel of one hand.
- Supraglottic airways are indicated in neonatal resuscitation if EMTs are allowed to use them. Neonatal sizes are available in these devices.

Analysis: Neonatal Resuscitation (multiple)

These changes aren't major. Updating the respiration rate referenced in your exams is a good idea so you hit the nooks and crannies your students may be asked. Neonatal resuscitation is often taught near the end of the course and doesn't always get the attention it deserves. This would be a good time to plan a bit more presentation and lab time for the topic, either in the resuscitation or obstetric sections.

NOTE: There has been considerable discussion in EMS circles about the use of mechanical CPR devices. The AHA does not recommend routine use of these devices and states that they do not improve outcomes. The recommendation on this and dual sequential defibrillation didn't change from 2020 to 2025. If you train on these devices or teach them in your class, we don't recommend making any changes based on the 2025 guidelines. Use of mechanical CPR devices, especially in situations with limited crew and in the back of the moving ambulance, seems appropriate based on the guidelines.

This is a summary of major changes that we believe will affect EMT practice and exams. We always recommend that educators review the 2025 AHA guidelines themselves. Here are links to the full guidelines and the highlights document.

Highlights: https://cpr.heart.org/-/media/CPR-Files/2025-documents-for-cpr-heart-edits-posting/Resuscitation-Science/252500_Hghlghts_2025ECCGuidelines.pdf?sc_lang=en

Full guidelines: https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/executive-summary

Updated Trauma Guidelines 2024 - 2025

The National Association of EMS Physicians has published several position papers over the last year. Some of these make some very interesting statements. While they don't always recommend an immediate change in practice, they do provide a few changes as well as hints about the future direction of trauma care. We've added a few comments about implementation for each paper.

Prehospital Trauma Compendium Evaluation and Management of Suspected Pelvis Fractures an NAEMSP Position Statement and Resource Document

This document casts doubt on several things, including the ability to identify pelvic trauma, the efficacy of pelvic binding (and how well it is performed), and the amount of bleeding in pelvic injury.

Analysis: Teach solid anatomy and physiology, especially differentiating "hip" from "pelvis." If pelvic circumferential compression devices (PCCDs or "binders") are used, they should be over the trochanters, and the legs should be internally rotated by securing the feet together.

Pelvic binders will remain in the 15th edition of Emergency Care, and we will monitor for additional science in this area.

Prehospital Trauma Compendium Management of Suspected Femoral Shaft Fractures A Position Statement and Resource Document of NAEMSP

This paper downplays the necessity for traction splinting in femoral injury. The difficulty in identifying isolated femur fractures and the apparent rarity of isolated femur fractures is cited for this reasoning.

Analysis: While we will keep traction splinting in the 15th edition of Emergency Care because it is required in many states, by the looks of this paper, its days may be numbered. Fixation splinting may be a reasonable alternative to traction splinting, especially when speed is needed (e.g. multiple trauma).

Prehospital Trauma Compendium Traumatic Pneumothorax Care Position Statement and Resource Document of NAEMSP

We appear to be back to 3-sided dressings or a vented commercial chest seal for open pneumothorax. Chest seals are no longer recommended when we ventilate a patient with an open chest wound.

Analysis: This actually makes sense. Tension pneumothorax is a common enough issue when ventilating a patient with an open chest injury that this recommendation is made. What matters: a solid foundation in A&P and pathophysiology so that students understand WHY this recommendation is in place. Your students should also be able to identify a developing tension

pneumothorax. If you've taught these things, your students will understand and make better decisions on the exam and in the field.

Prehospital Trauma Compendium Prehospital Management of Adults with Traumatic Out-of-Hospital Circulatory Arrest a Joint Position Statement and Res

Epinephrine is "out" in traumatic OHCA. This document seems to predict that compressions may be the next to go.

Analysis: Not a big change at the EMT level, but we wanted you to see this. We'll still do compressions on trauma codes, but we are finally looking deeper at this. What matters: this reminds us about how important it is to teach about the sympathetic nervous system and epinephrine at all levels.

Prehospital Trauma Compendium Prehospital Management of Spinal Cord Injuries A NAEMSP Comprehensive Review and Analysis of the Literature

We must perform an accurate and detailed spinal assessment. This document validated that the old spinal immobilization on a board is definitely out. It also starts a conversation about whether spinal motion restriction and cervical spine immobilization are even necessary.

Analysis: We'll still include spinal motion restriction in the 15th edition of Emergency Care, but if this paper tells us the way the wind is blowing, we may see soft cervical collars more (which we anticipated and included in the 15th edition) and a continued relaxing of the need for spinal motion restriction. Spinal assessment remains essential, and the 15th edition features a full-page flowchart on spinal assessment and decision-making.

That's all for this update. It is a significant one, as numerous updates and position papers have been issued. We'll continue to monitor this and keep you informed, so you and your students will stay up to date and well-prepared for the NREMT exam and practice.

If you have a question or feedback on any of the information included here, please reach out to your Pearson BRADY rep, who can put you in touch with the authors.

NOTE: This is a summary to help educators understand and implement the changes. All educators should read and evaluate guidelines themselves and determine how they will affect students' education and practice. Always follow your local protocols and state and regional guidelines for course content and equipment requirements. Your medical director is an excellent resource as you adjust to these guidelines and position papers.