Major changes to the previously published ALS guidelines relate to:

- Refocusing on the provision of good cardiopulmonary resuscitation (CPR) (including minimising the interruptions to CPR).
- Minimising the potential harm associated with ventilation.
- Maximising the likelihood of successful defibrillation.

- Multiple human clinical studies have described initial biphasic defibrillator energy levels ranging from 100 J to 200 J, and subsequent energy levels ranging from 150 J to 360 J, without clearly demonstrating an optimal energy level.
- It is recommended that the default energy level for biphasic waveforms in adults should be 200 J for all shocks (although other energy levels may be used providing there are relevant clinical data for a specific defibrillator suggesting that these energy levels provide adequate shock success).
- With a monophasic defibrillator, an initial shock of 360 J is recommended.

- In the vast majority of situations, the ARC approach to the detailed management of cardiac arrest is almost identical to most recent versions of other published international guidelines.

- Differences include:
  1. The continued support in Australia for a sequence of up to three shocks when the arrest is witnessed, and a defibrillator is immediately available.
  2. The ALS flow chart, which is a slightly more detailed version of the universal algorithm.

- In addition, a new guideline has been developed to expand on the legal and ethical issues related to resuscitation.

- Various studies have demonstrated that hyperventilation is associated with increased intrathoracic pressure, decreased coronary and cerebral perfusion, and, in animals, decreased return of spontaneous circulation. Further studies have reported unexpected return of spontaneous circulation in cases in which resuscitation had ceased, and ventilation was shown on repeated occasions (or was highly likely) to result in gas trapping and consequent haemodynamic compromise.

- recommendation for ventilation of a victim without an advanced airway is that ventilation should be continued at a ratio of 30 ventilation to 2 compressions until an advanced airway is in place.

- After an advanced airway (e.g., tracheal tube or LMA) is placed, it is reasonable to ventilate the lungs at a rate of 8–10 ventilations per minute.

- The stacked-shock strategy has been associated with prolonged periods without CPR, for what appears to be limited incremental success.

- The initiation of a one shock strategy may improve outcome by reducing interruption of chest compressions. This strategy would be of benefit in scenarios where a significant time is required for rhythm recognition and recharging of the defibrillator (e.g., > 10 seconds), but its benefits depend entirely on the quality of CPR performed between shocks.

- It is recommended that a single-shock strategy be used in patients in cardiac arrest requiring defibrillation for VF or pulseless VT. When using this strategy, CPR should be resumed immediately after shock delivery, and interruptions minimised.

- A stacked-shock strategy (using up to three shocks as necessary) is recommended in cases where the occurrence of the cardiac arrest (VF or VT) has been witnessed by the rescuer, and a manual defibrillator is immediately available. If further shocks are indicated, a single-shock strategy is recommended.