

83-Year-Old Dad in ICU After Cardiac Arrest

Families' FAQ: "How long will it take him to wake up?" | Quick tip for families in intensive care

A son started CPR right away when his 83-year-old father had a cardiac arrest at home. Paramedics cooled him to 33°C for 48 hours, then rewarmed him and withdrew sedation. After 6 days in ICU, with his kidneys initially not working, he still hasn't woken up. Here is what the family needs to know.

Q. Why did the team cool him down?

When the heart stops and restarts, the brain is briefly starved of oxygen, which can cause significant neurological injury. **Targeted Temperature Management (TTM)**, also called therapeutic hypothermia, deliberately lowers body temperature (typically 32 to 36°C) for 24 to 48 hours to reduce brain swelling and slow cell death. It is a well-established, guideline-supported treatment. Not waking immediately after rewarming is expected and does not mean something has gone wrong.

Q. How long does it take an 83-year-old to wake up after cardiac arrest and TTM?

It is highly individual. Sedation and opiates used during cooling can take **3 to 7 days or longer** to clear, especially in the elderly. **Kidney impairment** slows drug clearance further, and at 83 metabolism is slower. Some patients show responsiveness within 24 to 72 hours of rewarming, others take 7 to 14 days or longer, and in some cases there is no meaningful recovery. Not waking at 6 days doesn't necessarily mean no recovery, but it can't be dismissed either: it is a critical window for neurological assessment.

Q. Why do his kidneys and blood pressure medications matter?

Waking up isn't just about the brain: all organ systems need to stabilize first. The team is managing several systems at once. Reducing blood pressure medications, if safe, supports kidney blood flow. Once the kidneys recover, sedatives can finally be cleared.

Q. What should the ICU team be doing right now?

Neurological assessment: regular checks of movement, eye opening, response to voice and pain, and pupils; possibly an **EEG** (brain activity, hidden seizures), CT or MRI (hypoxic brain injury) and **SSEPs** (a specialist test that helps predict recovery). **Kidney support:** possibly CRRT (slow ICU dialysis) to clear toxins and residual drugs. **Cardiovascular and respiratory care:** close monitoring, ventilator weaning, and a tracheostomy if he can't breathe independently. **Basics:** feeding tube nutrition, pressure injury and DVT prevention, mouth care.

Q. What is a goals-of-care conversation and why do we need one?

At 83, after an out-of-hospital arrest with kidney failure and prolonged unconsciousness, statistical outcomes are sobering, but many people do survive and recover. Ask: What are the realistic best- and worst-case outcomes? What does his Advance Care Directive or Power of Attorney say? What were his expressed wishes? What level of treatment is appropriate if he doesn't recover neurologically? Is the plan curative or shifting toward comfort care? **These aren't conversations about giving up;** they honor him as a person.

Q. What should we ask the ICU team?

1. What is his current neurological assessment? Any purposeful movement? **2.** Has an EEG, CT or MRI been done, and what did they show? **3.** Are SSEPs planned? **4.** How is kidney function trending, and is CRRT considered? **5.** Could any medication still be suppressing consciousness? **6.** Does he breathe any part of the time on his own? **7.** What is the realistic prognosis, and what is the plan if he doesn't wake in 7 to 14 days? **8.** Can we have a formal family meeting and a goals-of-care conversation?

Q. Which medical records should we request?

Request **everything**, now and regularly, not at the end of the stay: ICU nursing and medical notes, specialist reports (neurology, cardiology, nephrology), blood results and trends, imaging, medication charts, EEG results, vital sign, ventilation and fluid balance charts, and neurological assessments including his **Glasgow Coma Scale (GCS)**. Trends show whether things are improving, plateauing or deteriorating. Any delay in access should concern you.

Q. What if he can't be weaned from the ventilator?

You are not limited to indefinite ICU or a basic nursing home. **Intensive Care at Home**, Australia's only third-party accredited intensive care at home nursing service, provides Critical Care Registered Nurses 24 hours a day for tracheostomy ventilation and NIV/BiPAP, NDIS-funded pathways for eligible participants, and palliative ventilation at home, across all states and territories. Call **1300 921 536**; families in the USA, Canada, UK, India and elsewhere are welcome to reach out.

Q. What should we do right now?

Request all medical records immediately, ask for a formal family meeting with the intensivist, ask the neurological questions above, have an honest goals-of-care conversation, and **don't make any major decision, including withdrawing treatment, without independent advice.**

Need independent expert advocacy? Intensive Care Hotline can help.

Patrik Hutzel brings 25 years of critical care nursing experience. We review records in plain language, prepare your questions before every family meeting, join ICU team conversations by phone, video or in person, and support goals-of-care decisions. Book a **free 15-minute consulting call**. intensivecarehotline.com | support@intensivecarehotline.com | intensivecareathome.com

General information for families, not a substitute for advice from your loved one's treating medical team.