



Medical Arrest	
ADULT	PEDIATRIC
Primary Direction	
<ul style="list-style-type: none"> In the absence of factors requiring rapid transport (e.g., unsafe scene), all attempts should be made to perform resuscitative efforts on scene for a MINIMUM of 20 minutes or until ROSC is achieved. Transport pediatrics after 10 minutes of on-scene ALS interventions. Movement and transport of patients interrupts CPR and prevents adequate depth and rate of compressions. 	
BLS	
Compression depth 2" - 2.5"	Compression depth of at least 1/3 the diameter of the chest size
<p><u>Operating with less than 3 EMS personnel.</u></p> <p>Provide High Performance CPR</p> <ul style="list-style-type: none"> If Mechanical Compression Device is utilized, minimize pauses, and follow guidelines under General Protocols 554.00. <p>Automated External Defibrillator (AED)</p> <ul style="list-style-type: none"> Follow AED prompts, shock if indicated. <p>Once compressions and AED are deployed</p> <ul style="list-style-type: none"> Passive Oxygenation via Non-rebreather mask 15 LPM OPA and bilateral NPAs <p style="text-align: center;"><u>Operating with 3 or more EMS personnel *OR* after 8 minutes of resuscitation</u></p> <ul style="list-style-type: none"> High Performance CPR Ventilate BVM with 100% Oxygen 1 ventilation every 6-8 seconds Establish Agency approved appropriately sized Supraglottic Airway (SGA) device. <p><i>Consider earlier ventilations for pediatrics, as most medical cardiac arrests in pediatrics are hypoxia driven.</i></p>	
ALS	
<p>Cardiac monitor (Defibrillation Pads).</p> <p>EtCO₂.</p> <p>IV/IO Access (Humeral IO for adults is preferred over tibia IO).</p> <p>Identify and treat any potential reversible causes.</p>	
Ventricular Fibrillation (VF)/Pulseless Ventricular Tachycardia (VT)	
<p>Manual Defibrillation on a 2-minute cycle</p> <ul style="list-style-type: none"> Pre-charge the monitor at least 15 seconds before pulse check, continue compressions during charging. Minimize pause to less than 10 seconds. Switch compressors every 2 minutes if not using mechanical compression device. 	

<p>Defibrillate using manufacturer recommended energy dose.</p> <ul style="list-style-type: none"> Repeat as necessary at every pulse check. Increase dose per manufacturer recommendation. <p>Epinephrine (1:10,000) 1 mg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. Max dose 5 mg. <p>Amiodarone 300 mg (first dose) Slow push IV/IO</p> <ul style="list-style-type: none"> Repeat x 1 in 3 - 5 minutes with 150 mg. Flush with NS 10 mL 	<p>Defibrillate 2 J/kg</p> <ul style="list-style-type: none"> Repeat every 2 minutes at 4 J/kg. <p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. No Max. <p>Amiodarone 5 mg/kg Slow Push IV/IO</p> <ul style="list-style-type: none"> Max single dose 300 mg. May repeat x 1 in 3 - 5 minutes. Flush with NS 10 mL
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Asystole/Pulseless Electrical Activity (PEA)

Address reversible causes based on applicable protocols

<p>Epinephrine (1:10,000) 1 mg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. Up to a Max of 5 mg <p>Calcium Chloride 1 gm IV/IO</p> <ul style="list-style-type: none"> Administer over 2 minutes. Only If Hyperkalemia highly suspected <u>Do not use for prolonged downtime.</u> 	<p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. No Max
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Airway Considerations

- BLS airway or SGA is the preferred method of airway management during cardiac arrest unless advanced airway is indicated.
- See General Protocols (554.00) for advanced airway management options.

Consideration in Pregnancy Greater Than 20 Weeks Gestations

- Place patient 25 degrees left lateral on backboard for CPR.
- IV/IO should be above the diaphragm.
- Pregnant patients are more prone to hypoxia so oxygenation and airway management should be prioritized.
- Consider early SGA or ETT.
- Do not interrupt CPR to perform procedures.
- Prepare for early transport after 4 minutes of CPR.

Termination of Resuscitation (TOR)

- After a minimum of 20 minutes of resuscitation, consider TOR in the following conditions:**
- Patient remains pulseless with no signs of life (unreactive pupils, EtCO2 less than 10 mmHg, developing lividity).
 - Persistent asystole
 - PEA less than 40 BPM.

Special Considerations

- Consider transport if patient has persistent narrow complex PEA greater than 100, or persistent V-Tach/V-Fib after 20 minutes of CPR.
- If resuscitative efforts are terminated, personnel shall confirm and document the patient's cardiac rhythm in 2 separate ECG Leads and document rhythm strips of at least 6 second duration.
- This policy does not apply to Mass Casualty Incidents.
- Transmit Code Report via Physio Control Monitor – Required for all cardiac arrests.

Base Hospital Orders

Contact Base Hospital for additional treatment or transport decisions

Effective Date: xx/xx/xxxx

Next Review Date: xx/xx/xxxx

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