

<b>CARDIAC ARREST (ATRAUMATIC)</b>	
<b>ADULT</b>	<b>PEDIATRIC (≤34 KG)</b>
<b>BLS Procedures</b>	
<ul style="list-style-type: none"> <li>• Universal Algorithm #601</li> <li>• High Performance CPR (HPCPR) (10:1) per Procedure #712                             <ul style="list-style-type: none"> <li>• Continuous compressions with 1 short breath every 10 compressions</li> </ul> </li> <li>• AED application (if shock advised, administer 30 compressions prior to shocking)</li> <li>• Pulse Oximetry                             <ul style="list-style-type: none"> <li>• O<sub>2</sub> administration per Airway Management Protocol #602</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Same as Adult (except for neonate)</li> <li>• Neonate (&lt;1 month) follow AHA guidelines</li> <li>• CPR compression to ventilation ratio                             <ul style="list-style-type: none"> <li>• Newborn – CPR 3:1</li> <li>• 1 day to 1 month – CPR 15:2</li> <li>• &gt;1 month – HPCPR 10:1</li> </ul> </li> <li>• AED – pediatric patient &gt;1 year</li> <li>• Use Broselow tape or equivalent if available</li> </ul>
<b>ALS Procedures</b>	
<p style="text-align: center;"><b>Rhythm analysis and shocks</b></p> <ul style="list-style-type: none"> <li>• At 200 compressions begin charging the defibrillator while continuing CPR</li> <li>• Once fully charged, stop CPR for rhythm analysis</li> <li>• <b>Defibrillate V-Fib/Pulseless V-tach</b> – Shock at 120J and immediately resume CPR                             <ul style="list-style-type: none"> <li>• Subsequent shock, after 2 mins of CPR: 150J, then 200J</li> <li>• Recurrent V-fib/Pulseless V-tach use last successful shock level</li> </ul> </li> <li>• <b>No shock indicated</b> – dump the charge and immediately resume CPR</li> </ul> <p style="text-align: center;"><b>V-Fib/Pulseless V-Tach and Non-shockable Rhythms</b></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1:10,000</b> 1mg IV/IO repeat every 3-5 min                             <ul style="list-style-type: none"> <li>• Do not give epinephrine during first cycle of CPR</li> </ul> </li> </ul> <p style="text-align: center;"><b>V-Fib/Pulseless V-Tach</b></p> <ul style="list-style-type: none"> <li>• <b>Lidocaine</b> 1.5mg/kg IV/IO repeat once in 3-5 min (max total dose 3 mg/kg)</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>Emphasize resuscitation and HPCPR rather than immediate transport</u></b></li> </ul> <p style="text-align: center;"><b>Rhythm analysis and shocks</b></p> <ul style="list-style-type: none"> <li>• Coordinate compressions and charging same as adult</li> <li>• <b>Defibrillate V-Fib/Pulseless V-Tach</b> – shock at 2 J/kg and immediately resume CPR                             <ul style="list-style-type: none"> <li>• Subsequent shock, after 2 mins of CPR: 4J/kg</li> <li>• Recurrent V-Fib/Pulseless V-tach use last successful shock level</li> </ul> </li> <li>• <b>No shock indicated</b> – dump the charge and immediately resume CPR</li> </ul> <p style="text-align: center;"><b>V-Fib/Pulseless V-Tach and Non-shockable Rhythms</b></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1:10,000</b> 0.01 mg/kg (0.1 ml/kg) IV/IO not to exceed 0.3mg, repeat every 3-5 min                             <ul style="list-style-type: none"> <li>• Do not give epinephrine during first cycle of CPR</li> </ul> </li> </ul> <p style="text-align: center;"><b>V-Fib/Pulseless V-Tach</b></p> <ul style="list-style-type: none"> <li>• <b>Lidocaine</b> 1 mg/kg IV/IO repeat every 5 min (max total dose 3 mg/kg)</li> </ul>
<b>Base Hospital Orders Only</b>	
<p style="text-align: center;">ROSC with Persistent Hypotension</p> <ul style="list-style-type: none"> <li>• <b>Push-Dose Epinephrine 10 mcg/ml</b> 1ml IV/IO every 1-3 min</li> </ul>	<p>Contact closest Base Hospital for additional orders</p> <p style="text-align: center;"><b>ROSC with Persistent Hypotension for Age</b></p>

<ul style="list-style-type: none"> <li>Repeat as needed titrated to SBP &gt;90mmHg</li> <li><u>See notes for mixing instructions</u></li> </ul> <p style="text-align: center;"><b><u>OR</u></b></p> <ul style="list-style-type: none"> <li><b>Epinephrine Drip</b> start at 10 mcg/min IV/IO infusion             <ul style="list-style-type: none"> <li>Consider for extended transport</li> <li><u>See formulary for mixing instructions</u></li> </ul> </li> </ul> <p><b>Contact STEMI Receiving Center (French Hospital)</b></p> <ul style="list-style-type: none"> <li>Refractory V-Fib or V-Tach not responsive to treatment</li> <li>Request for a change in destination if patient rearrests en route</li> <li>Termination orders when unresponsive to resuscitative measures</li> <li>As needed</li> </ul> <p><b>Contact appropriate Base Station per Base Station Report Policy #121</b> – Atraumatic cardiac arrests due to non-cardiac origin (OD), drowning, etc.)</p>	<ul style="list-style-type: none"> <li><b>Push-Dose Epinephrine 10 mcg/ml</b> 1 ml IV/IO (0.1 ml/kg if &lt;10kg) every 1-3 min             <ul style="list-style-type: none"> <li>Repeat as needed titrated to age appropriate SBP</li> <li><u>See notes for mixing instructions</u></li> </ul> </li> </ul> <p style="text-align: center;"><b><u>OR</u></b></p> <ul style="list-style-type: none"> <li><b>Epinephrine Drip</b> start at 1 mcg/min, up to max of 10 mcg/min IV/IO infusion             <ul style="list-style-type: none"> <li>Consider for extended transport</li> <li><u>See formulary for mixing instructions</u></li> </ul> </li> <li>As needed</li> </ul>
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**Notes**

- Mixing Push-Dose Epinephrine 10 mcg/ml (1:100,000):** Mix 9 ml of Normal Saline with 1 ml of **Epinephrine 1:10,000**, mix well.
- Use manufacturer recommended energy settings if different from listed.
- Assess for reversible causes: tension PTX, hypoxia, hypovolemia, hypothermia, hyperkalemia, hypoglycemia, overdose.
- Vascular access – IV preferred over IO – continue vascular access attempts even if IO access established).
- Consider Oral Intubation or Supraglottic Airways (Adults), provider discretion.
- If the provider cannot accomplish an ALS airway, they should document in the PCR why an ALS airway wasn't accomplished.
- Once an SGA has been placed, it should not be removed for an ETI.
- Stay on scene to establish vascular access, provide for airway management, and administer the first dose of epinephrine followed by 2 min of HPCPR.
- Adult ROSC that is maintained:
- Obtain 12-lead ECG and vital signs.
- Transport to the nearest STEMI Receiving Center ***regardless of 12-lead ECG reading.***
- Maintain O2 Sat greater than or equal to 94%.
- Monitor ETCO2
- With BP < 100 mmHg, contact SRC (French Hospital) for fluid, or pressors.
- Termination for patients > 34 kg – Contact SRC (French Hospital) for termination orders.
- If the patient remains pulseless and apneic following 20 minutes of resuscitative measures.

- Persistent ETCO<sub>2</sub> values < 10 mmHg, consider termination of resuscitation.
- Documentation shall include the patient's failure to respond to treatment and of a non-viable cardiac rhythm (copy of rhythm strip).
- Pediatric patients less than or equal to 34 kg.
- Evaluate and treat for respiratory causes.
- Use Broselow tape if available.
- Contact and transport to the nearest Base Hospital.
- Receiving Hospital shall provide medical direction/termination for pediatric patients.