Cardiac Arrest #1

EMT
1. Initiate CPR until AED arrives unless valid DNR or signs incompatible with life are present; refer to Termination of Resuscitation protocol, Red 14
2. Attach AED as soon as available with minimal interruptions in chest compressions and follow AED prompts
3. Place oral and/or nasal airway(s)
4. High-flow O₂ with BVM ventilation at a ratio of 30:2 or 1 breath every 10 chest compressions during recoil and without interrupting compressions
5. Request ALS
6. Continue 2-minute cycles of chest compressions and AED checks
7. If ROSC occurs, refer to Adult Post-Resuscitation Care protocol, Red 16
8. Consider termination of resuscitation; refer to Red 14

ADVANCED EMT
9. Establish IV/IO without interrupting chest compressions
10. Manage the airway per Blue 3. Avoid respiratory rate greater than 10/minute in cardiac arrest
11. Defibrillate as indicated

PARAMEDIC
12. One medication intervention at each 2-minute reassessment per ACLS protocol
13. EPINEPHrine 1 mg of 1 mg/10 mL IV/IO push (within 30 seconds) every 3-5 minutes

NOTE: For Pediatric Medication doses, see Red 12
a. VF/VT: amiodarone 300 mg IV/IO; may consider additional 150 mg IV/IO one time
b. Torsades: 2 grams of magnesium sulfate IV/IO
c. For refractory VF/VT (total of 3 shocks, dose of EPINEPHrine and amiodarone), refer to Refractory VF/VT protocol, Red 13
d. For PEA, in addition to standard therapies, consider treatment based on QRS complex width and rate: narrow/fast vs wide/slow

PEA

Narrow/Fast QRS Complex
Treatment:
1) IV fluid bolus
2) Consider bilateral needle decompression for suspected tension pneumothorax
Potential causes include: hypovolemia or mechanical obstruction of blood flow (tension pneumothorax, pericardial tamponade, pulmonary embolism)

Wide/Slow QRS Complex
Treatment:
1) Sodium Bicarbonate
2) Consider Calcium Gluconate for suspected hyperkalemia
Potential causes include: metabolic/toxicologic etiologies such as hyperkalemia (eg. dialysis patients) or overdose (eg. TCA, sodium channel blocker, etc.)

Continued