Team Focused CPR

- Ideally, providers in each EMS agency will use an "incident command" approach when using this protocol to ensure the most effective and efficient cardiac arrest care. Training should include teamwork simulations integrating BLS, and ALS crew members who regularly work together. High-performance systems should practice teamwork using "incident command" techniques with predefined roles and crew resource management principles. *Services may choose any reasonable Incident Command model One example is as follows:*
    - **POSITION #1 (right side of patient):**
        - Initiates 100 chest compressions at rate of 100-120 / min
        - Assists Position 3 with ventilations in off cycle
    - **POSITION #2 (left side of patient):**
        - Sets up and operates the defibrillator
        - Alternates 100 compressions with Position 1
        - Assists Position 3 with ventilations in off cycle
    - **POSITION #3 (At patient's head):**
        - Opens airway and inserts OPA
        - Assembles BVM
        - Provides 2 handed mask seal
        - Prepares and inserts advanced airway (when appropriate)
    - **POSITION #4 (Outside CPR triangle):**
        - CPR Team Leader Role "Coaches" the metrics
        - Calls for compressor change every 1 minute
        - Calls for rhythm analysis every 2 minutes
        - Monitor CPR quality and use of metronome (if equipped) at 100-120 bpm
        - Assumes duties of Position 5/6 if limited to four rescuers throughout resuscitation as scope of practice allows (e.g., AEMT or Paramedic) and positions self in P5 or P6 position.
    - **POSITION #5 (Outside CPR triangle):**
        - Initiates IV/IO access
        - Administers medications as directed by code commander
    - **POSITION #6 (Outside CPR triangle):**
        - Code(incident) Commander (Ideally a Paramedic or highest level licensure available)
        - Communicates / Interfaces with CPR Team Leader
        - Is responsible for all patient treatment decisions
        - Communicates with family / loved ones as necessary

        - Completes Cardiac Arrest Check List

- Clear Some Space to optimize your working environment. Move furniture or get the patient in a position that will allow a rescuer space to kneel on both sides of them, and where there is sufficient room at the head. Effectiveness of chest compressions decrease during patient movement. Therefore resuscitate the patient as close to the scene as operationally feasible.
- Position 1 and 2 are ideally set up on opposite sides of patient's chest and perform continuous chest compressions, alternating after every 100 compressions to avoid fatigue.
- REMEMBER: Effective chest compressions are one of the most important therapies for the pulseless patient. Effective is defined as:
    - A rate of at least 100 and less than 120 compressions/minute - Use metronome or CPR feedback device if available to ensure that compression rate is 100-120/ minute.
    - A depth of 2 inches
    - Allow for complete chest recoil
    - Minimize interruptions. Recall, two of the most common interruptions occur during airway management and during patient movement. If operationally feasible, the patient should be resuscitated on scene with as little movement as possible. Also, airway management strategies should not interrupt chest compressions.
    - Do not hyperventilate as it increases intrathoracic pressure and decreases blood return to the heart. Ventilate at a rate of 8 – 10 breaths per minutes, with enough volume to produce adequate chest rise.
- Chest compressions should only be interrupted during rhythm check (AED analysis or manual) and defibrillation shocks. Continue compressions when AED/ defibrillator is charging.
- Pre-charge manual defibrillators prior to rhythm check to ensure rapid defibrillation if a shockable rhythm is present. If no shock is indicated, disarm the device "dump the charge"
- Utilize $ETCO_2$ to assess CPR quality and monitor for signs of ROSC
- Use of a CPR checklist to ensure that all best practices are followed during CPR.
- Should an individual EMS service wish to use a resuscitation model other than ACLS/BLS (such as Cardio-Cerebral Resuscitation), this must be approved by a service medical director and all members of that service must be trained to the alternate model.