

<b>CARDIAC ARREST (ATRAUMATIC)</b>	
<b>ADULT</b>	<b>PEDIATRIC (≤34 kg)</b>
<b>BLS</b>	
<ul style="list-style-type: none"> <li>• Universal Protocol #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</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 Standing Orders</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 1 mg IV/IO</b> 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 1.5 mg/kg IV/IO</b> repeat once in 3-5 min (max total dose 3 mg/kg)</li> </ul>	<ul style="list-style-type: none"> <li>• <u><b>Emphasize resuscitation and HPCPR rather than immediate transport</b></u></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: 4 J/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 0.01 mg/kg (0.1 ml/kg) IV/IO</b>, not to exceed 0.3 mg, 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 1 mg/kg IV/IO</b> repeat every 5 min (max total dose 3 mg/kg)</li> </ul>
<b>Base Hospital Orders Only</b>	
<p style="text-align: center;"><b>ROSC with Persistent Hypotension</b></p> <ul style="list-style-type: none"> <li>• <b>Push-Dose Epinephrine 10 mcg/mL 1 mL IV/IO</b> every 1-3 min                             <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> </li> </ul> <p style="text-align: center;"><b>OR</b></p>	<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>• <b>Push-Dose Epinephrine 10 mcg/mL 1 mL IV/IO (0.1 mL/kg if &lt;10 kg)</b> every 1-3 min                             <ul style="list-style-type: none"> <li>○ repeat as needed titrated to age appropriate SBP</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>● Epinephrine Drip 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>Contact STEMI Receiving Center (French Hospital)</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>Contact appropriate Base Station per Base Station Report Policy #121 - Atraumatic cardiac arrests due to non-cardiac origin (OD, drowning, etc.)</p>	<ul style="list-style-type: none"> <li>○ <u>See notes for mixing instructions</u></li> </ul> <p style="text-align: center;"><b>OR</b></p> <ul style="list-style-type: none"> <li>● Epinephrine Drip start at 1 mcg/kg, 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>
<p><b>Notes</b></p>	
<ul style="list-style-type: none"> <li>● <u>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</u></li> <li>● Use manufacturer recommended energy settings if different from listed</li> <li>● Assess for reversible causes             <ul style="list-style-type: none"> <li>○ Tension PTX, hypoxia, hypovolemia, hypothermia, hyperkalemia, hypoglycemia, overdose</li> </ul> </li> <li>● Vascular access – IV preferred over IO – continue vascular access attempts even if IO access established</li> <li>● Oral Intubation and Supraglottic Airways (Adults) – Utilize if airway is not patent or with maintained ROSC</li> <li>● Adult ROSC that is maintained:             <ul style="list-style-type: none"> <li>○ Obtain 12-lead ECG and vital signs</li> <li>○ Transport to the nearest STEMI Receiving Center <i>regardless of 12-lead ECG reading</i></li> <li>○ Maintain O<sub>2</sub> Sat ≥ 94%</li> <li>○ Monitor ETCO<sub>2</sub></li> <li>○ Protect airway with oral intubation or Supraglottic Airway.</li> <li>○ With BP &lt; 100 mmHg, contact SRC (French Hospital) for fluid, or pressors</li> </ul> </li> <li>● Termination for patients &gt; 34 Kg - Contact SRC (French Hospital) for termination orders             <ul style="list-style-type: none"> <li>○ If the patient remains pulseless and apneic following 20 minutes of resuscitative measures</li> <li>○ Persistent ETCO<sub>2</sub> values &lt; 10mmHg, consider termination of resuscitation</li> <li>○ Documentation shall include the patient’s failure to respond to treatment and of a non-viable cardiac rhythm (copy of rhythm strip)</li> </ul> </li> <li>● Pediatric patients ≤ 34 kg             <ul style="list-style-type: none"> <li>○ <u>Stay on scene</u> to establish vascular access, provide for airway management, and administer the first dose of epinephrine followed by 2 min of HPCPR</li> <li>○ Evaluate and treat for respiratory causes</li> <li>○ Use Broselow tape if available</li> <li>○ Contact and transport to the nearest Base Hospital</li> <li>○ Receiving Hospital shall provide medical direction/termination for pediatric patients</li> </ul> </li> </ul>	