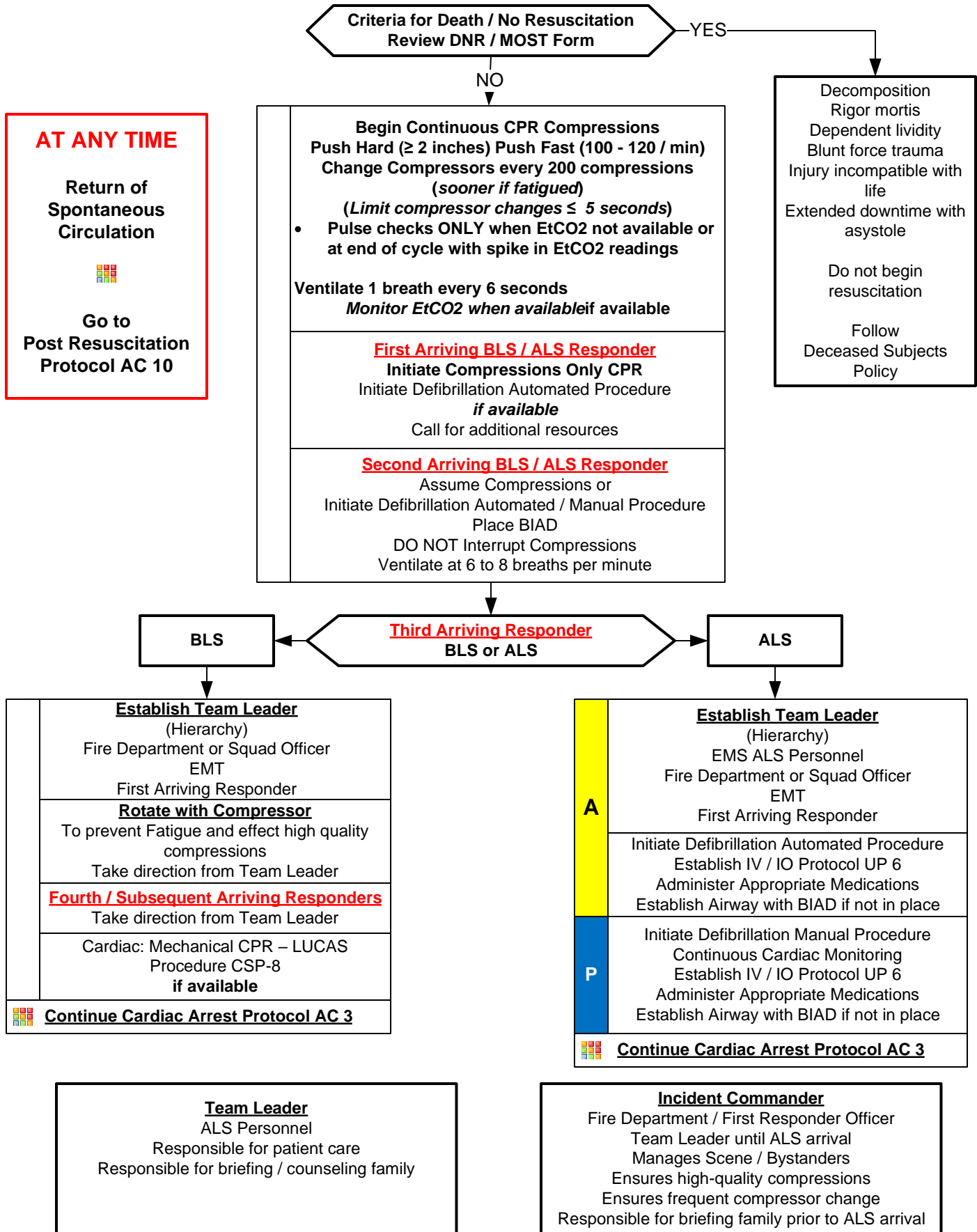




Team Focused CPR





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Typical Tiered Response:

First Arriving BLS/ MR:

Initiate Compression Only CPR and call for help/ notify of CPR.

Second Arriving BLS/ MR:

Assume compressions if First Responder has compressed longer than 200 compressions, otherwise will initiate Defibrillation Automated Procedure if available. Depending on time spent during compressions First or Second Responder will place BIAD without interrupting compressions, place respiratory timer, activate, and ventilate every 6 seconds with Red light.

Third or Fourth Arriving BLS/ MR:

Allows establishment of Team Leader. Third Arriving may be Team Leader or take direction from Team Leader.

Team Leader:

Responsible for ensuring High Quality/ Continuous/ Uninterrupted Compressions, change of compressors every 200th compression and ensure the patient is not being hyperventilated. Responsible for talking with family and ensuring they are aware victim has no pulse and is not breathing. Inform them that everything that can be done is being performed now. Be respectful, direct and compassionate, as well as honest. They have a very poor chance of survival, typically < 8 %.

Fire Department / Squad Officer:

In addition to Team Leader. CPR should be managed like any other Fire Scene. Personnel not immediately needed should be moved to a staging area and summoned when needed. This decreases confusion and noise on scene and limits the overwhelming environment the family is likely already experiencing.

ALS On Scene First:

ALS Team Leader is established. Begin compressions if downtime is < 15 minutes. If downtime is > 15 minutes apply ECG monitor / Quick Look and Defibrillation Manual Procedure is initiated if applicable. If asystole consider termination. IV / IO procedure performed and medications are administered per appropriate protocol. BIAD is placed.

Location:

Resuscitation should be performed where the patient is found on-scene. A safe location with ample space should be sought, but patient movement should be limited as this interrupts compressions. If arrest occurs in a public place then effort will be made to maintain patient dignity. Move to unit only if necessary. Resuscitation should not be performed during transport as this degrades performance and places you and the public at risk of injury. If a family insists on transport then do so **non-emergency** to limit injury risk and maximize compression quality. 20 minutes of high-quality resuscitation should be attempted before transport to maximize patient's survivability.

Movement of patient if needed:

A coordinated effort will be employed when moving a patient undergoing CPR. The team leader should make sure everyone is prepared for the move and this should occur when a planned compressor cycle change is indicated. Brief movements of short distances should be interspersed with 400 compressions. Moves should not take more than 10 seconds each. Rapid return of continuous chest compressions should resume at the end of each move. Do not perform CPR during move.

Talking with Family:

Most important aspect. Be honest, be straightforward and do not be technical. Begin to gather the information and start your explanation from that point. Be very clear the patient is not breathing and their heart is not beating which means they are dead (use the word dead.) Explain what is being done and allow the family to be present for the resuscitation if they desire. Ensure them that all that can be done is being done right now and that transporting will actually worsen their loved ones chance of survival. Let them know that after 30 minutes if we have no response then we should stop as the chance of survival now is less than 1 %. Our goal is to talk / update the family on separate four (4) occasions during the resuscitation. Follow AGLS.

- **Follow Termination of Resuscitation On Scene Protocol AC-12.**

Pearls

- **This protocol is optional and given only as an example. Agencies may and are encouraged to develop their own.**
- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks. Refer to optional protocol or development of local agency protocol.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE, ventilate ONLY at every 20th compression with BVM, BIAD, or ETT.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- Reassess and document BIAD and / or endotracheal tube placement and EtCO₂ frequently, after every move, and at transfer of care.
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation.**
- **IV access is preferred route. Follow IV or IO Access Protocol UP 6.**
- **Defibrillation:** Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
 - Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.
 - Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
- Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.