Cardiac Arrest; Adult

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES →
- Decomposition
- Rigor mortis
- Dependent lividity
- Blunt force trauma
- Injury incompatible with life
- Extended downtime with asystole or Wide Complex PEA ≤ 40 bpm

Do not begin resuscitation

Follow Deceased Subjects Policy

NO ↓

Begin Continuous CPR Compressions
Push Hard (≥ 2 inches)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes
(sooner if fatigued)
(Limit changes / pulse checks ≤ 10 seconds)

Ventilate 1 breath every 6 seconds
30:2 Compression:Ventilation if no Advanced Airway
Monitor EtCO2
if available

ALS Available?

NO → AED Procedure CSP 5 *if available*

YES → **P** Cardiac Monitor

Shockable Rhythm?

NO → AED Procedure CSP 5

YES → AED Procedure CSP 5

Continue CPR 2 Minutes
Repeat and reassess
Airway Protocol(s) AR 1, 2, 3

NO → Asystole / PEA Protocol AC 1 ***as indicated***
Airway Protocol(s) AR 1, 2, 3

YES → VF / VT Protocol AC 9
Tachycardia Protocol(s) AC 6, 7 ***as indicated***
Airway Protocol(s) AR 1, 2, 3

Arrest secondary to Opioid OD?

YES →
Naloxone 0.4 - 2 mg IN / IM
Peds: 0.1 mg/kg IN
Maximum 4 mg

A *Consider*
Naloxone 0.4 - 2 mg
Peds: 0.1 mg/kg
IV / IO / IM / IN / ETT
Maximum 4 mg

NO ↓

Termination on Scene Protocol AC 12 ***as indicated***

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

Cardiac Arrest; Adult

Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assign responders to predetermined tasks.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE: If no advanced airway (BIAD, ETT) compression to ventilation ratio is 30:2. If advanced airway in place, ventilate 10 breaths per minute with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **It is appropriate to provide passive oxygenation when there is limited resources prior to establishing the Team Focused Approach / Pit-Crew Approach.**
- **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 is secondary to high-quality chest compressions and early defibrillation**.
- **IV access is preferred route. Follow IV or IO Access Procedure.**
- **Defibrillation:**
  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.
- **End Tidal CO2 (EtCO2)**
  If EtCO2 is < 10 mmHg, improve chest compressions.
  If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Special Considerations**
  Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Transcutaneous Pacing:**
  Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival
- 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.