



- compressions in cases of no bystander chest compressions or to perform defibrillation as soon as possible after chest compressions initiated in cases of witnessed arrest
5. There is insufficient evidence to recommend the routine use of extracorporeal CPR (ECPR) for patients with cardiac arrest. In settings where it can be rapidly implemented, ECPR may be considered for select cardiac arrest patients for whom the suspected etiology of the cardiac arrest is potentially reversible during a limited period of mechanical cardiorespiratory support
 6. Chest compressions should be reinitiated immediately after defibrillation as pulses, if present, are often difficult to detect and rhythm and pulse checks interrupt compressions
 7. Continue chest compressions between completion of AED analysis and AED charging
 8. The effectiveness of chest compressions decreases when moving patients
 - a. Patients should therefore be resuscitated as close to the point at which they are first encountered and should only be moved if the conditions on scene are unsafe or do not operationally allow for resuscitation
 - b. Chest compressions are also less effective in a moving vehicle
 - c. It is also dangerous to EMS clinicians, patients, pedestrians, and other motorists to perform chest compressions in a moving ambulance
 - d. For these reasons and because in most cases the care provided by EMS clinicians is equivalent to that provided in emergency departments, resuscitation should occur on scene
 9. The maximum setting on the defibrillator should be used for initial and subsequent defibrillation attempts. Defibrillation dosing should follow manufacturer's recommendation in the case of biphasic defibrillators. If the manufacturer's recommendation is unknown, use highest setting possible. In the case of monophasic devices, the setting should be 360 J (joule) (or 4 J/kg for children)
 10. IV or IO access without interrupting chest compressions
 11. Administer epinephrine (0.1 mg/kg, maximum dose 1 mg) IV/IO during the first or second round of compressions
 12. At present, the most effective mechanism of airway management is uncertain due to some systems managing the airway aggressively and others managing the airway with basic measures and both types of systems finding excellent outcomes. Regardless of the airway management style, consider the following principles:
 - a. Airway management should not interrupt chest compressions
 - b. Carefully follow ventilation rate and prevent hyperventilation
 - c. Consider limited tidal volumes
 - d. There is uncertainty regarding the proper goals for oxygenation during resuscitation
 - i. Current recommendations suggest using the highest flow rate possible through NRB or BVM
 - ii. This should not be continued into the post-resuscitation phase in which the goal should be an oxygen saturation (SpO₂) of 94–98%
 - e. **Pediatric Considerations:** Special attention should be applied to the pediatric population and airway management/respiratory support. Given that the most likely cause of cardiac arrest is respiratory, airway management may be considered early in the patient's care
 - i. However, the order of Circulation-Airway-Breathing is still recommended as the order of priority by the American Heart Association for pediatric resuscitation to ensure timely initiation of chest compressions to maintain perfusion, regardless of the underlying cause of the arrest