

Pediatric V-Fib/Pulseless V-Tach

For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

History

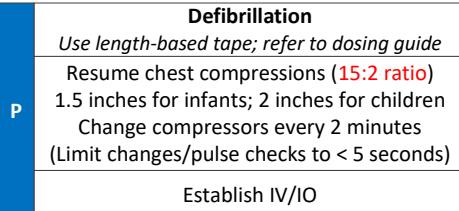
- Events leading to arrest
- Estimated downtime
- Prior resuscitation attempts
- Past medical history
- Medications
- Known terminal illness

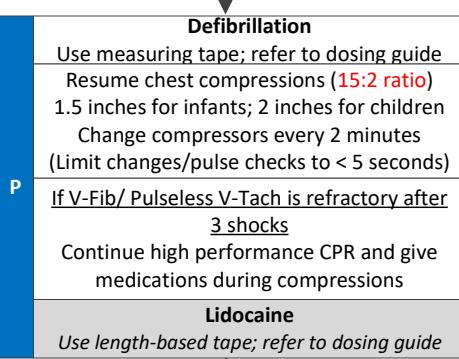
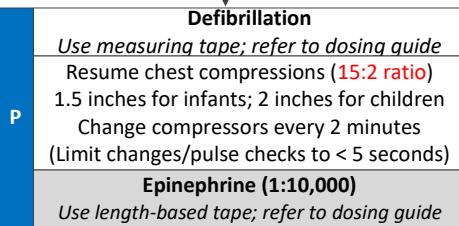
Signs and Symptoms

- Pulseless
- Apneic

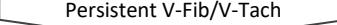
Differential

- Airway obstruction/respiratory disease
- Medical vs. trauma
- VF vs. pulseless VT
- Asystole
- PEA
- Primary cardiac event vs. respiratory arrest or drug overdose

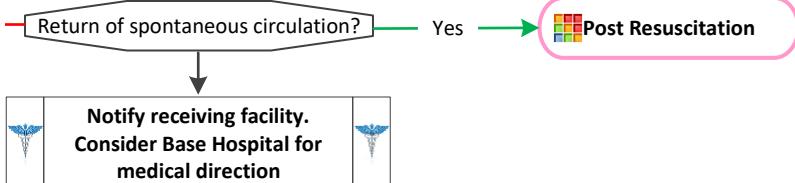
 Enter from Cardiac Arrest

AT ANY TIME
 Return of spontaneous circulation

 Go to Post Resuscitation


Yes

 Persistent V-Fib/V-Tach

No

 Aystole/PEA


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Pearls

- Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with a BVM, airway adjunct, and appropriately sized mask. Patient survival is often dependent on proper ventilation and oxygenation.
- Efforts should be directed at high quality chest compressions with limited interruptions.
- Use appropriately sized pediatric BVM with EtCO₂.
- Do not delay chest compressions while applying any device or intervention.
- Use a metronome during chest compression to ensure proper rate.
- Provide resuscitative efforts for 30 minutes to maximize chance of ROSC.
- If resuscitative efforts do not attain ROSC, consider cessation of efforts per Policy 507 – Determining Death.
- Resuscitation is based on proper planning and organized execution. Procedures require space and patient access. Make room to work. Utilize a team focused approach assigning responders to predetermined tasks.
- Reassess airway and document EtCO₂ frequently.
- Defibrillation vests should be removed by EMS personnel before compressions, but do not cut vests. Once removed, disengage battery to prevent alarming.

