

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	9006.22
	<u>PROGRAM DOCUMENT:</u> Pediatric Medical Cardiac Arrest	Initial Date:	02/24/95
		Last Approved Date:	09/14/23
		Effective Date:	05/01/24
		Next Review Date:	09/01/25

Signature on File

EMS Medical Director

Signature on File

EMS Administrator

Purpose:

- A. To establish treatment standards in treating pediatric cardiac arrest patients.
- B. To establish pediatric treatment standards for Asystole, Pulseless Electrical Activity (PEA), Ventricular Fibrillation (VF), and Pulseless Ventricular Tachycardia (VT).

Authority:

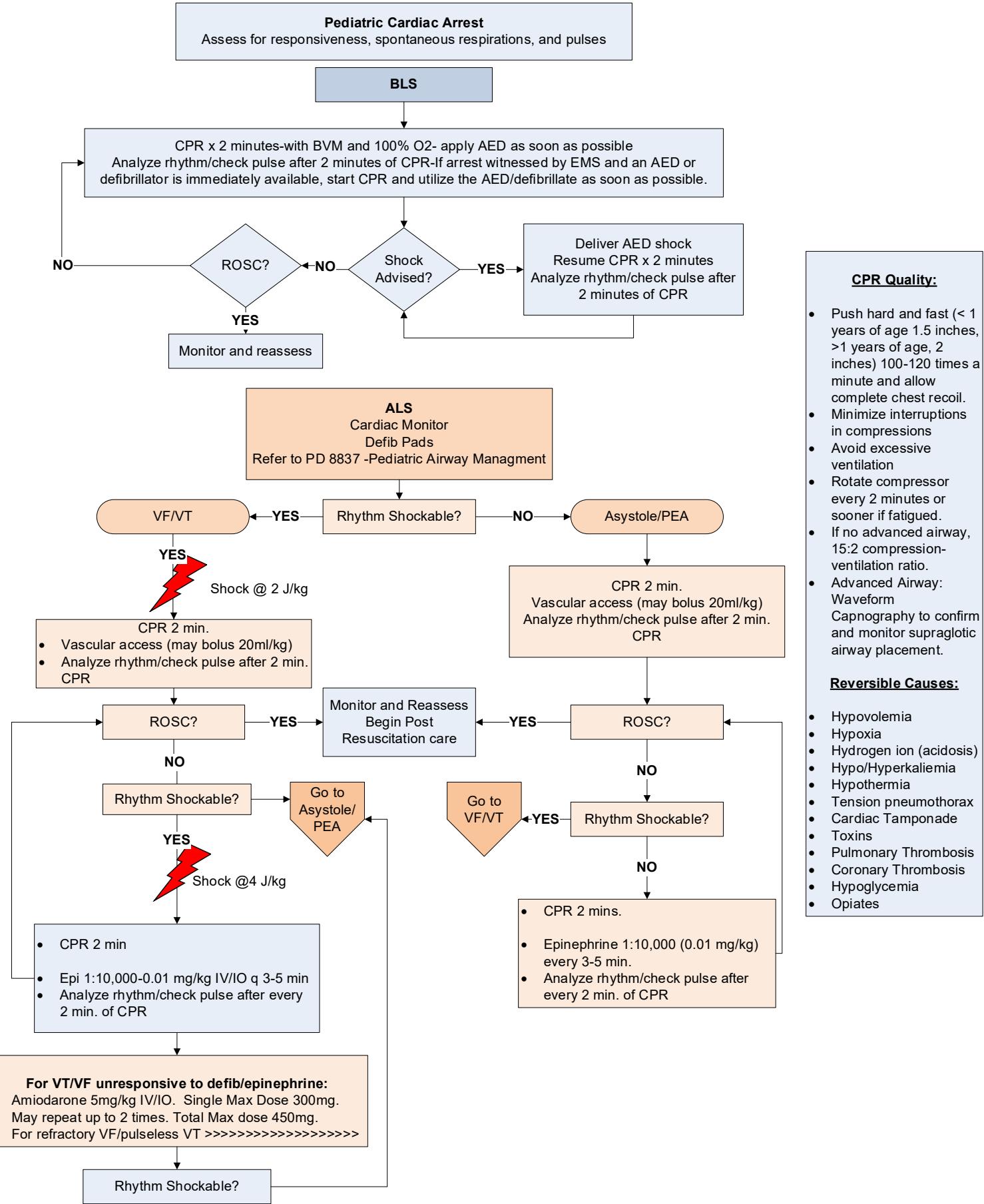
- A. California Health and Safety Code, Division 2.5
- B. California Code of Regulations, Title 22, Division 9

Protocol:

- A. High-quality Cardiopulmonary Resuscitation (CPR) is fundamental to the management of all cardiac arrest rhythms. Periodic pauses in CPR should be as brief as possible and only as necessary to assess rhythm, shock VF/VT, vascular access, drug delivery, and perform a pulse check when an organized rhythm is detected or an advanced airway is placed for patients as per SCEMSA Policy 8837 – Pediatric Airway Management.
- B. CPR must be performed with a “Chest Compression, Airway, Breathing” sequence (C-A-B) to emphasize the importance of maintaining blood flow with good compressions.
- C. Airway management per SCEMSA PD# 8837 – Pediatric Airway Management.
- D. Whenever feasible, transport the medical Durable Power of Attorney (DPOA) or immediate family member with the patient to the hospital. DPOA and immediate family members can provide medical insight and consent for special therapies or termination of resuscitation to hospital staff.
- E. The ability to maintain temperature in prehospital settings in pediatric patients is a significant problem with a dose-dependent increase in mortality for temperatures below 37°C or 98.6°F. Simple interventions to prevent hypothermia can reduce mortality. During transport, warm and maintain normal temperature, being careful to avoid hyperthermia.

NOTE: It is important to spend the 20 minutes doing effective CPR to attempt to get ROSC in the field.

If CPR and advanced life support is performed for 20 minutes with no ROSC, the patient will be transported to the ED and not pronounced on scene.



POST RESUSCITATION CONSIDERATIONS:

- A. IV fluids should be placed at TKO unless hypotension is present.
- B. Post-resuscitation Dysrhythmia See PD# 9014 – Cardiac Dysrhythmias.
- C. Hypotension/Shock:
 - Administer 20ml/kg fluid bolus. Repeat once. Reassess vital signs and lung sounds after each bolus.
 - To determine if shock is present, assess capillary refill (\leq 2 seconds) and brachial and femoral pulses (absent, weak, or present).
 - Systolic blood pressure parameters for pediatric patients older than one year can be approximated by the following formulas:
 - a. 90mm HG + (2 x age in years)
 - b. 70mm HG + (2x age in years) – Lower limit

C. Push Dose Epinephrine

1. 0.01 mg/ml (10 mcg/ml)-0.5-2ml (5-20 mcg) IV/IO every 2-5 minutes. Titrate to systolic blood pressure (SBP) for the patient's age, improvement of symptoms, or a total of 0.3 mg is given.

NOTE: Monitor SBP while administering/titrating.

Cross Reference: PD# 8837 – Pediatric Airway Management
 PD# 9013 – Pediatric Shock
 PD# 9014 – Pediatric Cardiac Dysrhythmias