

<b>PULSELESS CARDIAC ARREST (ATRAUMATIC)</b>	
<b>ADULT</b>	<b>PEDIATRIC (≤34 kg)</b>
<b>BLS</b>	
<ul style="list-style-type: none"> <li>• Universal Protocol #601</li> <li>• High Performance CPR (HPCPR) (10:1) per Procedure #712                             <ul style="list-style-type: none"> <li>○ Continuous compressions with 1 short breath every 10</li> </ul> </li> <li>• AED application (if shock advised, administer 30 compressions prior to shocking)</li> <li>• Pulse Oximetry                             <ul style="list-style-type: none"> <li>○ O<sub>2</sub> administration per Airway Management Protocol #602</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Same as Adult (except for neonate)</li> <li>• Neonate (&lt; 1 month) follow AHA guidelines</li> <li>• CPR compression to ventilation ratio                             <ul style="list-style-type: none"> <li>○ Newborn – CPR 3:1</li> <li>○ 1 day to 1 month – CPR 15:2</li> <li>○ &gt; 1 month – HPCPR 10:1</li> </ul> </li> <li>• AED – pediatric patient &gt; 1 year</li> <li>• Use Broselow tape or equivalent if available</li> </ul>
<b>ALS Standing Orders</b>	
<ul style="list-style-type: none"> <li>• <b>Rhythm analysis and shocks</b> – At 200 compressions begin charging the monitor – continue CPR while monitor is charging. Once fully charged, stop CPR for rhythm analysis:                             <ul style="list-style-type: none"> <li>○ V-fib/Pulseless V-tach – shock at 120J</li> <li>○ Subsequent shock at 150J then 200J</li> <li>○ Recurrent V-fib/Pulseless V-tach use last successful shock level</li> <li>○ No shock indicated – dump the charge</li> </ul> </li> <li>• <b>V-fib/Pulseless V-tach</b> – medications                             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:10,000</b> 1 mg IV/IO repeat every 3-5 min</li> <li>○ <b>Lidocaine</b> 1.5 mg/kg IV/IO repeat once in 3-5 min (max total dose 3 mg/kg)</li> </ul> </li> <li>• <b>Non-shockable rhythm</b> – medications                             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:10,000</b> 1 mg IV/IO repeat every 3-5 min</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Rhythm analysis and shocks</b> – At 200 compressions begin charging the monitor – continue CPR while monitor is charging. Once fully charged, stop CPR for rhythm analysis:                             <ul style="list-style-type: none"> <li>○ V-fib/Pulseless V-tach - shock at 2J/kg</li> <li>○ Subsequent shock at 4J/kg</li> <li>○ Recurrent V-fib/Pulseless V-tach use last successful shock level</li> <li>○ No shock indicated – dump the charge</li> </ul> </li> <li>• <b>V-fib/Pulseless V-tach</b> – medications                             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:10,000</b> 0.01 mg/kg (0.1 ml/kg) IV/IO, not to exceed 0.3mg, repeat every 3-5 min</li> <li>○ <b>Lidocaine</b> 1 mg/kg IV/IO repeat every 5 min (max total dose 3 mg/kg)</li> </ul> </li> <li>• <b>Non-shockable rhythm</b> – medications                             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:10,000</b> 0.01 mg/kg (0.1 ml/kg) IV/IO, not to exceed 0.3mg, repeat every 3-5 min</li> </ul> </li> </ul>
<b>Base Hospital Orders Only</b>	
<p style="text-align: center;"><b>ROSC with Persistent Hypotension</b></p> <ul style="list-style-type: none"> <li>• <b>Dopamine</b> 5-20 mcg/kg/min IV/IO infusion <b>OR</b></li> <li>• <b>Push-Dose Epinephrine 10 mcg/mL</b> 1 mL IV/IO every 1-3 min                             <ul style="list-style-type: none"> <li>○ repeat as needed to maintain SBP &gt;90mmHg</li> <li>○ <u>See notes for mixing instructions</u></li> </ul> </li> </ul> <p><b>Contact STEMI Receiving Center (French Hospital)</b></p> <ul style="list-style-type: none"> <li>• Refractory V-Fib or V-Tach not responsive to treatment</li> </ul>	<p>Contact closest Base Hospital for additional orders</p> <p style="text-align: center;"><b>ROSC with Persistent Hypotension for Age</b></p> <ul style="list-style-type: none"> <li>• <b>Dopamine</b> 5-20 mcg/kg/min IV/IO infusion <b>OR</b></li> <li>• <b>Push-Dose Epinephrine 10 mcg/mL</b> up to 1 mL IV/IO every 1-3 min                             <ul style="list-style-type: none"> <li>○ repeat as needed to maintain age appropriate SBP</li> <li>○ <u>See notes for mixing instructions</u></li> </ul> </li> </ul> <ul style="list-style-type: none"> <li>• As needed</li> </ul>

<ul style="list-style-type: none"> <li>• Request for a change in destination if patient rearrests en route</li> <li>• Termination orders when unresponsive to resuscitative measures</li> <li>• As needed</li> </ul> <p><b>Contact appropriate Base Station per Base Station Report Policy #121</b> - Atraumatic cardiac arrests due to non-cardiac origin (OD, drowning, etc.)</p>	
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**Notes**

- **Mixing Push-Dose Epinephrine 10 mcg/mL (1:100,000): Mix 9 mL of Normal Saline with 1 mL of Cardiac Epinephrine 1:10,000 (0.1 mg/mL), mix well**
- **Use manufacturer recommended energy settings if different from listed**
- **Assess for reversible causes**
  - Tension PTX, hypoxia, hypovolemia, hypothermia, hyperkalemia, hypoglycemia, overdose
- **Vascular access** – IV preferred over IO – continue vascular access attempts even if IO access established
- **Oral Intubation (Adults)** – Consider only if airway is not compliant or with maintained ROSC
- **Adult ROSC that is maintained:**
  - Obtain 12-lead ECG and vital signs
  - Transport to the nearest STEMI Receiving Center *regardless of 12-lead ECG reading*
  - Maintain O<sub>2</sub> Sat ≥ 94%
  - Monitor ETCO<sub>2</sub>
  - Consider oral intubation
  - With BP < 100 mmHg, contact SRC (French Hospital) for fluid, or Push-Dose Epinephrine orders
- **Termination for patients > 34 Kg - Contact SRC (French Hospital) for termination orders**
  - If the patient remains pulseless and apneic following 20 minutes of resuscitative measures
  - Persistent ETCO<sub>2</sub> values < 10mmHg, consider termination of resuscitation
  - Documentation shall include the patient’s failure to respond to treatment and of a non-viable cardiac rhythm (copy of rhythm strip)
- **Pediatric patients ≤ 34 kg**
  - Stay on scene to establish vascular access, provide for airway management, and administer the first dose of epinephrine followed by 2 min of HPCPR
  - Emphasize quality CPR rather than immediate transport
  - Evaluate and treat for respiratory causes
  - Use Broselow tape if available
  - Contact and transport to the nearest Base Hospital
  - Receiving Hospital shall provide medical direction/termination for pediatric patients