

Replaces BLS # 501 Medical Cardiac Arrest and ALS# 610 Adult Pulseless Arrest

PULSELESS CARDIAC ARREST (ATRAUMATIC)	
ADULT	PEDIATRIC (≤34 kg)
BLS	
<ul style="list-style-type: none"> • Universal Protocol #601 • High Performance CPR (HPCPR) (10:1) per Procedure #712 <ul style="list-style-type: none"> ○ Continuous compressions with 1 short breath every 10 • AED application (if shock advised, administer 30 compressions prior to shocking) 	<ul style="list-style-type: none"> • Same as Adult (except for neonate) • Neonate (< 1 month) follow AHA guidelines • CPR compression to ventilation ratio <ul style="list-style-type: none"> ○ Newborn – CPR 3:1 ○ 1 day to 1 month – CPR 15:2 ○ > 1 month – HPCPR 10:1 • AED – pediatric patient > 1 year • Use Broselow tape or equivalent if available
BLS Optional	
Pulse Oximetry – O ₂ administered per Airway Management Protocol #602	
ALS Standing Orders	
<ul style="list-style-type: none"> • Rhythm analysis and shocks – 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"> ○ V-fib/Pulseless V-tach – shock at 120J ○ Subsequent shock at 150J then 200J ○ Recurrent V-fib/Pulseless V-tach use last successful shock level ○ No shock indicated – dump the charge • V-fib/Pulseless V-tach – medications <ul style="list-style-type: none"> ○ Epinephrine 1:10,000 1 mg IV/IO repeat every 3-5 min ○ Lidocaine 1.5 mg/kg IV/IO repeat once in 3-5 min (max total dose 3 mg/kg) • Non-shockable rhythm – medications <ul style="list-style-type: none"> ○ Epinephrine 1:10,000 1 mg IV/IO repeat every 3-5 min 	<ul style="list-style-type: none"> • Rhythm analysis and shocks – 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"> ○ V-fib/Pulseless V-tach - shock at 2J/kg ○ Subsequent shock at 4J/kg ○ Recurrent V-fib/Pulseless V-tach use last successful shock level ○ No shock indicated – dump the charge • V-fib/Pulseless V-tach – medications <ul style="list-style-type: none"> ○ Epinephrine 1:10,000 0.01 mg/kg (0.1 ml/kg) IV/IO repeat every 3-5 min ○ Lidocaine 1 mg/kg IVP/IO repeat every 5 min (max total dose 3 mg/kg) • Non-shockable rhythm – medications <ul style="list-style-type: none"> ○ Epinephrine 1:10,000 0.01 mg/kg (0.1 ml/kg) IV/IO repeat every 3-5 min
Base Hospital Orders Only	
<p>Contact STEMI Receiving Center (French Hospital)</p> <ul style="list-style-type: none"> • Dopamine 5-20 mcg/kg/min with BP < 100 mmHg • Refractory V-Fib or V-Tach not responsive to treatment • Request for a change in destination if patient rearrests en route • Termination orders when unresponsive to resuscitative measures • As needed <p>Contact appropriate Base Station per Base Station Report Policy #121 - Atraumatic cardiac arrests due to non-cardiac origin (OD, drowning, etc.)</p>	<ul style="list-style-type: none"> • As needed – Contact closest Base Hospital for additional orders

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Notes	
<ul style="list-style-type: none"> • Use manufacturer recommended energy settings if different from listed • Assess for reversible causes <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ Obtain 12-lead ECG and vital signs ○ Transport to the nearest STEMI Receiving Center <i>regardless of 12-lead ECG reading</i> ○ Maintain O₂ Sat ≥ 94% ○ Monitor ETCO₂ ○ Consider oral intubation ○ With BP < 100 mmHg, contact SRC (French Hospital) for fluid or Dopamine orders • Termination for patients > 34 Kg - Contact SRC (French Hospital) for termination orders <ul style="list-style-type: none"> ○ If the patient remains pulseless and apneic following 20 minutes of resuscitative measures ○ Persistent ETCO₂ 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 <ul style="list-style-type: none"> ○ 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 	