

Cardiac Arrest

History

- Code status (DNR or POLST)
- Events leading to arrest
- Estimated downtime
- History of current illness
- Past medical history
- Medications
- Existence of terminal illness

Signs and Symptoms

- Unresponsive
- Apneic
- Pulseless

Differential

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

Decomposition
Rigor mortis
Dependent lividity

Injury incompatible with life
or traumatic arrest with
asystole

Do not begin resuscitation

Follow Policy 1004 –
Determination of Death

For suspected Excited
Delirium patients

Consider fluid bolus early and
contact Base Hospital for
Sodium Bicarbonate order

Criteria for death/no resuscitation
Review DNR/POLST form

Yes

No

Follow FP09 - Cardiac Arrest
Management

AT ANY TIME

Return of spontaneous
circulation



Go to Post Resuscitation TG

Begin continuous chest compressions
Push hard (> 2 inches) and fast (100-120/min)
Use metronome to ensure proper rate
Change compressors every 2 minutes
(Limit changes/pulse checks to < 5 seconds)

E

Apply mechanical compression device
if available

ALS available?

No

Yes

E Apply AED if available

Shockable rhythm?

No

Yes

E Continue CPR
5 cycles over 2 minutes
Repeat and assess

E Automated defibrillation
Continue CPR
5 cycles over 2 minutes
Repeat and assess

Follow Airway TG

Follow Airway TG

Notify receiving facility.
Contact Base Hospital for
medical direction, as needed.

P Cardiac monitor
EtCO₂ monitoring

Shockable rhythm?

No

Yes

Follow
Asystole/PEA
and Airway TG
as indicated

Follow VF/VT
and Airway TG
as indicated

Adult Cardiac Treatment Guidelines



Cardiac Arrest

Pearls

- Efforts should be directed at high quality and continuous chest compressions with limited interruptions. Consider early IO placement if available or direct IV access if anticipated.
- Passive ventilation for the first three cycles (6 minutes) of CPR. After that time, the patient should be ventilated using a BLS airway and BVM at a rate of 6 ventilation/minute (1:10 seconds) with continuous CPR.
- Placement of an advanced airway should be deferred unless a provider is unable to ventilate the patient with a BLS airway and BVM.
- Do not delay chest compressions while applying any device or intervention.
- Use a metronome during chest compression to ensure proper rate.
- In cases of clear-cut traumatic arrest, epinephrine is not indicated in PEA or asystole. Epinephrine will not correct arrest caused by a tension pneumothorax, cardiac tamponade, or hemorrhagic shock. If there is any doubt as to the cause of arrest, treat as a non-traumatic arrest.
- If a non-shockable rhythm persists for 30 minutes despite aggressive resuscitative efforts, consider cessation of efforts as outlined in the Determination of Death policy.
- The AutoPulse device is limited to 80 compressions/minute, which is acceptable when using this device during cardiac arrest.
- 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 and document ETT placement and EtCO₂ frequently, after every move, and at transfer of care.
- Maternal arrest: Treat mother per appropriate TG with immediate notification to the Base Hospital along with rapid transport. Place pillows or padding underneath mother to displace fetus from inferior vena cava as to ensure continued fetal blood circulation; left lateral position. IV/IO access should be preferably placed above the diaphragm. Defibrillation is safe at all energy levels.

