	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8031.20
	<u>PROGRAM DOCUMENT:</u> Cardiac Arrest	Draft Date:	08/12/93
		Effective:	11/01/16
		Revised:	03/14/16
		Review:	05/01/18

 EMS Medical Director

 EMS Administrator

Purpose:

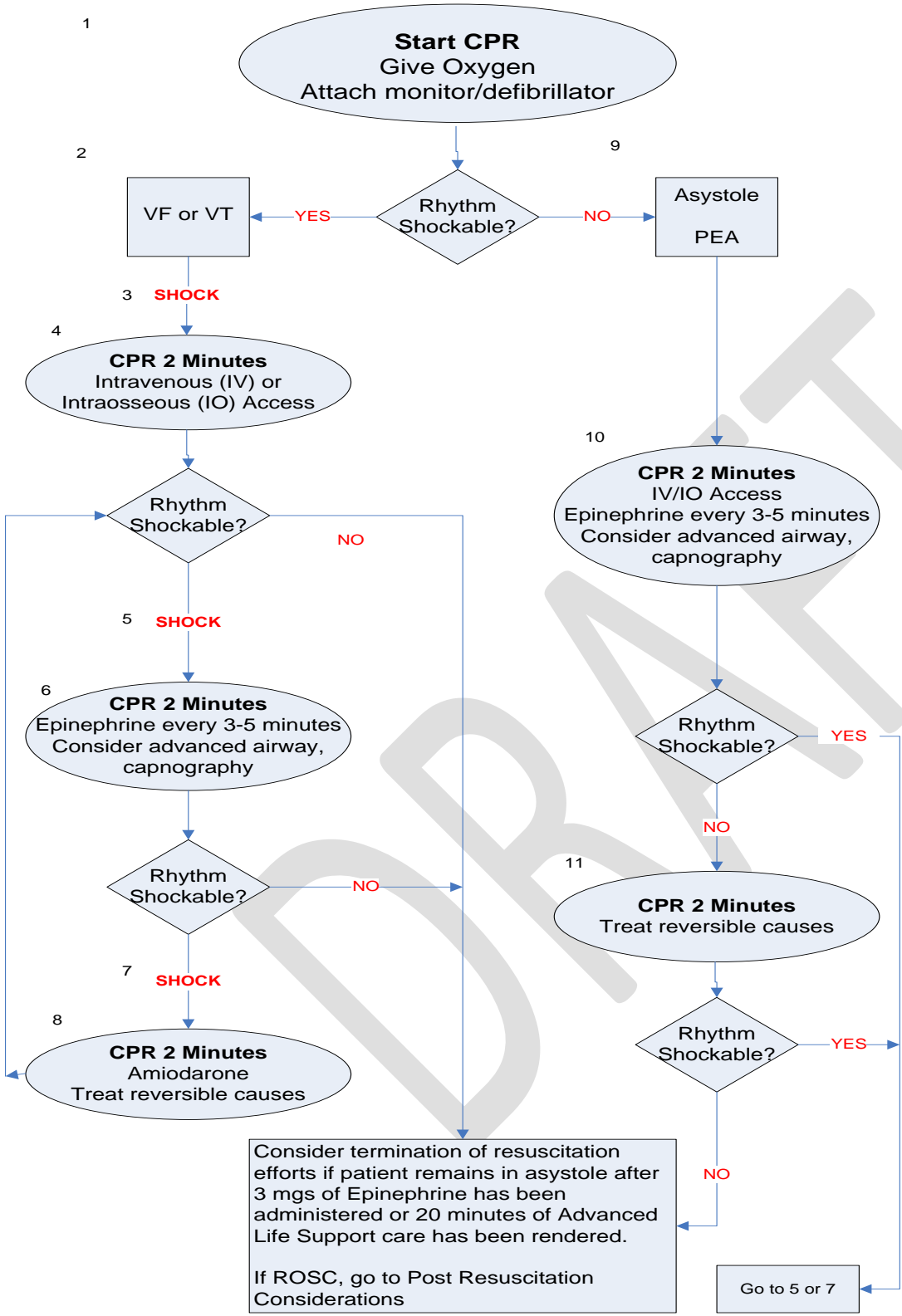
- A. To serve as the treatment standard for **Sacramento County** Emergency Medical Technicians (EMT) and Paramedics in treating cardiac arrest patients.
- B. To serve as the treatment standard for Asystole, Pulseless Electrical Activity (PEA), Ventricular Fibrillation (VF), and Pulseless Ventricular 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, perform a pulse check when an organized rhythm is detected, ~~or place an advanced airway.~~
- B. CPR must be performed with a “Chest Compressions, Airway, Breathing” sequence (C-A-B) to emphasize the importance of maintaining blood flow with good compressions.
- C. Performing CPR while a defibrillator is readied for use is strongly recommended for all patients in cardiac arrest.
- D. Oral Tracheal tube placement should be confirmed with ETCO2 detection device or waveform Capnography ~~when available.~~
- E. Vascular access, drug delivery, and advanced airway placement should not cause significant interruptions in chest compressions or delay defibrillation.



- CPR Quality**
- Push hard (≥ 2 inches [5 cm]) and fast (≥ 100 /min) and allow complete chest recoil
 - Minimize interruption in compressions
 - Avoid excessive ventilation
 - Rotate compressor every 2 minutes
 - If no advanced airway, 30:2 compression-ventilation ratio
 - Quantitative waveform capnography
 - If PETCO₂ <10 mmHg, attempt to improve CPR quality
- Return of Spontaneous Circulation (ROSC)**
- Pulse and blood pressure
 - Abrupt sustained increase in PETCO₂ (typically ≥ 40 mmHg)
- Shock Energy**
- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 Joules); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
 - **Monophasic:** 360 Joules.
- Drug Therapy**
- **Epinephrine IV/IO Dose:** 1 mg every 3-5 minutes
 - **Amiodarone IV/IO Dose:** First dose: 300 mgs bolus. Second dose: 150 mg
- Advanced Airway**
- Supraglottic advanced airway or endotracheal (ET) intubation
 - Waveform capnography to confirm and monitor ET tube placement
 - 8-10 breaths per minute with continuous chest compressions
- Reversible Causes**
- Hypovolemia
 - Hypoxia
 - Hydrogen ion (acidosis)
 - Hypo/Hyperkalemia
 - Hypothermia
 - Tension pneumothorax
 - Tamponade, cardiac
 - Toxins
 - Thrombosis, pulmonary
 - Thrombosis, coronary

Post Resuscitation Considerations:

- A. Intravenous (IV) or Intraosseous (IO) fluids should be placed at, to keep open (TKO) unless hypotension is present.
- B. Post-resuscitation bradycardia, hypotension, shock and pulmonary edema.
 - 1. Bradycardia, see Bradycardia protocol
 - 2. Pulmonary edema, see CHF/Pulmonary Edema protocol
 - 3. Hypotension/Shock
 - a. Normal Saline 1 liter, may repeat once. Reassess vital signs after each bolus
 - b. BASE HOSPITAL ORDER ONLY:
Dopamine at 10 mcg/Kg/min if SBP < 90 mmHg.

DRAFT