Contra Costa County Emergency Medical Services

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

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**AT ANY TIME**

Return of spontaneous circulation

Go to Post Resuscitation TG

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**Decomposition**
- Rigor mortis
- Dependent lividity

**Injury incompatible with life**
- or traumatic arrest with asystole

**Do not begin resuscitation**

Follow Policy 1004 – Determination of Death

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**For suspected Excited Delirium patients**

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

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**Criteria for death/no resuscitation**

Review DNR/POLST form

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**Follow FP09 – Cardiac Arrest Management**

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**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)

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**Apply mechanical compression device**

if available

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**ALS available?**

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**Apply AED if available**

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**Shockable rhythm?**

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**Continue CPR**

- 5 cycles over 2 minutes
- Repeat and assess

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**Follow Airway TG**

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**Notify receiving facility.**

Contact Base Hospital for medical direction, as needed.

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**Cardiac monitor**

- EtCO₂ monitoring

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**Shockable rhythm?**

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**Follow Asystole/PEA and Airway TG as indicated**

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**Follow VF/VT and Airway TG as indicated**

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**Effective Jan. 2016**

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**Effective Jan. 2020**

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**Contra Costa Cardiac Treatment Guidelines**

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**Treatment Guideline AC01**

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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.