## History
- Events leading to arrest
- Estimated downtime
- Prior resuscitation attempts
- Past medical history
- Medications
- Known terminal illness

## Signs and Symptoms
- Pulseless
- Apneic

## Differential
- Medical vs. trauma
- VF vs. pulseless VT
- Asystole
- PEA
- Primary cardiac event vs. respiratory arrest or drug overdose
- Consider reversible causes

---

### AT ANY TIME
Return of spontaneous circulation

Go to Post Resuscitation TG

### Reversible Causes
- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypothermia
- Hypo/Hyperkalemia
- Hypoglycemia
- Tension pneumothorax
- Tamponade (cardiac)
- Toxins
- Thrombosis (pulmonary)(PE)
- Thrombosis (coronary)(MI)

---

### Defibrillation 360J
- Resume high quality chest compressions
- Change compressors every 2 minutes
  (Limit changes/pulses checks < 5 seconds)

### Establish IV/IO

### Defibrillation 360J
- Resume high quality chest compressions
- Change compressors every 2 minutes
  (Limit changes/pulses checks < 5 seconds)

### Defibrillation 360J
- Epinephrine (1:10,000) 1mg IV/IO
- Resume high quality chest compressions
- Change compressors every 2 minutes
  (Limit changes/pulses checks < 5 seconds)

### Amiodarone 300mg IV/IO
- May repeat 150mg if rhythm persists

### Early transport to a SRC is indicated
for witnessed arrest with suspicion of pulmonary embolism or
V. Fib arrest resistant to four (4) shocks (refractory V-Fib)

### Criteria for discontinuation?
- Yes → Discontinue Resuscitation
  Follow Policy 1004 – Determination of Death
- Exit to Post Resuscitation TG

### No → Return of spontaneous circulation?
- Yes → Notify receiving facility.
  Contact Base Hospital for medical direction, as needed.
- Exit to Post Resuscitation TG
Pearls

- Efforts should be directed at high quality and continuous chest compressions with limited interruptions and early defibrillation when indicated. 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.
- Use a metronome during chest compression to ensure proper rate.
- 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.
- Contact Base Hospital prior to transport of non-ROSC patients.
- The AutoPulse device is limited to 80 compressions/minute, which is acceptable when using this device during cardiac arrest.
- Effective chest compressions and prompt defibrillation are the keys to successful resuscitation.
- Reassess and document ETT placement and EtCO₂ frequently, after every move, and at transfer of care.
- Do not stop chest compressions to check for placement of ETT or to give medications.