



CARDIAC ARREST; ADULT

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

Criteria for Death / No Resuscitation Review DNR / MOST Form

Decomposition
Rigor mortis
Dependent lividity
Blunt force trauma
Injury incompatible with life
Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Subjects Policy

Begin Continuous CPR Compressions
Push Hard (≥ 2 inches)
Push Fast (110 compressions / min)
Change Compressors every 2 minutes
(Limit changes / pulse checks ≤ 10 seconds)
Ventilate 1 breath every 6 seconds
Monitor EtCO2

At compression # 180 of each cycle:
Charge defibrillator at 200 joules
If SHOCKABLE rhythm present, deliver shock and immediately continue chest compressions
If NONSHOCKABLE rhythm present, utilize DISARM soft key

AED Procedure *if available*

ALS Available

Cardiac Monitor

Shockable Rhythm

AED Procedure

Shockable Rhythm

Asystole / PEA
Protocol AC 1
as indicated

Airway
Protocol(s) AR 1, 2, 3

VF / VT
Protocol AC 9
Tachycardia
Protocol(s) AC 6, 7
as indicated

Airway
Protocol(s) AR 1, 2, 3

Continue CPR
2 Minutes

Repeat and reassess

Airway
Protocol(s) AR 1, 2, 3

Arrest secondary to Opioid OD?

NALOXONE
Adult: 0.4 – 2 mg IN / IM
Pediatric: 0.1 mg/kg IN
(Maximum 4 mg)

NALOXONE
Adult: 0.4 – 2 mg
Pediatric: 0.1 mg/kg
IV / IO / IM / IN / ETT
(Maximum 4 mg)

Termination on Scene
Protocol AC 12
as indicated

Notify Destination or Contact Medical Control



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Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assign responders to predetermined tasks. Refer to optional protocol or development of local agency protocol.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE: Ventilate 1 breath every 6 seconds with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **Passive oxygenation optional in agencies practicing Team Focused Approach / Pit-Crew Approach.**
- **Reassess and document BIAD and / or endotracheal tube placement and EtCO₂ frequently, after every move, and at transfer of care.**
- **IV / IO access and drug delivery is secondary to high-quality chest compressions and early defibrillation.**
- **IV access is preferred route. Follow IV or IO Access Protocol UP 6.**
- **Defibrillation:**
 - Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
 - Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.
 - Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
- **End Tidal CO₂ (EtCO₂)**
 - If EtCO₂ is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
 - If EtCO₂ spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Special Considerations**
 - Maternal Arrest** - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. IV access is preferred route. Defibrillation is safe at all energy levels.
 - Renal Dialysis / Renal Failure** - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
 - Opioid Overdose** - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
 - Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike** – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Transcutaneous Pacing:**
 - Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival
 - Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
 - Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.