TEAM FOCUSED CPR
ADULT AND PEDIATRIC

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES →

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

Do not begin resuscitation

Follow Deceased Subjects Policy

NO ↓

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

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

P

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

First Arriving BLS / ALS Responder
Initiate Compressions Only CPR
Initiate Defibrillation Automated Procedure
if available
Call for additional resources

Second Arriving BLS / ALS Responder
Assume Compressions or
Initiate Defibrillation Automated / Manual Procedure
Place BIAD
DO NOT Interrupt Compressions
Ventilate at 6 to 8 breaths per minute

↓

BLS ← **Third Arriving Responder** → **ALS**
BLS or ALS

↓ BLS

Establish Team Leader
(Hierarchy)
Fire Department or Squad Officer
EMT
First Arriving Responder

Rotate with Compressor
To prevent Fatigue and effect high quality compressions
Take direction from Team Leader

Fourth / Subsequent Arriving Responders
Take direction from Team Leader

Continue Cardiac Arrest Protocol AC 3

↓ ALS

A

Establish Team Leader
(Hierarchy)
EMS ALS Personnel
Fire Department or Squad Officer
EMT
First Arriving Responder

Initiate Defibrillation Automated Procedure
Establish IV / IO Protocol UP 6
Administer Appropriate Medications
Establish Airway with BIAD if not in place

P

Initiate Defibrillation Manual Procedure
Continuous Cardiac Monitoring
Establish IV / IO Protocol UP 6
Administer Appropriate Medications
Establish Airway with BIAD if not in place

Continue Cardiac Arrest Protocol AC 3

Team Leader
ALS Personnel
Responsible for patient care
Responsible for briefing / counseling family

Incident Commander
Fire Department / First Responder Officer
Team Leader until ALS arrival
Manages Scene / Bystanders
Ensures high-quality compressions
Ensures frequent compressor change
Responsible for briefing family prior to ALS arrival

Adult Cardiac Protocol Section

TEAM FOCUSED CPR

ADULT AND PEDIATRIC

Scene conditions and safety hazards may indicate immediate patient movement to the ambulance or initiation of transport. Transport decision should be made based on location and the patient's clinical presentation.

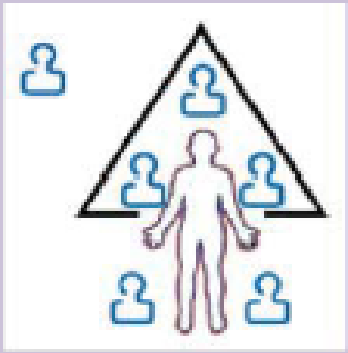
Quality CPR has been found to be much less effective in a moving ambulance. For the best chance of positive patient outcomes, CPR should be performed where the patient is found, continuously with minimal interruptions and as little movement of the patient as possible.

The "CPR Triangle" encompasses the patient's head and upper torso. This area should be limited to those responders that are performing chest compressions and airway management.

ALS personnel responsible for IV/IO access, medication administration, or monitor/defibrillator operation should position themselves near the patient's legs, outside of the "CPR Triangle".

Transport of any patient with CPR in progress will be routine traffic to the closest facility.

Resuscitation attempts in Adult Cardiac Arrest should continue up to 45 minutes on scene or until ROSC is achieved.



Resuscitation attempts in Pediatric Cardiac Arrest (all patients ≤ 18 y/o) should continue for 20 minutes on scene or until ROSC is achieved. All Pediatric Cardiac Arrest patients should be transported.

Pearls

- **This protocol is optional and given only as an example. Agencies may and are encouraged to develop their own.**
- **Team Focused Approach / Pit-Crew Approach recommended; assigning 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 are secondary to high-quality chest compressions and early defibrillation.**
- **Follow IV or IO Access Protocol UP 6.**
- **<u>Defibrillation:</u> 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.**
- **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.**