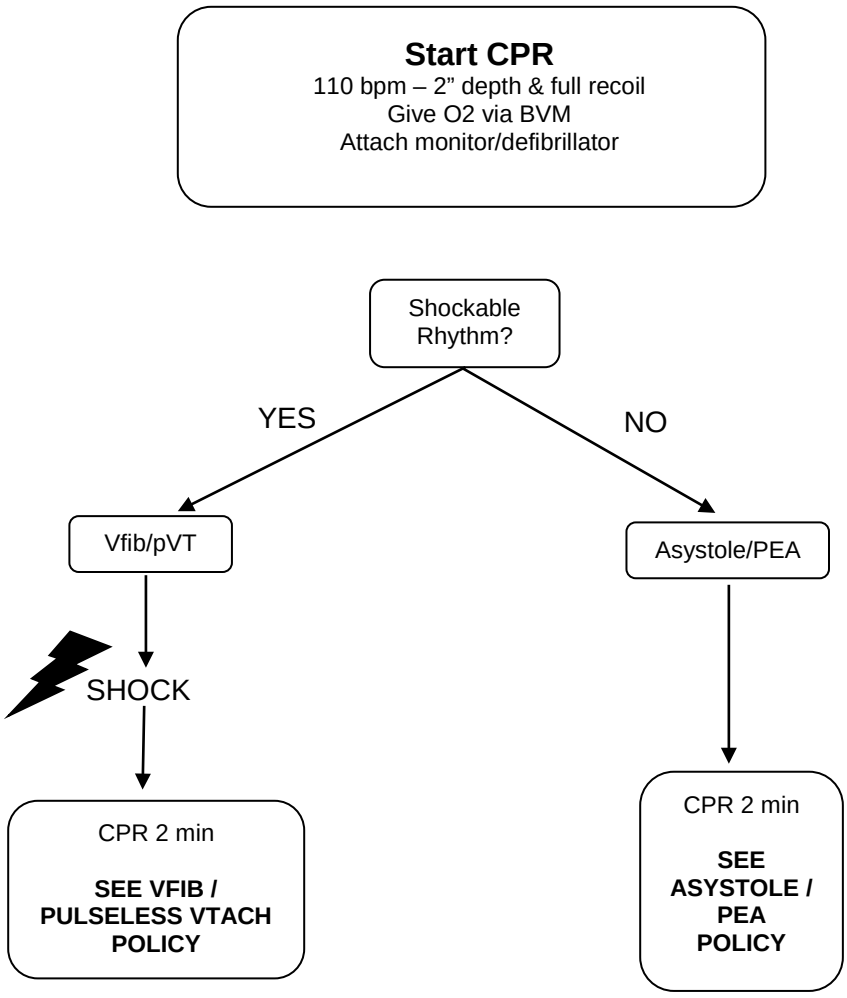
ADULT CARDIAC ARREST

ALWAYS USE STANDARD PRECAUTIONS

INDICATION

- Unresponsive; no breathing or has agonal respirations; no pulse



Critical Information:

- Witnessed vs Unwitnessed
- Consider pre-cordial thump if witnessed and defibrillator not immediately available
- Compress at 110 bpm. Use metronome or similar device
- Manual CPR is preferred; mechanical CPR is an acceptable alternative
- Change compressors every 2 minutes
- Minimize interruptions
- If hypothermic < 95F, delay compressions for 3 minutes; focus on ventilations and active rewarming
- Defibrillate per manufacturer's recommendations.
- Do not stop compressions while defibrillator is charging
- Resume compressions immediately after shock

BLS Airway Management

- *BLS airway is preferred during the first 5 min*
- Use two-person BLS airway management whenever possible
- Avoid excessive ventilation
- 30:2 compression/ventilation ratio

ALS Airway Management

- King Airway/Video laryngoscopy (VL) preferred
- Laryngoscopy for ETT must occur with CPR in progress. Do not interrupt CPR for >10 seconds for tube placement
- Use continuous ETCO2 to monitor CPR effectiveness and advanced airway placement.
- Maintain O2 sat 94-99%
- 1 breath every 6 seconds

Special Considerations

- Movement of patient during CPR may be detrimental to outcome
- Provide resuscitation on scene until ROSC or when patient meets Determination of Death criteria
- Regardless of the above, transportation is warranted in the following situations: refractory VF, unsafe scene conditions, unstable airway, hypothermia/hyperthermia as a primary cause of arrest, any patient pulled from a fire in cardiac arrest
- To assure ROSC continues, remain on scene for 5-10 minutes and then transport to a STEMI Receiving Center