Follow Initial Protocol for All Patients

**B6. Medical - Cardiac Arrest**

**Goals:**
- Minimize Interruptions in compressions
- Early Defibrillation
- Preservation of neurologic function

**Signs/Symptoms:**
- Apneic
- Pulseless
- Unresponsive

**Documentation Key Points:**
- Presumed Etiology
- Last seen normal time
- Bystander CPR/AED

---

**Follow Initial Protocol for All Patients**

1. G11. CPR
2. G22. EKG
3. G4. AED
4. Utilize G43. ResQCPR System
5. ETCO2 Monitoring

**Steps:**

- Asystole PEA
- Presenting Rhythm
- Defibrillation
- 2 Minutes
- E1. Airway Management/Crash Airway
- H16. Epinephrine 1 mg IV/IO
- Every 3-5 minutes

**Rhythm Shockable?:**
- Yes
  - Go to 5 or 7
  - G11. CPR 2 Minutes
- No
  - G11. CPR 2 Minutes
  - G21. Defibrillation

**Reversible Causes to consider:**
- Hypovolemia
- Hypoxia
- Hydrogen Ion (Acidosis)
- Hypo/Hyperkalemia
- Hypothermia
- Tension Pneumothorax
- Tamponade, Cardiac
- Toxins
- Thrombosis, Pulmonary
- Thrombosis, Cardiac

**Special Considerations**
- Consider G20. Double Sequential Defibrillation after three (3) or more defibrillation attempts.
- Presumed Non-Traumatic Cardiac arrests should be worked where patient is found for 10 minutes or ROSC is obtained.
- G5. Automated CPR device should be utilized, if feasible, for extrication and transport of patient.
- Defibrillation should be at defibrillator manufacturers recommended joules, or maximum allowable. (Typically 100-200 J)
- If traumatic, utilize F7. Traumatic Cardiac Arrest.

---

G20. Double Sequential Defibrillation
G5. Automated CPR Device
F7. Traumatic - Cardiac Arrest

Protocol: B6. Medical - Cardiac Arrest
Date of Most Recent Update: 6/2020
Original Adoption Date: 8/00
Past Protocol Updates: 5/05, 5/09, 9/10, 12/13, 4/16
Medical Director: Chad Torstenson, MD; Cory Vaudt, DO