



Resuscitation:
CARDIAC ARREST – ADULT (MEDICAL)
Practice Guideline

Patient Care Goals:
 1. Return of Spontaneous Circulation (ROSC)
 2. Preservation of neurologic function

Patient Presentation:
Inclusion Criteria:
 Adult (18 or older) without palpable pulses
Exclusion Criteria:
 Patients with valid DNR/POLST order
 Obvious death as defined as: decapitation, rigor mortis, dependent lividity, decomposition, full thickness burns >90% of body, hypothermia with rigid airway or ice formation in airway
 Obvious traumatic etiology (see Traumatic Cardiac Arrest practice guideline)

Defibrillation:
 Anterolateral pad placement, biphasic dose 200J
 Resume compressions immediately after shock

Refractory Vfibr/Vtach (defined as persistent rhythm not responding to 300 mg of amiodarone, and 3 defibrillation attempts from any device):
 Limit Epinephrine to 3 doses while refractory
 Apply second pad in the anterior/posterior orientation and for delivery of remaining shocks
Refractory VF/VT + Lucas CPR = LOAD & GO
 (NOTE: OLMC is OPTIONAL but not necessary)
 Refractory VF/VT without Lucas CPR = Potential transport based on OLMC and ROSC hosp. proximity

Medications:
 Epinephrine 1:10 THOUSAND 1 mg q3-5 min IV/IO
 Amiodarone IV/IO, 300mg bolus (first dose) then 150mg bolus (second dose) after 8-10 min

Advanced Airway:
 King airway placement or Endotracheal intubation
 Refer to Airway Management Practice Guideline

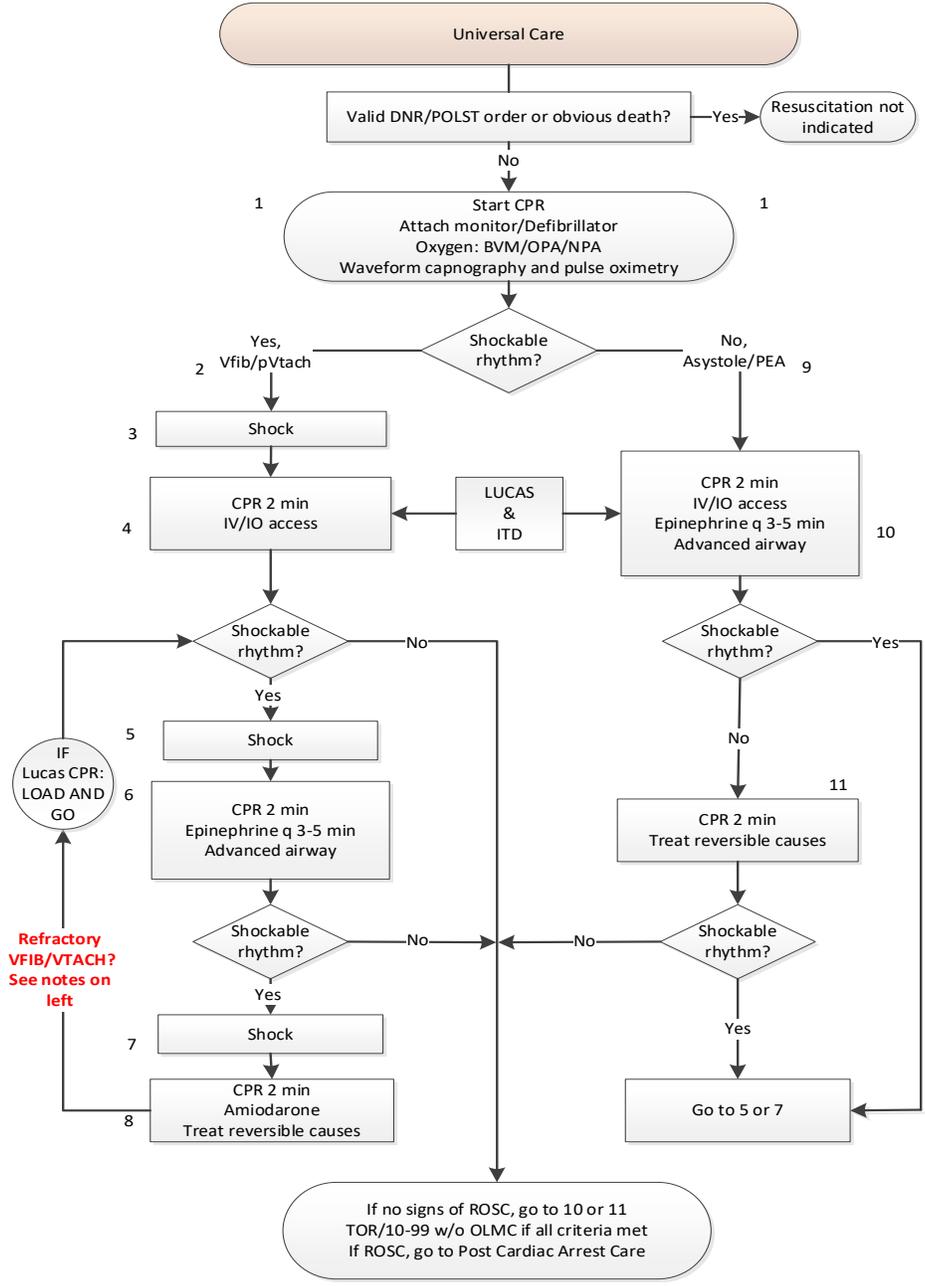
Quality Improvement:
 Push hard (> 2 inches) and fast (100-120/min)
 Minimize interruptions in compressions
 Rotate compressors every 2 minutes
 Avoid excessive ventilation (1 breath every 6 seconds)
 Capnography

Key Documentation elements:
 Times of resuscitation and all interventions
 Witnessed? Bystander CPR? Public AED?
 Initial rhythm shockable/first monitored rhythm?
 Capnography confirmation/values
 Any ROSC

TOR/10-99 criteria w/o OLMC
 Age 18 or older
 Cardiac arrest not witnessed by EMS Provider.
 Continuous asystole throughout resuscitation effort.
 Not believed related to environmental hypothermia.
 Patent airway.
 High quality CPR.
 15 minute resuscitation effort with deterioration of EtCO₂ to 10 mm Hg or less.
 Document termination of resuscitation by standing order of OLMC physician #0034.

Safety Considerations:
 Generally transport only after ROSC- however circumstances may arise when transport is indicated such as certain submersion, thoracic penetrating trauma arrest, or refractory vfibr/vtach cases; a mechanical CPR device is encouraged.

Notes:
 If fire victim has ROSC/hypotension/alt loc, evaluate for cyanide poisoning and consider administration of hydroxocobalamin (Cyanokit®).
 There is no evidence of naloxone improving the chance of ROSC due to opiate overdose. Focus on good CPR with standard ACLS rather than attempts with naloxone.



Call early OLMC immediately if unclear DNR/POLST or if patient pregnant >20 weeks.
 Contact OLMC after 3 rounds of Epi if patient does not meet all TOR criteria.