Pediatric Specific
CARDIAC ARREST – PEDIATRIC (MEDICAL)
Practice Guideline

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

Patient Presentation:
Inclusion Criteria:
Pediatric patient 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 (Traumatic Cardiac Arrest PG)

Defibrillation:
Anterolateral pad placement, 2 J/kg first shock; 4 J/kg subsequent shocks to max single shock dose of 200 J
Resume compressions immediately after shock
Refractory Vfib/Vtach, defined as persistent rhythm not responding to loading dose of amiodarone, and 3 defibrillation attempts from any device:
Limit Epinephrine to 3 doses while refractory

Medications:
Epinephrine 1:TEN THOUSAND 0.01 mg/kg (max of 1 mg per dose) q3-5 min IV/IO
Amiodarone IV/IO, 5 mg/kg bolus (max 300 mg); may repeat bolus (max 150 mg) after 8-10 min
NS bolus 20 mL/kg pressure bag over 5 mins; repeat X 1 if no ROSC
Magnesium (Torsades de pointes) IV/IO 50 mg/kg bolus
Calcium gluconate (hyperkalemia) IV/IO 60 mg/kg slow push

Advanced Airway:
SGA Airway placement
Refer to Airway Management Practice Guideline

Quality Improvement:
High quality CPR: Push hard (> 1/3 AP diameter of chest) and fast (100-120/min)
Minimize interruptions in compressions
Rotate compressors every 2 minutes
Avoid excessive ventilation
Capnography

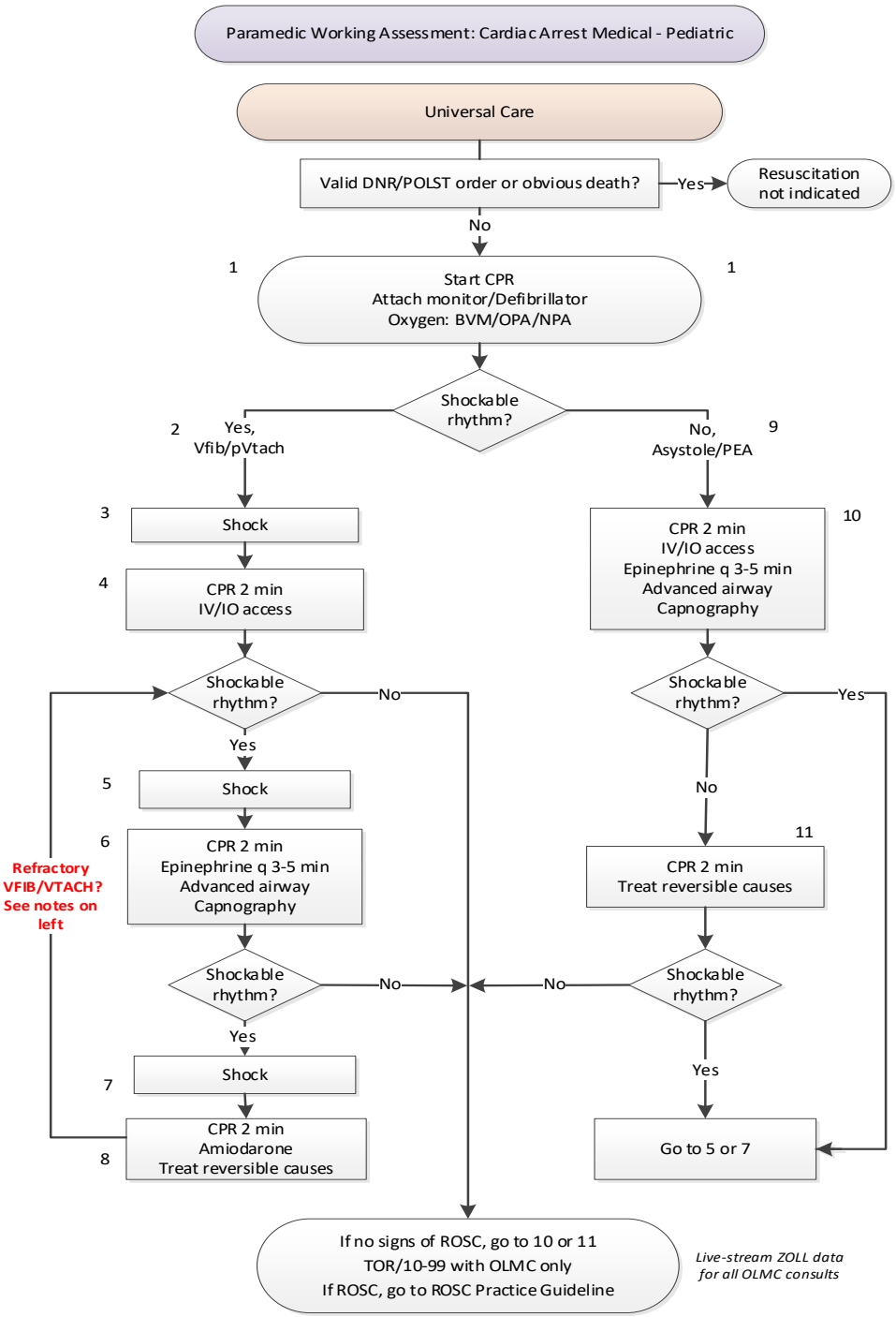
Key Documentation elements:
Times of resuscitation and all interventions, any ROSC
Witnessed? Bystander CPR? Public AED?
Initial rhythm shockable/first monitored rhythm?

TOR/10-99 criteria with OLMC consult

***Note**: contact OLMC early for values of zero that recur or persist after troubleshooting*

Safety Considerations:
Patients with *ongoing CPR* should be transported to closest RESUS destination. Transport of patients with ongoing resuscitation may arise in certain circumstances such as submersion, rVF/VT, pseudo PEA, OLMC recs.

Notes:
If fire victim has ROSC/hypotension/alt loc, evaluate for cyanide poisoning and consider administration of hydroxocobalamin (Cyanokit®)
There is no evidence naloxone improves chance of ROSC due to opiate OD; focus on good CPR w/standard ACLS rather than attempts w/naloxone
HANGING victims - treat as asphyxia medical arrest



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MEDICAL CARDIAC ARREST

MEDICAL ARREST SBAR

INTRO

Hello. This is MED ( )
with a (AGE) (SEX)
on scene of a MEDICAL cardiac arrest

Remember to LIVE STREAM ZOLL DATA

Situation

S	Arrest witnessed	by	EMS, Bystander, Unwitnessed
	Bystander CPR (and/or defib)	was	Performed, Not performed
	LKW Time	of	Military time, Unknown
	Initial Rhythm	was	VF, VT, PEA +rate, Asystole
	Current Rhythm	is	VF, VT, PEA +rate, Asystole
B	Airway	is	BVM only, King airway, ET tube
	Initial EtCO2	was	value
	Current EtCO2	is	value
	Access	is	IV, IO, Not obtained
	IV Fluid Volume	totals	x mLs
	Epinephrine	times	1, 2, 3, 4 …
	Amiodarone	times	1, 2
	Other medications administered	include	D10, Naloxone, other
	Defibrillation	times	1,2,3,4 …
	Glucose	reading	value
	CPR	type is	Mechanical, Manual
	Other interventions	include	LSIs

Significant details of the situation and PMHx

A	Past medical history	includes	MI, CABG, STENT, HTN, CHF, Diabetes, COPD, Asthma, current major illness
	Significant details of situation	include	?any missing *pertinent* details?
	Minutes working this code	is	x mins

Requests & Recommendations

R

- ❖ We are considering…
- ❖ We are looking for guidance on next steps
- ❖ We are requesting TOR

MEDICAL CARDIAC ARREST