### TREATMENT PROTOCOL: NON-TRAUMATIC CARDIAC ARREST (ADULT) *

1. Basic airway
2. If arrest not witnessed by EMS:
   - CPR for 2min at a compression rate of at least 100/min, minimize interruptions to chest compressions
3. Cardiac monitor: document rhythm and attach ECG strip
4. If asystole, confirm in more than one lead
5. If fine V-Fib is suspected, treat with V-Fib/Pulseless V-Tach

A 12-lead ECG shall be acquired on patients who complains of chest pain/discomfort of suspected cardiac etiology, non-traumatic post cardiac arrest patients with a return of spontaneous circulation (ROSC) and/or patients who the paramedics suspect are experiencing an acute cardiac event.

<table>
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<tr>
<th>ASYSTOLE / PEA</th>
<th>V-FIB / PULSELESS V-TACH</th>
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| 6. If confirmed PEA, consider causes ❶ | 6. Defibrillate ❷
   | Biphasic at 200J (typically) |
   | Monophasic at 360J |
| 7. Venous access, if unable: place IO (if available) | 7. CPR for 2min |
| 8. **Epinephrine** (0.1mg/mL) ❸ | 8. Venous access, if unable: place IO (if available) |
| 1mg IV or IO | |
| 9. Consider advanced airway ❹, capnography | 9. Check rhythm ❺, and if indicated: |
| 10. If narrow complex and heart rate greater than 60bpm: **Normal saline** fluid challenge | Defibrillate |
| 10ml/kg IV or IO at 250ml increments | Biphasic at 200J, monophasic at 360J |
| 11. CPR for 2min | 10. CPR for 2min |
| 12. **CONTINUE SFTP or BASE CONTACT** | |
| 13. **Epinephrine** (0.1mg/mL) | |
| 1mg IVP or IO | |
| May repeat every 3-5min | |
| 14. If down time greater than 20min: **Sodium bicarbonate** | |
| 1mEq/kg IV push | |
| May repeat 0.5mEq/kg every 10-15min | |
| 15. If resuscitative efforts are successful: Perform 12-lead ECG ❹ | |
| 16. If resuscitative efforts are unsuccessful and the patient does not meet ALL criteria for Termination of Resuscitation in Ref. No. 814, Section II.A., consult with the Base Physician ❺ | 14. **CONTINUE SFTP or BASE CONTACT** |
| | 15. **Amiodarone** |
| | 300mg IV or IO |
| 16. CPR for 2min | 17. Check rhythm, and if indicated: |
| | Defibrillate |
| | Biphasic at 200J, monophasic at 360J |
| 18. **Epinephrine** (0.1mg/mL) | |
| 1mg IVP or IO | |
| May repeat every 3-5min | |
| 19. CPR for 2min | 20. Check rhythm, and if indicated: |
| | Defibrillate |
| | Biphasic at 200J, monophasic at 360J |
| 21. **Amiodarone** | |
| 150mg IV or IO | |
| Maximum total dose 450mg | |
| 22. CPR for 2min | 23. Check rhythm, and if indicated: |
| | Defibrillate |
| | Biphasic at 200J, monophasic at 360J |
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25. If resuscitative efforts are successful:
   Perform 12-lead ECG

26. If resuscitative efforts are unsuccessful
   consult with the Base Physician

SPECIAL CONSIDERATIONS

1. Consider causes of PEA: acidosis; cardiac tamponade; drug overdose; hyperkalemia;
   hypothermia; hypovolemia; hypoxia; massive MI; pulmonary embolus; or tension pneumothorax
   Drugs to consider for specific suspected causes:

   If hypoglycemia is suspected:
   Dextrose 10% 250mL IV
   250ml IV or IO

   If narcotic overdose is suspected:
   NARCAN (naloxone)
   0.8-2mg IV or IO
   2mg IN or IM

   If dialysis patient:
   CALCIUM CHLORIDE - BASE CONTACT REQUIRED
   1gm IV or IO

   SODIUM BICARBONATE – BASE CONTACT REQUIRED
   1mEq/kg IV or IO

   If tricyclic overdose suspected:
   SODIUM BICARBONATE – BASE CONTACT REQUIRED
   1mEq/kg IV or IO

   If calcium channel blocker overdose suspected:
   CALCIUM CHLORIDE – BASE CONTACT REQUIRED
   1gm IV or IO

2. Attempt to limit interruptions in CPR to no more than 10sec with advanced airway. Should
   utilize end tidal CO₂ monitoring for advanced airway and monitoring ROSC.

3. Pulse check if a change in ECG rhythm, take no longer than 10sec to check for a pulse. If
   no pulse is detected within 10sec, resume chest compressions.

4. If hypothermia is suspected, administer only one dose of epinephrine and no other
   medications until the patient is re-warmed

5. Biphasic defibrillator settings may vary; refer to manufacturer’s guidelines. If unknown,
   use 200J for biphasic, 360J for monophasic

6. If hypothermia is suspected, defibrillate only once until the patient is re-warmed

7. If hypothermia is suspected, resuscitation efforts should not be abandoned until the
   patient is re-warmed, or the base hospital orders termination of resuscitative efforts

8. Post cardiac arrest patients with ROSC, with or without a 12 lead ECG analysis equivalent to “Acute MI”, shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service agreement rules and/or considerations.