




# Cardiac Arrest; Adult

**AT ANY TIME**

**Return of Spontaneous Circulation**



**Go to Post Resuscitation Protocol AC 10**

Criteria for Death / No Resuscitation Review DNR / MOST Form

YES

Decomposition  
Rigor mortis  
Dependent lividity  
Blunt force trauma  
Injury incompatible with life  
Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Subjects Policy

NO

**Begin Continuous CPR Compressions**  
*Push Hard (≥ 2 inches)*  
*Push Fast (100 - 120 / min)*  
*Change Compressors every 2 minutes (sooner if fatigued)*  
*(Limit changes / pulse checks ≤ 10 seconds)*

Ventilate 1 breath every 6 seconds  
30:2 Compression:Ventilation if no Advanced Airway  
*Monitor EtCO2 if available*

AED Procedure *if available*

ALS Available

**P** Cardiac Monitor

Shockable Rhythm

NO

YES

AED Procedure

Shockable Rhythm

NO

YES

Asystole / PEA  
Protocol AC 1  
*as indicated*

Airway  
Protocol(s) AR 1, 2, 3

VF / VT  
Protocol AC 9  
Tachycardia  
Protocol(s) AC 6, 7  
*as indicated*

Airway  
Protocol(s) AR 1, 2, 3

Continue CPR 2 Minutes

Repeat and reassess

Airway  
Protocol(s) AR 1, 2, 3

Arrest secondary to Opioid OD?

NO

YES

**A**



Naloxone 0.4 – 2 mg IN / IM  
Peds: 0.1 mg/kg IN

Maximum 4 mg

Naloxone 0.4 – 2 mg  
Peds: 0.1 mg/kg  
IV / IO / IM / IN / ETT

Maximum 4 mg

Termination on Scene  
Protocol AC 12  
*as indicated*

 **Notify Destination or Contact Medical Control** 



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## Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assign responders to predetermined tasks. Refer to optional protocol or development of local agency protocol.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE: If no advanced airway (BIAD, ETT) compression to ventilation ratio is 30:2. If advanced airway in place, ventilate 10 breaths per minute with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **Passive oxygenation optional in agencies practicing Team Focused Approach / Pit-Crew Approach.**
- **Reassess and document BIAD and / or endotracheal tube placement and EtCO2 frequently, after every move, and at transfer of care.**
- **IV / IO access and drug delivery is secondary to high-quality chest compressions and early defibrillation.**
- **IV access is preferred route. Follow IV or IO Access Protocol UP 6.**
- **Defibrillation:**
  - Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
  - Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.
  - Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
- **End Tidal CO2 (EtCO2)**
  - If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  - If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Special Considerations**
  - Maternal Arrest** - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  - Renal Dialysis / Renal Failure** - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  - Opioid Overdose** - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  - Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike** – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Transcutaneous Pacing:**
  - Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
- Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.