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PIT CREW TEAM-FOCUSED CPR **CARDIAC PROTOCOL #3-17**

HISTORY

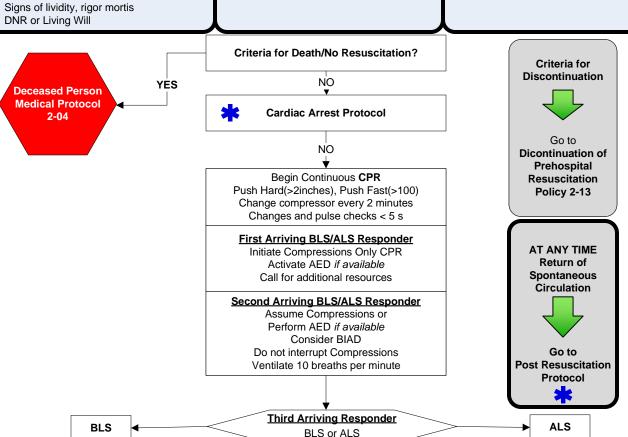
- Events leading to arrest
- Estimated downtime
- Past medical history
- Medications
- Existence of terminal illness

SIGNS AND SYMPTOMS

- Unresponsive
- Apneic
- **Pulseless**

DIFFERENTIAL

- Medical v. Trauma
- Vfib v. Pulseless Vtach
- Asystole
- Pulseless Electrical Activity (PEA)



Establish Team Leader/Commander

Rotate with Compressor Take direction from Team Leader

Fourth/Subsequent Arriving Responders Take direction from Team Leader

Establish Team Leader/Commander

Initiate Manual Defibrillation Procedure Establish IV/IO Continuous Cardiac Monitoring Administer appropriate Medications Establish Airway with BIAD in not in place Monitor EtCO2

Pit Crew Position Functions:

- #1: Cardiac Monitor Analysis, defibrillation
- #2: CPR Team Leader, quality CPR coordinator, airway is secondary
- #3: IV/IO Access, Medications, Fluids
- #4: Checklist, History, Family
- #5: Helper, rotational CPR

Consider use of Trinity EMS Pit Crew/Team-Focused CPR Checklist for documentation and direction of resuscitation



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LEFT VENTRICULAR ASSIST DEVICES **CARDIAC PROTOCOL #3-18**

HISTORY

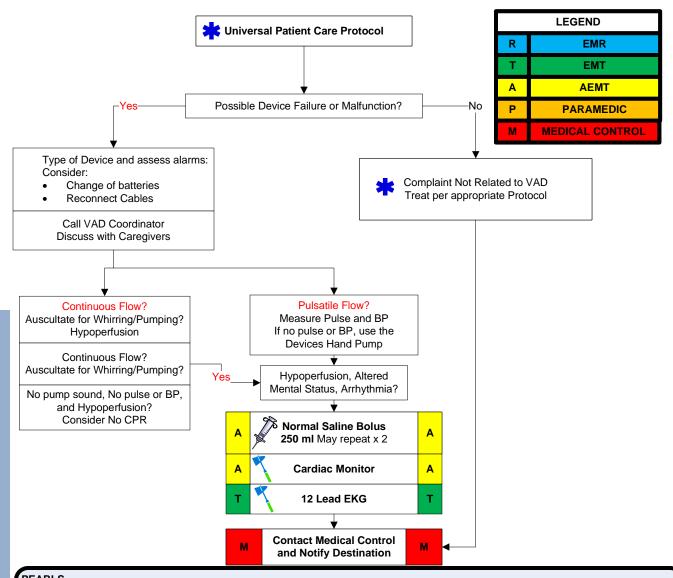
- End Stage Heart Failure
- Surgically-Implanted device that assists action of one or both ventricles
- Anticoagulated

SIGNS AND SYMPTOMS

- Non-pulsitile blood flow
- LVAD and non-LVAD related emergencies
- Altered Mental Status
- Bleeding

DIFFERENTIAL

- Stroke
- Cardiac Arrest
- Dysrhythmia
- Bleeding
- Dehydration
- Cardiac Tamponade
- Device faillure
- **Battery Depletion**



- Place defib pads away from ICD and VAD site. Discuss with caregivers/VAD coordinator
- Hypoperfusion will often be improved with a fluid bolus
- Ask if patient can have chest compressions, defibrillation? Do they have advanced directives? CPR may cause Death Transport with all device equipment, instructions, batteries, handpumps, controllers and knowledgeable caregivers



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ASYSTOLE CARDIAC PROTOCOL # 3 - 01

HISTORY

- ✓ Past medical history
- ✓ Medications
- ✓ Events leading to arrest
- ✓ End stage renal disease
- ✓ Estimated downtime
- ✓ Suspected hypothermia
- ✓ Suspected overdose
- DNR form

SIGNS AND SYMPTOMS

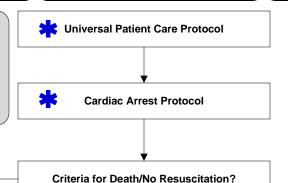
- ✓ Pulseless
- ✓ Apneic
- √ No electrical activity on EKG
- No auscultated heart tones

DIFFERENTIAL

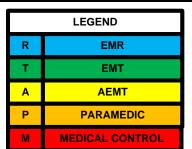
- ✓ Medical or trauma
- / Hypoxia
- ✓ Potassium (hypo/hyper)
- / Drug overdose
- ✓ Acidosis
- ✓ Hypothermia
- ✓ Device (lead) error
 - Death

Criteria for Withholding Resuscitation:

- ✓ Valid DNR order
- ✓ Rigor Mortis and/or Dependent Lividity
- ✓ Decapitation
- ✓ Incineration



NO





AT ANY TIME

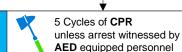
Return of Spontaneous

Circulation

Post Resuscitation

Protocol





When **Epin** 1:10,

When IV/IO available Epinephrine 1 mg IV/IO 1:10,000

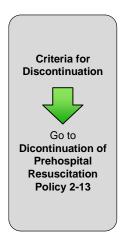
R

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Repeat every 3 – 5 minutes

Continue **Epinephrine** and **CPR** and address correctable causes

Contact Medical Control and Notify
Destination



PEARLS

- ✓ Always confirm asystole in more than one lead
- ✓ Successful resuscitation of asystole requires the identification and correction of a cause. Causes of asystole include:

Acidosis Tension Pneumothorax

Hypovolemia Hypoglycemia

Hyperkalemia Overdose (Narcotics, Tricyclic Anti-depressants, Calcium Channel Blockers, Beta Blockers)



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ATRIAL FIBRILLATION CARDIAC PROTOCOL # 3 - 02

HISTORY

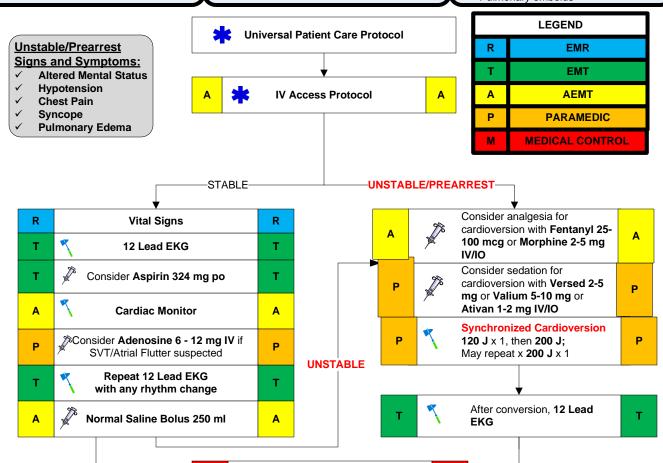
- ✓ Medications
 - (Aminophylline, Diet pills, Thyroid supplements, Decongestants, Digoxin)
- ✓ Diet (caffeine, chocolate)
- ✓ Drugs (nicotine, cocaine)
- ✓ Past medical history
- ✓ History of palpitations/heart racing

SIGNS AND SYMPTOMS

- ✓ HR >130/min
- ✓ QRS < .12 sec</p>
- ✓ Dizziness, Chest pain, Shortness of breath
- ✓ Potential presenting rhythm
 - Sinus tachycardia
 - Atrial fibrillation/flutter
 - Multifocal atrial tachycardia
 - PSVT

DIFFERENTIAL

- ✓ Heart disease (WPW, Valvular)
- ✓ Sick sinus syndrome
- Myocardial Infarction
- ✓ Electrolyte imbalance
- ✓ Exertion, Pain, Emotional stress
- ✓ Fever
- √ Hypoxia
- ✓ Hypovolemia or Anemia
- ✓ Drug effect/Overdose
- Hyperthyroidism
 - Pulmonary embolus



Contact Medical Control and Notify Destination

- ✓ Adenosine may not be effective in identifying atrial fibrillation, but it is not harmful
- ✓ Monitor for respiratory depression and hypotension associated with Versed
- ✓ Continuous pulse oximetry is required for all atrial fibrillation patients
- Occument all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention



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BRADYCARDIA CARDIAC PROTOCOL # 3 - 03

HISTORY

- ✓ Past medical history
- ✓ Medications

Beta blockers

Calcium channel blockers

Clonidine

Digoxin

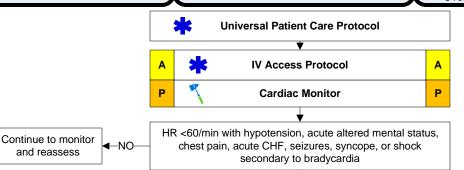
✓ Pacemaker

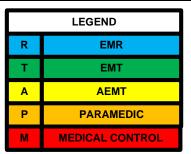
SIGNS AND SYMPTOMS

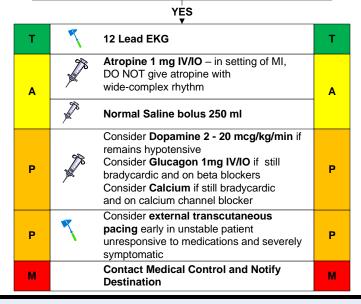
- HR <60/min with hypotension, acute altered mental status, chest pain, acute CHF, seizures, syncope, or shock secondary to bradycardia
- ✓ Chest pain
- ✓ Respiratory distress
- ✓ Hypotension or shock
- ✓ Altered mental status
- ✓ Syncope

DIFFERENTIAL

- ✓ Acute myocardial infarction
- Hypoxia
- ✓ Pacemaker failure
- √ Hypothermia
- ✓ Sinus bradycardia
- ✓ Athletes
- ✓ Head injury (increased ICP) or stroke
- ✓ Spinal cord lesion
- ✓ Sick sinus syndrome
 - AV blocks (1°, 2°, 3°)
 - Overdose







PFARIS

- ✓ The use of Lidocaine, Beta Blockers, and Calcium Channel Blockers in heart block can worsen bradycardia and lead to
 asystole and death
- ✓ Pharmacological treatment of bradycardia is based upon the presence or absence of symptoms. If symptomatic, treat. If asymptomatic, monitor the patient
- ✓ In wide complex, slow rhythm, consider hyperkalemia
- Remember: The use of Atropine for PVC's in the presence of myocardial infarction may worsen heart damage
- ✓ Consider treatable causes for bradycardia: Beta Blocker overdose, Calcium Channel Blocker overdose, etc.
- ✓ Be sure to aggressively oxygenate the patient and support respiratory effort



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CARDIAC ARREST CARDIAC PROTOCOL # 3 - 04

HISTORY

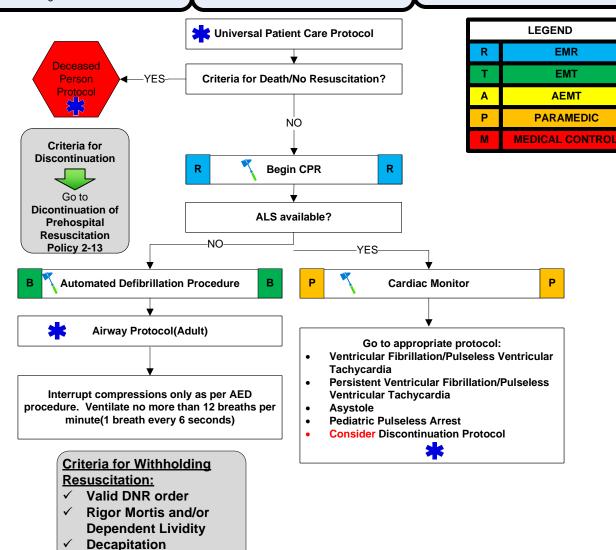
- Events leading to arrest
- ✓ Estimated downtime
- ✓ Past medical history
- ✓ Medications
- ✓ Existence of terminal illness
- ✓ Signs of lividity, rigor mortis
- ✓ DNR or Living Will

SIGNS AND SYMPTOMS

- ✓ Unresponsive
- ✓ Apneic
- ✓ Pulseless

DIFFERENTIAL

- ✓ Medical vs. Trauma
- ✓ Vfib vs. Pulseless Vtach
- ✓ Asystole
- ✓ Pulseless Electrical Activity(PEA)



PEARLS

- ✓ Success is based on proper planning and execution. Procedures require space and patient access. Make room to work
- ✓ Reassess airway frequently and with every patient move

Incineration

- ✓ Maternal arrest-Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport
- Adequate compressions with high quality CPR and timely defibrillation are the keys to success



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CHEST PAIN – CARDIAC AND STEMI CARDIAC PROTOCOL # 3 - 05

HISTORY

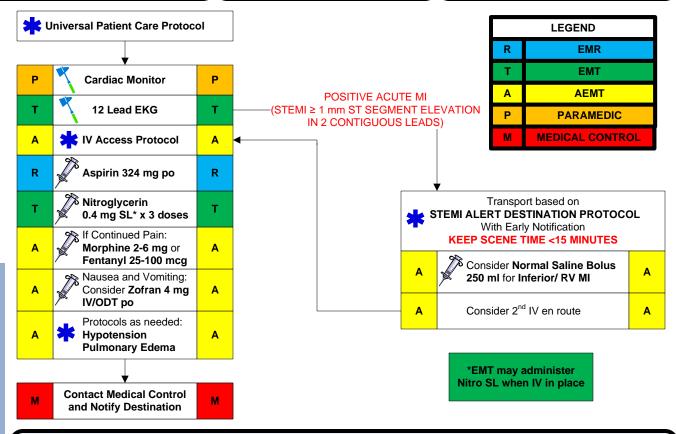
- ✓ Age ≥35 years
- ✓ Medications
- ✓ Viagra, Levitra, Cialis
- ✓ Past medical history (MI, Angina, Diabetes, post menopausal)
- ✓ Allergies (Aspirin, Morphine, Lidocaine)
- ✓ Recent physical exertion
- ✓ Palliation/Provocation
- ✓ Quality (crampy, sharp, dull, etc.)
- ✓ Region, Radiation, Referred
- ✓ Severity (1-10)
 - Time (onset/duration/repetition)

SIGNS AND SYMPTOMS

- Chest pain (pain, pressure, aching, vice-like tightness)
- ✓ Location (substernal, epigastric, arm, jaw, neck, shoulder)
- ✓ Radiation of pain
- ✓ Pale, diaphoresis
- ✓ Shortness of breath
- ✓ Nausea, vomiting, dizziness
- √ Time of onset

DIFFERENTIAL

- ✓ Trauma v. Medical
- ✓ Angina v. Myocardial Infarction
- ✓ Pericarditis
- ✓ Pulmonary embolism
- ✓ Asthma/COPD
- Pneumothorax
- Aortic dissection/Aneurysm
- ✓ GE reflux or Hiatal hernia
- ✓ Esophageal spasm
- Chest wall injury or pain
- ✓ Pleural pain
 - Overdose (cocaine) or methamphetamine



- ✓ It is Trinity policy to withhold Nitroglycerin from patients <30 years old without a history of heart disease and SBP<180</p>
- Avoid Nitroglycerin in any patient who has used erectile dysfunction medications in the past 36 hours due to potential for severe hypotension
- ✓ Patients with STEMI (ST- elevation Myocardial Infarction) should be taken to the appropriate destination based on EMS System STEMI Plan
- ✓ If patient has taken nitroglycerin without relief, consider potency of medication
- ✓ Monitor for hypotension after administration of Nitroglycerin and narcotics (Morphine, Fentanyl) AND administer only for SBP > 100
- ✓ Nitroglycerin and narcotics may be repeated per dosing guidelines in Formulary
- ✓ Diabetics and geriatric patients often have atypical pain, or only generalized complaints
- ✓ Document the time of the 12-Lead EKG in the PCR as a Procedure along with the interpretation



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HYPERTENSION CARDIAC PROTOCOL #3-06

HISTORY

- Documented hypertension
- Related diseases: diabetes, CVA, renal failure, cardiac
- Medications (compliance?)
- Erectile dysfunction medication
- Pregnancy

SIGNS AND SYMPTOMS

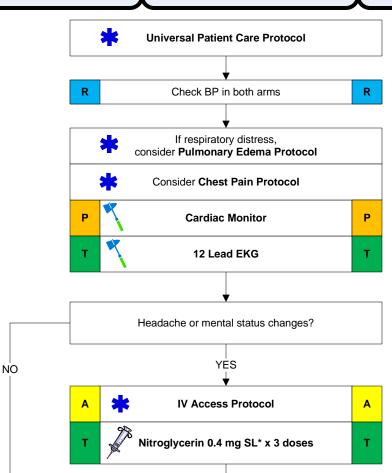
- Systolic BP ≥200

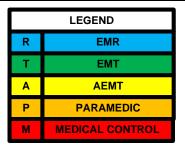
✓ Diastolic BP ≥110 AND AT LEAST **ONE** OF THESE

- Headache
- Nosebleed
- Blurred vision
- Dizziness

DIFFERENTIAL

- Hypertensive encephalopathy
- Primary CNS injury (Cushing's response = bradycardia with hypertension)
- Myocardial infarction
- Aortic dissection/Aneurysm
- Pre-eclampsia/Eclampsia





EMT may administer nitroglycerin SL if IV present* Consider ALS intercept early

- Avoid Nitroglycerin in any patient who has used Viagra or Levitra in the past 24 hours or Cialis in the past 36 hours due to potential severe hypotension
- Never treat elevated blood pressure based on one set of vital signs
- Nitroglycerin may be given to lower blood pressure in patients who have an elevated diastolic BP of ≥ 110 and are symptomatic with chest pain, respiratory distress, syncope, headache, or mental status changes
- Symptomatic hypertension is typically revealed through end organ damage to the cardiac, CNS, or renal systems

Contact Medical Control and Notify Destination

All symptomatic patients with hypertension should be transported with head elevated

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HYPOTENSION CARDIAC PROTOCOL # 3 - 07

HISTORY

- ✓ Blood loss vaginal or gastrointestinal bleeding, AAA, ectopic
- ✓ Fluid loss vomiting, diarrhea, fever
- ✓ Infection
- ✓ Cardiac ischemia (MI, CHF)
- ✓ Medications
- ✓ Allergic reaction
- ✓ Pregnancy
- History of poor oral intake

SIGNS AND SYMPTOMS

- ✓ Restlessness, confusion
- Weak, rapid, pulse
- ✓ Pale, cool, clammy skin
- ✓ Delayed capillary refill
- √ Hypotension
- ✓ Coffee-ground emesis
- ✓ Tarry stools

DIFFERENTIAL

Shock

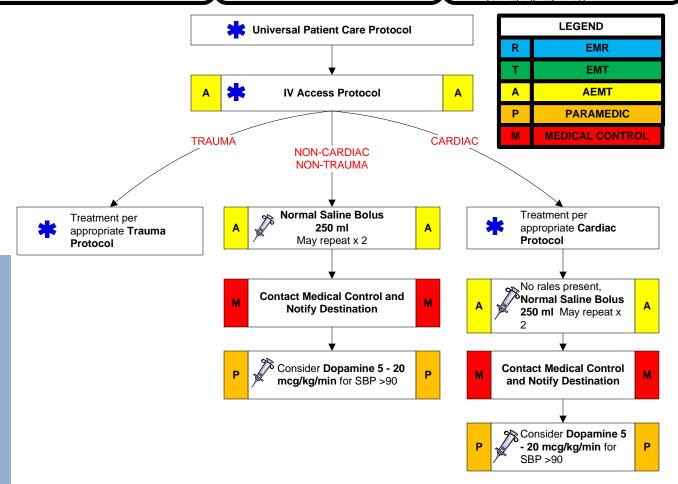
Hypovolemic Cardiogenic

Septic

Neurogenic

Anaphylactic

- Ectopic pregnancy
- ✓ Dysrhythmias
- ✓ Pulmonary embolus
- ✓ Tension pneumothorax
- ✓ Medication effect/overdose
- ✓ Vasovagal
 - Physiologic (pregnancy)



- √ Hypotension can be defined as a systolic blood pressure of less than 90
- ✓ Consider performing orthostatic vital signs on patients in non-trauma situations if suspected blood or fluid loss
- Consider all possible causes of shock and treat per appropriate protocol
- For non-cardiac, non-trauma hypotension, Dopamine should only be started after 2 liters of NS have been given



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THERAPEUTIC HYPOTHERMIA CARDIAC PROTOCOL # 3 - 08

HISTORY

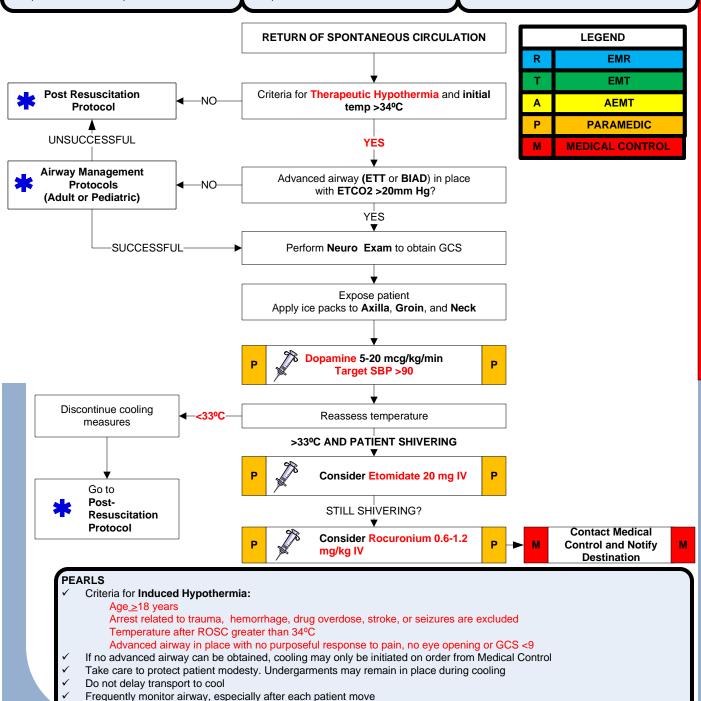
- Non-traumatic cardiac arrests
- Drownings, hangings, and asphyxiation are permissible for this protocol

SIGNS AND SYMPTOMS

- Cardiac arrest
 - Return of spontaneous circulation post cardiac-arrest

DIFFERENTIAL

 Continue to address specific differentials associated with the original dysrhythmia



Patients may develop metabolic alkalosis with cooling. Do not hyperventilate



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PULSELESS ELECTRICAL ACTIVITY CARDIAC PROTOCOL # 3 - 10

HISTORY

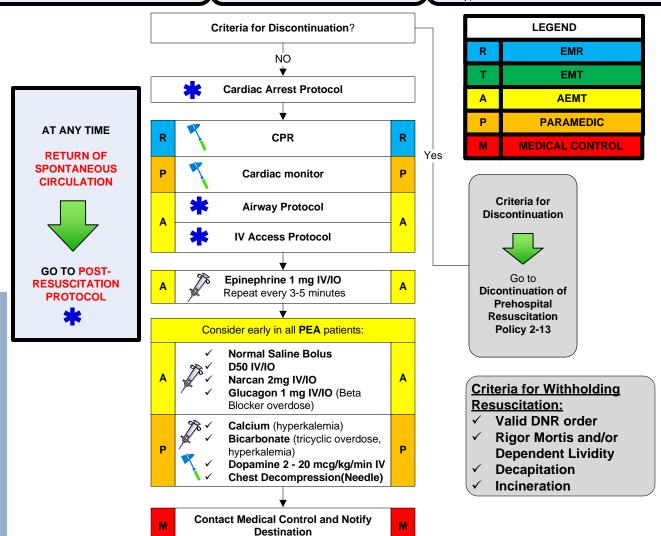
- ✓ Past medical history
- ✓ Medications
- ✓ Events leading to arrest
- ✓ End stage renal disease
- ✓ Estimated downtime
- ✓ Suspected hypothermia
- ✓ Suspected overdose
- ✓ DNR Form

SIGNS AND SYMPTOMS

- ✓ Pulseless
- ✓ Apneic
- ✓ Electrical activity on the EKG
- ✓ No heart tones on auscultation

DIFFERENTIAL

- ✓ Hypovolemia (Trauma, AAA, other)
- ✓ Cardiac tamponade
- ✓ Hypothermia
- ✓ Drug overdose
- ✓ Massive myocardial infarction
- / Hypoxia
- ✓ Tension pneumothorax
- / Pulmonary embolus
- ✓ Acidosis
 - Hyperkalemia



- ✓ Consider each possible cause listed in the differential. Survival is based on identifying and correcting the cause!
 - Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options: consider 5 H's and 5 T's



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SUSPECTED STROKE CARDIAC PROTOCOL # 3 - 11

HISTORY

- ✓ Known cardiovascular history
- ✓ Medications
- ✓ History of trauma
- ✓ Change in condition

SIGNS AND SYMPTOMS

- ✓ Decreased mental status or lethargy
- ✓ Change in baseline mental status
- ✓ Bizarre behavior
- ✓ Hemiparesis, hemiplegia
- √ Facial droop
- ✓ Slurred speech
- ✓ Confusion
 - Aphasia

DIFFERENTIAL

- √ Head trauma
- CNS (stroke, tumor, seizure, infection

LEGEND

EMR EMT

AEMT

PARAMEDIC

MEDICAL CONTROL

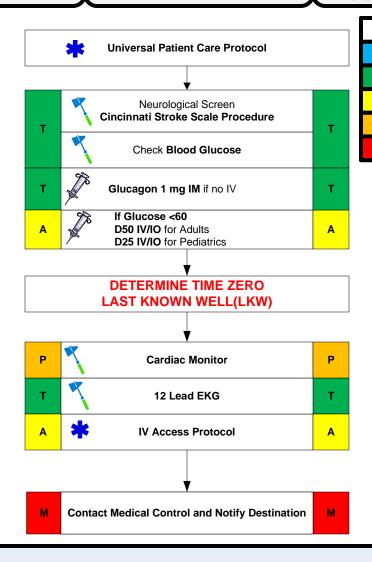
- ✓ Cardiac (MI, CHF)
- ✓ Diabetes (hypo/hyperglycemia)
- ✓ Toxicological or Ingestion
- ✓ Acidosis/Alkalosis
- ✓ Environmental Exposure
- ✓ Electrolyte Abnormality

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Mental Health disorder



- ✓ Recommended Exam: Mental Status, HEENT, Skin, Heart, Lungs, Neuro, Extremities
- √ It is vital to determine Time Zero, the time the patient was last known to be neurologically normal
- ✓ Bring a family member or witness to confirm Time Zero LKW
- Checking the glucose level is crucial

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SUPRAVENTRICULAR TACHYCARDIA CARDIAC PROTOCOL # 3 - 12

HISTORY

- Medications
 - aminophylline, diet pills, thyroid supplements, decongestants, digoxin
- ✓ Diet caffeine, chocolate
- Drugs nicotine, cocaine
- ✓ Past medical history
- ✓ History of palpitations/heart racing
- ✓ Syncope/near syncope

SIGNS AND SYMPTOMS

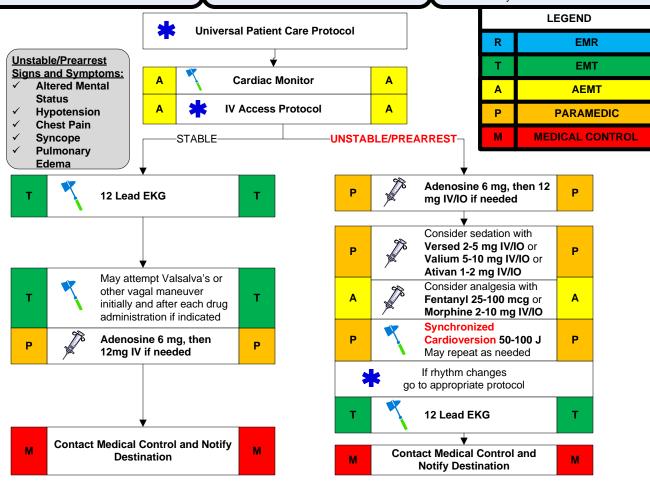
- ✓ HR >150/min
- QRS < .12 sec (if QRS > .12 sec, go to Wide-Complex Tachycardia protocol)
- If history of WPW, go to Wide-Complex Tachycardia protocol
- ✓ Dizziness, CP, SOB
- ✓ Potential presenting rhythm -

Atrial/Sinus tachycardia Atrial fibrillation/flutter

Multifocal atrial tachycardia

DIFFERENTIAL

- ✓ Heart disease (WPW, Valvular)
- ✓ Sick sinus syndrome
- ✓ Myocardial infarction
- ✓ Electrolyte imbalance
- Exertion, pain, emotional stress
- ✓ Fever
- √ Hypoxia
- ✓ Hypovolemia or Anemia
- ✓ Drug Effect/Overdose (see History)
- Hyperthyroidism
- Pulmonary Embolus



PFARI S

- ✓ If patient has history of or if 12 Lead EKG reveals Wolfe-Parkinson-White (WPW), DO NOT administer a calcium channel blocker (e.g., Diltiazem) or Beta Blockers
- ✓ Adenosine may not be effective in identifying atrial flutter/fibrillation, yet is not harmful
- ✓ Monitor for hypotension after administration of calcium channel blockers or beta blockers
- ✓ Monitor for respiratory depression and hypotension associated with Midazolam
- Continuous pulse oximetry is required for all SVT patients
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention



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SYNCOPE CARDIAC PROTOCOL # 3 - 13

HISTORY

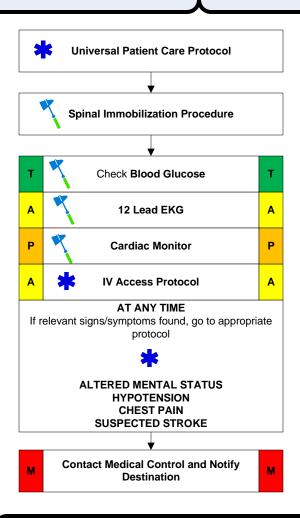
- Cardiac history, stroke, seizure
- ✓ Occult blood loss (GI, ectopic)
- √ Females: LMP, vaginal bleeding
- ✓ Fluid loss: nausea, vomiting, diarrhea
- ✓ Past medical history
- ✓ Medications

SIGNS AND SYMPTOMS

- ✓ Loss of consciousness with recovery
- Lightheadedness, dizziness
- ✓ Palpitations, slow or rapid pulse
- ✓ Pulse irregularity
- ✓ Decreased pulse pressure

DIFFERENTIAL

- ✓ Vasovagal
- Orthostatic hypotension
- ✓ Cardiac syncope
- ✓ Micturition/Defecation
- ✓ Syncope
- ✓ Psychiatric
- ✓ Stroke
- ✓ Hypoglycemia
- ✓ Seizure
- ✓ Shock
- √ Toxicological (Alcohol)
 - Medication effect (hypertension)



R EMR T EMT A AEMT P PARAMEDIC M MEDICAL CONTROL

- ✓ Assess for signs and symptoms of trauma if associated or questionable fall with syncope
- ✓ Consider dysrhythmias, GI bleed, ectopic pregnancy, and seizure as possible causes of syncope
- √ These patients should be transported
- ✓ More than 25% of geriatric syncope is cardiac dysrhythmia based



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VENTRICULAR FIBRILLATION/ **PULSELESS VENTRICULAR TACHYCARDIA CARDIAC PROTOCOL #3-14**

HISTORY

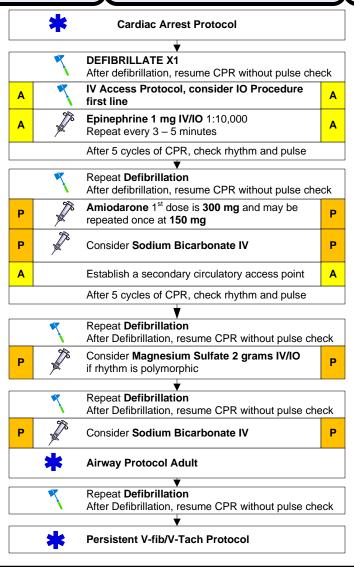
- Estimated down time
- Past medical history
- Medications
- Events leading to arrest
- Renal failure/dialysis
 - DNR or living will

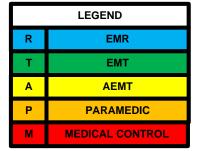
SIGNS AND SYMPTOMS

- Unresponsive, apneic, pulseless
- Ventricular fibrillation or ventricular tachycardia on EKG

DIFFERNTIAL

- Asystole
- Artifact/Device failure
- Cardiac
- Endocrine/Metabolic
- Drugs
- Pulmonary





AT ANY TIME **Rhythm Changes** Non-shockable Rhythm



GO TO APPROPRIATE **PROTOCOL**

AT ANY TIME Return of **Spontaneous** Circulation



GO TO **APPROPRIATE PROTOCOL**

- Reassess and document advanced airway placement and ETCO2 frequently, after every move, and at transfer of care Calcium chloride and sodium bicarbonate if hyperkalemia is suspected (renal failure, dialysis)
- Treatment priorities: uninterrupted compressions, defibrillation, then IV access and airway control
- Polymorphic ventricular tachycardia(Torsades de Pointes) may benefit from administration of Magnesium Sulfate
- Do not stop CPR to check for placement of ET tube or to give medications If arrest not witnessed by EMS, then 5 cycles of CPR prior to first defibrillation
- Effective CPR and prompt defibrillation are the keys to successful resuscitation
 - If BVM is ventilating the patient successfully, intubation should be deferred until rhythm change or 4 or 5 defibrillation sequences completed



CARDIAC PROTOCOL # 3

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V-FIB/PULSELESS V-TACH (PERSISTENT) CARDIAC PROTOCOL # 3 - 15

HISTORY

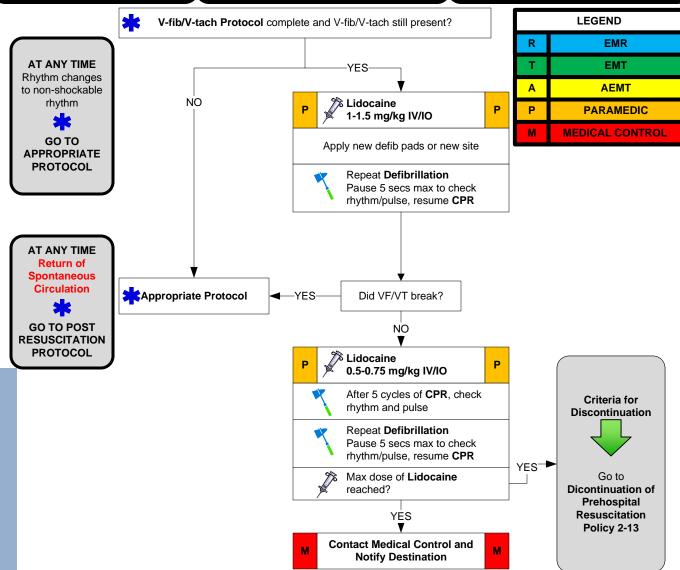
 Verified execution of resuscitation checklist

SIGNS AND SYMPTOMS

- Unresponsive, pulseless
- Persisted in ventricular fibrillation/tachycardia or returned to this rhythm post ROSC/other rhythm changes

DIFFERENTIAL

- ✓ Artifact/Device failure
- Cardiac
- ✓ Endocrine/Metabolic/Drugs
 - Pulmonary



- Recurrent ventricular fibrillation/tachycardia is successfully broken by standard defibrillation techniques, but subsequently returns. It is managed by ongoing treatment of correctable causes and use of anti-arrhythmic medication therapies
- ✓ Refractory ventricular fibrillation/tachycardia is an arrhythmia not responsive to standard external defibrillation techniques. It is initially managed by treating correctable causes and antiarrhythmic medications.
- ✓ Prolonged cardiac arrests may lead to tired providers and decreased compression quality. Ensure compression rotation, summon additional resources as needed, and ensure provider rest and rehab during and post-event
 ✓ If available, automated CPR devices are encouraged for prolonged cardiac arrests



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WIDE-COMPLEX TACHYCARDIA CARDIAC PROTOCOL # 3 - 16

HISTORY

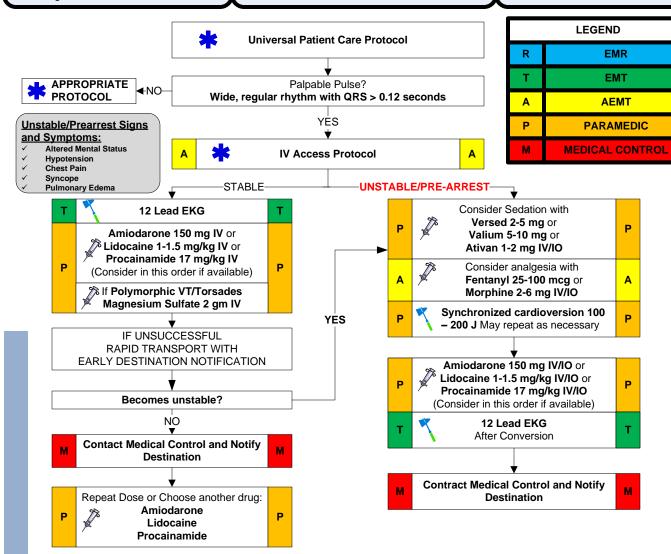
- Past medical history/medications, diet, drugs
- √ Syncope/near syncope
- ✓ CHF
- ✓ Palpitations
- ✓ Pacemaker
- ✓ Allergies: Lidocaine/Novocain

SIGNS AND SYMPTOMS

- Ventricular tachycardia on EKG (runs or sustained)
- ✓ Conscious with rapid pulse
- ✓ Chest pain, shortness of breath
- ✓ Dizzines:
- √ Rate usually 150 180 bpm for sustained v-tach
 - QRS > .12 sec

DIFFERENTIAL

- ✓ Artifact/device failure
- Cardiac
- ✓ Endocrine/Metabolic
- ✓ Drugs
- ✓ Pulmonary



- ✓ For witnessed/monitored ventricular tachycardia, try having the patient cough
- Polymorphic V-tach(Torsades de Pointes) may benefit from the administration of Magnesium Sulfate if available
- √ If presumed hyperkalemia (end stage renal disease, dialysis, etc.) administer sodium bicarbonate
 - Procainamide is no longer second line agent and should not be given if there is history of CHF



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POST-RESUSCITATION CARDIAC PROTOCOL # 3 - 09

HISTORY

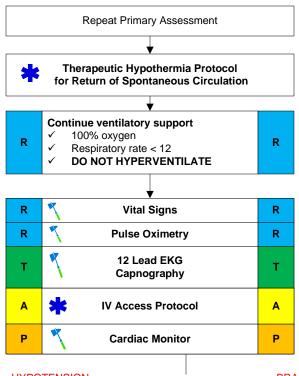
- Respiratory Arrest
- ✓ Cardiac Arrest

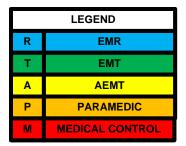
SIGNS/SYMPTOMS

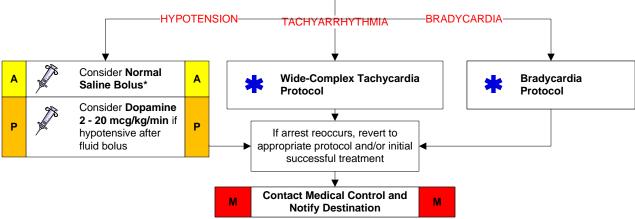
Return of Spontaneous Circulation(ROSC)

DIFFERENTIAL

Continue to address specific differentials associated with the original dysrhythmia







- ✓ Hyperventilation is a significant cause of hypotension and recurrence of cardiac arrest in the post resuscitation phase and must be avoided at all costs
- Most patients immediately post resuscitation will require ventilatory assistance
- √ The condition of post-resuscitation patients fluctuates rapidly and continuously; they require close monitoring
- √ Appropriate post-resuscitation management may best be planned in consultation with medical control
- ✓ Common causes of post-resuscitation hypotension include hyperventilation, hypovolemia, pneumothorax, and medication reaction to ACLS drugs
- Titrate Dopamine to maintain SBP>90. Ensure adequate fluid resuscitation is ongoing