BRADYCARDIA

BASE GUIDELINES

1. Determine ALS Standing Order treatments/procedures rendered prior to base hospital contact. Use ALS standing order as guidelines for treatments/procedures not initiated prior to base hospital contact.

2. Pediatric bradycardia is often associated with hypoxia. Oxygenation and ventilation are the primary field management for the emergency.

3. Consider the following as possible causes for pediatric bradycardia other than respiratory distress or hypoxia:

   A. Poisoning (including beta-blockers, clonidine, opioids)
   B. Carbon monoxide toxicity
   C. Occult head injury
   D. Hypothermia
   E. Electrolyte imbalance
   F. Hypoglycemia
   G. Congenital heart disease
   F. Sepsis/infection
   G. Envenomation

   Generally, in the field oxygenation, ventilation and rapid transport to a pediatric capable ERC are the primary focus.

2. Base Hospital may order repeat doses of epinephrine if response to first dose given by standing order is not effective:
   ► *Epinephrine 0.01 mg.kg IV/IO (0.1 mg/mL), may repeat once after 3 minutes.*
   Before ordering multiple doses of epinephrine it is imperative that the child not be hypovolemic. Assessment of intravascular volume (skin turgor, history) is important to decrease risk for complications from epinephrine administration.

3. Consider atropine if poor or no response to epinephrine:
   ► *Atropine 0.02 mg/kg IV/IO, may repeat every three minutes two times* if positive effect with first dose.

ALS STANDING ORDER

1. Monitor cardiac rhythm and document with rhythm strip.

2. Assure airway is open and without foreign body obstruction.

   ► *High flow oxygen by mask or nasal cannula as tolerated, assist ventilation with BVM as necessary.*

3. If pulse rate less than 60/minute and unresponsive to environment with signs of poor perfusion, initiate CPR and assure adequate ventilation.

4. If remains symptomatic (as described in # 3) or deteriorating:

   ► *Establish IV access*

   ► If signs of hypovolemia or dehydration suspected, *administer normal saline bolus 20 mL/kg* and make Base Hospital contact.

   ► If no evidence of hypovolemia, administer *Epinephrine: 0.01 mg/kg IV/IO (0.1 mg/mL)* and make Base Hospital contact.

5. If continued signs or poor perfusion, initiate transcutaneous pacing using appropriate sized pads with preferred anterior-posterior placement unless child is adult size (*refer to Procedure # PR-110*).

6. Make Base Hospital contact for destination and transport with ALS escort.

Approved:

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