CARDIOPULMONARY ARREST – PEDIATRIC

ALS STANDING ORDERS: ✖✖✖ BASE HOSPITAL CONTACT REQUIRED ✖✖✖

Make base hospital contact (CCERC pediatric base preferred) as soon as possible

Ventricular fibrillation (VF)
OR
Pulseless Ventricular tachycardia (VT)

1. Initiate or continue CPR and when defibrillator available:
   - ► *Defibrillate once at 2 J/kg biphasic setting (or pre-programmed/manufacturer's recommended defibrillator setting)*

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2. If at any time develops rhythm with pulse:
   - Ventilate and oxygenate
   - Assess for and correct hypoxia or hypovolemia
   - Contact Base Hospital (CCERC base preferred) for destination and transport with ALS escort.
   - If unable to make base hospital contact, transport to nearest ERC.

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3. If remains pulseless:
   - → Maintain CPR approximately 2 minutes
     - ► *High-flow oxygen by BVM*
   - → IV/IO vascular access without interruption of CPR

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4. Continually monitor cardiac rhythm:
   - → If persistent VF/pulseless VT
     - ► *Defibrillate once at 4 J/kg biphasic setting (or pre-programmed/manufacturer's recommended defibrillator setting)*
   - → If PEA or asystole: refer to PEA/Asystole section.

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5. For continued VF/ pulseless VT or if reverts back to VF/pulseless VT:
   - → Maintain CPR
   - ►Administer *Epinephrine 0.01 mg/Kg IV/IO (0.1 mg/ml preparation)*, repeat approximately every 3 minutes for continued VF/pulseless VT

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6. For continued VF/pulseless VT:
   - → Maintain CPR
     - ► *Defibrillate once at 4 J/kg biphasic setting (or pre-programmed/manufacturer's recommended defibrillator setting)*

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7. For continued VF/ pulseless VT:
   - → Maintain CPR
     - ► Administer A*miodarone 5 mg/kg IV/IO, may repeat 5 mg/kg IV/IO in 5 and 10 minutes. Maximum dose 450 mg; or*
     - ► *Lidocaine 1 mg/kg IV/IO. Maximum dose 100 mg, one time only.*

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8. After approximately 2 minutes of CPR, if there is continued VF/pulseless VT:
   - ► *Defibrillate once at 4 J/kg biphasic setting (or pre-programmed/manufacturer's recommended defibrillator setting)*

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9. For continued VF/ pulseless VT:
   - → Maintain CPR and request Base Hospital (CCERC base preferred) provide:
     - Further resuscitation orders and destination decision.

Approved: Carl Schultz, M.D.

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CARDIOPULMONARY ARREST – PEDIATRIC

Pulseless Electrical Activity (PEA)
OR
Asystole

1. Initiate or maintain CPR without interruption unless pulse obtained by any step below
   ► *High-flow oxygen by BVM*

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2. Continually monitor cardiac rhythm:
   → Maintain CPR for 2 minutes

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3. *IV/IO vascular access*

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4. ► Administer *Epinephrine 0.01 mg/kg IV/IO (0.1 mg/mL preparation)* approximately every 3-5 minutes

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5. For persistent PEA/Asystole, continue CPR for 2 minutes
   → Consider capnography

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6. Correct possible reversible causes:

hypovolemia	hypo/hyperkalemia	tamponade, cardiac
hypoxia	hypothermia	thrombosis, pulmonary
hydrogen ion (acidosis)	tension pneumothorax	thrombosis, coronary
hypoglycemia	toxins	

   If diabetic and hypoglycemia suspected, administer:
   ►*Dextrose 10% 5 mL/kg IV/IO (maximum dose 250 mL)*

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7. If VF/ pulseless VT develops:
   ► *Defibrillate once at 4 J/kg biphasic* setting (or pre-programmed/manufacturer's recommended defibrillator setting) and follow VF/pulseless VT algorithm

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8. If at any time develops rhythm with pulse:
   ► *Continue with* ventilation and oxygenation
   ► Contact Base Hospital (CCERC base preferred) for destination and transport with ALS escort.
   ► If unable to make base hospital contact, transport to nearest ERC.

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9. For continued PEA/asystole:
   → Maintain CPR and request Base Hospital (CCERC base preferred) provide:
   - Further resuscitation orders and destination decision