

8.07 PEDIATRIC CARDIAC ARREST:

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

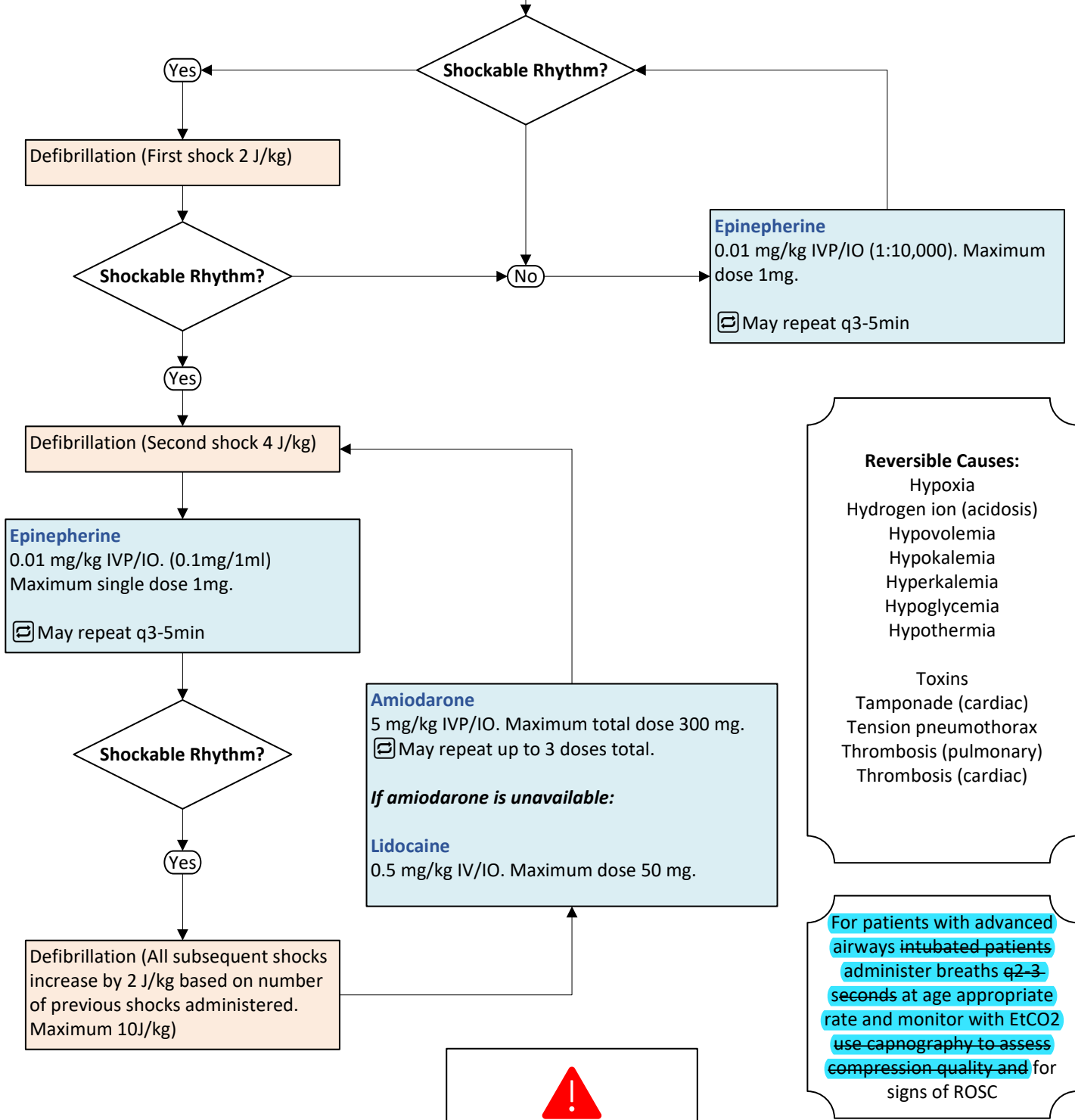
BLS – FAQ Link

Assess **Vital Signs**, ABC's and responsiveness, high flow **Oxygen** via BVM with BLS airway as indicated, apply AED, use pediatric pads if available (high flow via BVM with BLS airway as indicated)
HR < 60, START CPR (15:2)

ALS

Advanced airway management as indicated, attach defibrillator, establish IV/IO access, and correct **Reversible Causes**. Refer to **Protocol 2.04 Cardiac Arrest** and See current AHA guidelines for additional details.
Perform pulse and rhythm checks every 2 minutes
Continue CPR until ROSC or termination of efforts

**DRAFT
VERSION**



- Reversible Causes:**
- Hypoxia
 - Hydrogen ion (acidosis)
 - Hypovolemia
 - Hypokalemia
 - Hyperkalemia
 - Hypoglycemia
 - Hypothermia
 - Toxins
 - Tamponade (cardiac)
 - Tension pneumothorax
 - Thrombosis (pulmonary)
 - Thrombosis (cardiac)

For patients with advanced airways intubated patients administer breaths q2-3 seconds at age appropriate rate and monitor with EtCO2 use capnography to assess compression quality and for signs of ROSC

Make Base Hospital Contact
Termination of efforts

ROSC? Begin post cardiac arrest care

Effective: mm/dd/yy
Supersedes: 03/15/15

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BLS Treatment
<ul style="list-style-type: none">• Assess vital signs, circulation, airway, breathing, and responsiveness.• Oxygen (high flow via BVM with BLS airway as indicated)• If HR < 60, START CPR. (15:2) Apply AED Use pediatric pads, if available <p>If no change and HR still < 60 after airway/breathing/ventilation maneuvers, start CPR Perform pulse & rhythm checks Q2 minutes</p>
ALS Treatment
<p>Current American Heart Association Guidelines concerning Emergency Cardiac Care assessments and interventions shall always take precedence over local protocols when there is a conflict concerning techniques of resuscitation.</p>
<ul style="list-style-type: none">• Defibrillation (First shock 2 J/kg, Second shock 4 J/kg, All subsequent shocks increase by 2 J/kg based on number of previous shocks administered. Maximum 10 J/kg)• Advanced airway if indicated. For intubated patients patients with advanced airways administer breaths q2-3 seconds at age appropriate rate and use capnography monitor with EtCO₂ to assess compression quality and for signs of ROSC• Epinephrine 0.01 mg/kg IVP/IO (0.1mg/1ml). Maximum single dose 1mg. May repeat q3-5min• Amiodarone 5 mg/kg IVP/IO. Maximum total dose 300 mg. May repeat up to 3 doses total. If amiodarone is unavailable: Lidocaine 0.5 mg/kg IV/IO. Maximum dose 50 mg• Reversible Causes: hypoxia, hydrogen ion (acidosis), hypovolemia, hypokalemia, hyperkalemia, hypoglycemia, hypothermia, toxins, tamponade (cardiac), tension (pneumothorax, thrombosis (pulmonary), thrombosis (cardiac))
Base Hospital Contact Criteria
Termination of efforts.