

POST CARDIAC ARREST CARE

1. Establish IV/IO access.
2. Optimize ventilation and **oxygen**.
 - ✓ Maintain target oxygen saturation at 94-96%
 - ✓ Consider Advanced airway and waveform **capnography**
 - ✓ Do not hyperventilate. Start at 10-12 bpm and titrate PETCO₂ to 35-40 mmHg
3. If systolic BP < 90, assess volume status. If lungs clear, consider trial infusion of 0.9 NS. If crackles present, consider **dopamine** infusion at 5-10 mcg/kg/minute.*
4. Consider administering **sodium bicarbonate (NaHCO₃)** at 1 meq/kg IV/IO for prolonged resuscitation with effective ventilation or Return of Spontaneous Circulation (ROSC) after long arrest interval.
5. Search for and treat reversible causes (**5H's, 5 T's**).

✓ Hypovolemia	✓ Tension pneumothorax
✓ Hypoxia	✓ Tamponade, cardiac
✓ Hydrogen Ion (acidosis)	✓ Toxins
✓ Hypothermia	✓ Thrombosis pulmonary
✓ Hypo/hyper kalemia	✓ Thrombosis coronary
6. Report to the receiving hospital with the following information as soon as possible (use land line if more readily available than the HEAR system). Do not wait until routine patch.
 - ✓ State that you have a cardiac arrest - ROSC
 - ✓ Patient name, if contact through a secure cell or ground line
 - ✓ Age and gender
 - ✓ Findings on prehospital 12 lead EKG. Clearly communicate if EKG, by your interpretation and the computer program, shows AMI. Report the presence of any of the following potential mimickers
 - ➔ LVH

- BBB
 - Pacemaker
 - Pericarditis
 - Early repolarization
 - ✓ Name of cardiologist or, if none, primary care physician
 - ✓ Clinical presentation, brief and to the point
 - ✓ Vital signs
 - ✓ Prehospital treatment
7. Update the hospital and alert them, pending arrival, using the HEAR system. The following terminology should be used to describe the category of the ACS patient:
- A. Cardia-STEMI
 - B. Cardiac-High Risk
 - C. Cardiac Post Arrest

*If dopamine is unavailable, epinephrine may be substituted at a continuous infusion of 2-10 mcg/min IV/IO.