

TREATMENT:

Verify Arrest

Initiate HP CPR

Attach cardiac defibrillator or AED

In suspected opioid overdose, administer **naloxone**, but do not delay chest compressions or shocks.

1:10,000 Epinephrine 1 mg IV/IO as soon as access is obtained.

Continue CPR; check rhythm and switch compressors every 2 minutes

1:10,000 Epinephrine 1 mg IV/IO, repeat every 3-5 minutes.

If end-tidal CO₂ is ≥ 20 with an organized rhythm, initiate fluids per Shock protocol and consider **Norepinephrine**.

PEDIATRIC PATIENTS:

- Begin CPR and airway management.
- Administer **1:10,000 Epinephrine 0.01 mg/kg IV/IO**, repeat every 3-5 minutes.
- Consider and treat other possible causes. Obtain CBG

NOTES & PRECAUTIONS:

- DO NOT interrupt CPR when securing patients airway.
- If patient has return of spontaneous circulation, start cooling per Induced Hypothermia protocol.
- Transport all post ROSC patients of suspected cardiac nature to SCMC-Bend unless patient needs to be stabilized immediately or not enough resources are available. If post ROSC 12-lead shows STEMI, inform SCMC-Bend ED via HEAR or phone.
- Continued Epinephrine use after 3 rounds of Epi administration should have a prolonged administration interval (8-10 minute interval instead of 3-5 minutes).

KEY CONSIDERATIONS:

Consider and treat other possible causes:

- Acidosis - High performance CPR, routine administration of sodium bicarbonate not recommended
- Cardiac tamponade – Initiate rapid transport.
- Hyperkalemia – Treat per Hyperkalemia protocol.
- Hypothermia – Treat per Hypothermia protocol
- Hypovolemia – Treat with fluids per Shock protocol.
- Hypoxia – Oxygenate and ventilate
- Pulmonary embolus – Initiate rapid transport.
- Tension pneumothorax – Needle decompression.
- Tri-cyclic antidepressant overdose – **Sodium Bicarbonate 1 mEq/kg IV/IO**