Kittitas County Prehospital EMS Protocols

SUBJECT: POST RESUSCITATIVE CARE

A. Once Return of Spontaneous Circulation (ROSC) has been achieved, factors that contributed to the individual's cardiac arrest should be considered as soon as possible to prevent re-arrest. Post resuscitative care should focus on adequate oxygenation and perfusion to help protect all systems from hypoxic injury. The patient should be stabilized, loaded, and transported to the closest, most appropriate medical facility as soon as possible.

B. If ROSC is achieved *before* endotracheal intubation, consider RSI to ensure protection of the patient's airway. Always ensure adequate oxygenation and ventilation to target Spo2 $\geq$ 95% and ETCO2 35-45mmHg.

C. Obtain blood glucose check.

D. Obtain a 12-Lead EKG as soon as it is practical to do so.

E. If the patient has been successfully resuscitated from pulseless ventricular tachycardia or ventricular fibrillation, consider an **Amiodarone** infusion, 1mg/min.

F. Systolic blood pressure during post resuscitated care should be targeted between 90-100mmHg to ensure end organ perfusion. If the patient is hypotensive:

    a. Begin a fluid challenge of 500cc-1000cc of isotonic crystalloid – be alert to signs and symptoms of fluid overload.

    b. If the patient remains hypotensive, consider an infusion of **ONE** of the following vasopressors:

        i. Consider **Levophed** drip for persistent hypotension <90 or MAP <65. Consult drip table for rates, rate adjustments should be limited to 2-4 mcg/min every 5 minutes, up to 30mcg/min.

        ii. **Epinephrine 1:1,000** 1 mg per 100ml Isotonic crystalloid for a concentration of 10mcg/ml. Administer at a rate of 2-10mcg/min.

G. Continuously monitor EKG, pulse quality and vitals every 5 minutes.

H. If the patient begins to regain consciousness, consider sedation, and pain management per RSI protocol as blood pressure allows.