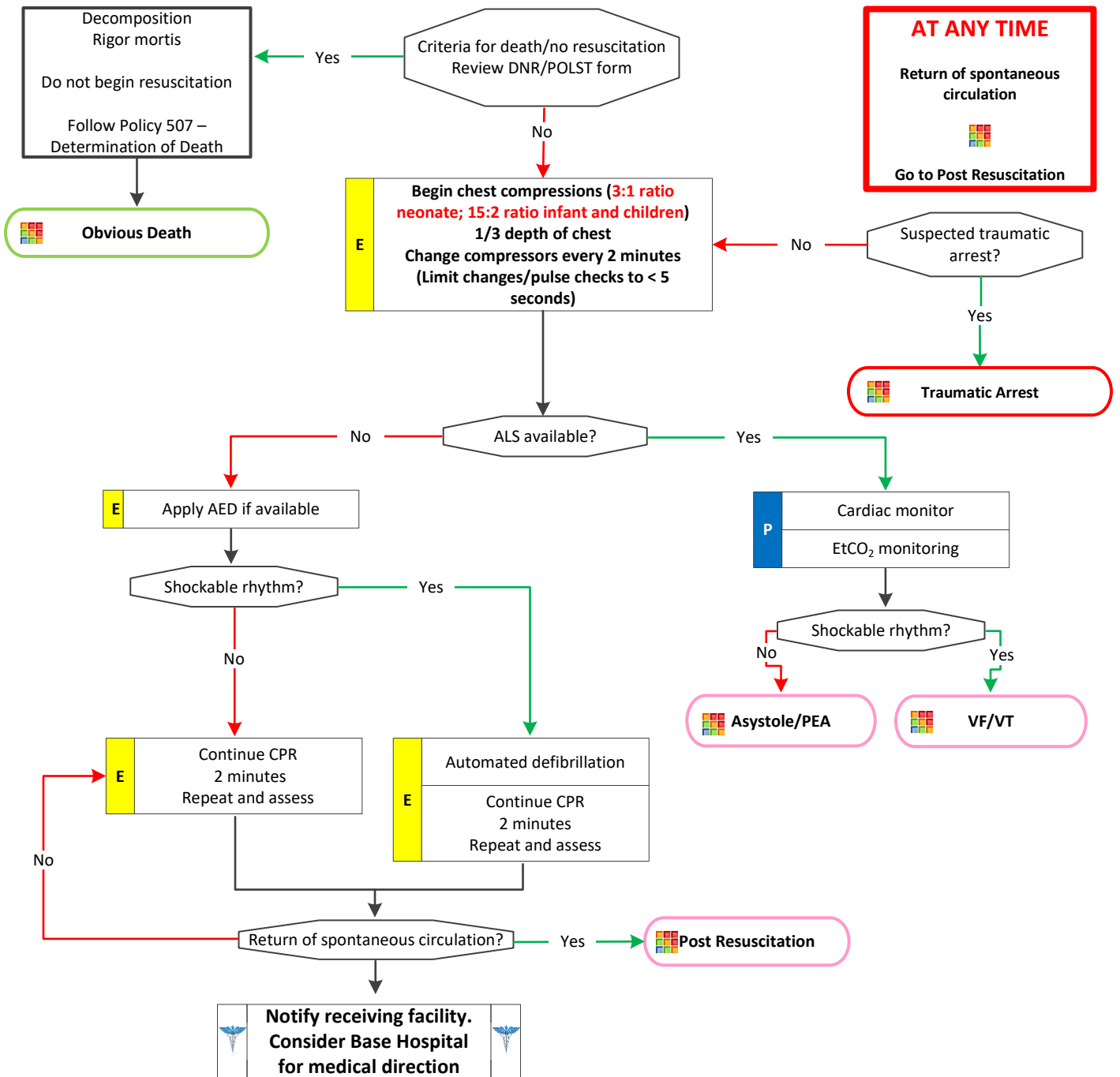


Pediatric Cardiac Arrest

For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

<p>History</p> <ul style="list-style-type: none"> • Code status (DNR or POLST) • Events leading to arrest • Estimated downtime • History of current illness • Past medical history • Medications • Existence of terminal illness 	<p>Signs and Symptoms</p> <ul style="list-style-type: none"> • Unresponsive • Apneic • Pulseless 	<p>Differential</p> <ul style="list-style-type: none"> • Airway obstruction/respiratory disease • Medical vs. trauma • VF vs. pulseless VT • Asystole • PEA • Primary cardiac event vs. respiratory arrest or drug overdose
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Pediatric Cardiac Arrest Treatment Protocols

Pediatric Cardiac Arrest

For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

Pearls

- Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with a BVM, airway adjunct, and appropriately sized mask. Patient survival is often dependent on proper ventilation and oxygenation.
- Efforts should be directed at high quality chest compressions with limited interruptions.
- Use appropriately sized pediatric BVM with EtCO₂.
- Do not delay chest compressions while applying any device or intervention.
- Use a metronome during chest compression to ensure proper rate.
- Provide resuscitative efforts for 30 minutes to maximize chance of ROSC. If immediate transport is necessary, make sure all necessary interventions are in place prior to transport.
- If resuscitative efforts do not attain ROSC, consider cessation of efforts per Policy 507 – Determining Death.
- Resuscitation is based on proper planning and organized execution. Procedures require space and patient access. Make room to work. Utilize a team focused approach assigning responders to predetermined tasks.
- Reassess airway and document EtCO₂ frequently.
- Pediatric pads for children should be used based on manufacturer recommendation.

