

Pediatric V-Fib/Pulseless V-Tach

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

<p>History</p> <ul style="list-style-type: none"> • Events leading to arrest • Estimated downtime • Prior resuscitation attempts • Past medical history • Medications • Known terminal illness 	<p>Signs and Symptoms</p> <ul style="list-style-type: none"> • Pulseless • Apneic 	<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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 Enter from Cardiac Arrest

P	Defibrillation
	<i>Use length-based tape; refer to dosing guide</i>
	Resume chest compressions (15:2 ratio) 1.5 inches for infants; 2 inches for children Change compressors every 2 minutes (Limit changes/pulse checks to < 5 seconds)
Establish IV/IO	

AT ANY TIME

Return of spontaneous circulation



Go to Post Resuscitation

P	Defibrillation
	<i>Use measuring tape; refer to dosing guide</i>
	Resume chest compressions (15:2 ratio) 1.5 inches for infants; 2 inches for children Change compressors every 2 minutes (Limit changes/pulse checks to < 5 seconds)
Epinephrine (1:10,000)	
<i>Use length-based tape; refer to dosing guide</i>	

P	Defibrillation
	<i>Use measuring tape; refer to dosing guide</i>
	Resume chest compressions (15:2 ratio) 1.5 inches for infants; 2 inches for children Change compressors every 2 minutes (Limit changes/pulse checks to < 5 seconds)
If V-Fib/ Pulseless V-Tach is refractory after 3 shocks	
Continue high performance CPR and give medications during compressions	
Lidocaine	
<i>Use length-based tape; refer to dosing guide</i>	

Persistent V-Fib/V-Tach

Yes

 Aystole/PEA

No

Return of spontaneous circulation?

No

Yes

 Post Resuscitation

**Notify receiving facility.
Consider Base Hospital for medical direction**

Pediatric Cardiac Arrest Treatment Protocols

Pediatric V-Fib/Pulseless V-Tach

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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 resuscitative efforts do not attain ROSC, consider cessation of efforts per Operations 10 – Determination of 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.
- Defibrillation vests should be removed by EMS personnel before compressions, but do not cut vests. Once removed, disengage battery to prevent alarming.

