# 2F POST-RESUSCITATION CARE

## PATIENT CARE GOALS

- Stabilize the patient's vital signs and prevent recurrence of dysrhythmias and arrest, while maintaining adequate oxygenation, ventilation, and perfusion.[1]
- Search for and treat (if able) the underlying cause of the arrest. [2]

## PARAMEDIC

1. **Airway**
   - Ensure ITD is removed, non-visualized airway/ET is properly secured and patient is easy to ventilate[3].
   - Assess pulse oximetry and end-tidal capnography continuously.
   - Maintain end-tidal $CO_2$ between 35-45 mmHg. If less than 35 slow ventilation rate. If greater than 45 increase ventilation rate.
2. **Circulation**
   - Continuous visualization of the cardiac monitor rhythm.
   - Continuous assessment of pulse quality and obtain frequent blood pressures (q. 2-3 minutes) If arrest recurs, follow the appropriate cardiac arrest guideline **(2B Cardiac Arrest Management, 2C VF/Pulseless VT,** or **2D PEA/Asystole)**.
   - For ROSC following VF or VT arrest administer **dopamine infusion starting at 5 mcg/kg/min**. Titrate up to 20 mcg/kg/min to maintain MAP of at least 65 mmHg.
   - For ROSC following PEA/Asystolic arrest administer **epinephrine** I**nfusion[4] at 0.1 - 0.5 mcg/kg/min** to maintain a MAP of 65-75 mmHg.
   - Obtain 12-Lead EKG. If STEMI activate cath lab per **7H 12-Lead ECG and Cath Lab Activation**.
   - If not already applied, place and secure the LUCAS to the patient/stretcher until completion of transport.
3. **Neurologic**
   - Assess AVPU.
   - Sedate per **1D Anxiety and Sedation Management** if the patient has an advanced airway in place and/or is actively moving or combative such that stabilization is at risk.
4. **Metabolic**
   - Obtain blood glucose and treat hypoglycemia per **3G Hypoglycemia** if glucose is less than 60 mg/dL[6]
5. **Temperature Control[6]**
   - Initiate cooling by applying ice packs to the patient's axilla, groin and neck unless patient is following verbal commands.
   - Do not attempt to warm patient unless hypothermia is the suspected cause of the arrest.

## DOCUMENTATION KEY POINTS

- At ROSC record the time, presence of pulse, ECG rhythm, and neurological status.
- 12-lead ECG interpretation.
- Interventions taken to maximize stability prior to transport.
- Continuous monitoring of vital signs and neurological status throughout transport.
- Initial and ongoing assessments, monitoring, interventions, patient response, and complications (if any) encountered.

## NOTES

[1] Once return of spontaneous circulation (ROSC) has been achieved all reasonable efforts should be taken to assure that the patient is stable enough for transport. It is reasonable to take a reasonable amount of time necessary to treat the reversible factors [2] prior to moving the patient to the ambulance or beginning transport.

[2] Causes and contributing factors cardiac arrest include:

- Hypovolemia
- Hypoxia
- Hydrogen ion excess (acidosis)
- Hypokalemia or hyperkalemia
- Hypoglycemia
- Hypothermia
- Toxins, drug overdose
- Tamponade (cardiac)
- Tension pneumothorax
- Thrombosis (coronary or pulmonary)
- Trauma (shock, increased ICP)

[3] If advanced airway has not already been placed consider performing according to **7F Advanced Airway Management**.

[4] **Epinephrine infusion:** Use either the infusion mixed during resuscitation or prepare a smaller infusion by mixing 7.5 ml of 1:1,000 epinephrine (from multi-dose vial) in 250 ml NS. Attach to 60 gtt tubing. Monitor carefully for infiltration at the IV/IO site. Continuous cardiac monitoring is required.

[5] Avoid hyperglycemia (> 160) by titrating $D_{10}$ administration.

[6] If shivering occurs and patient has an advanced airway in place, administer **midazolam (Versed)** per **1D Anxiety and Sedation Management**.