1. **Known Preexisting Cardiac History**
   a. Assess Patient
   b. Obtain and follow any printed patient care information on scene.
      i. Contact primary care physician(s) if appropriate
   c. Administer O2 if SPO2 <94%
   d. Transport to appropriate facility
      i. Closest if patient is unstable for transport to PCMC
      ii. PCMC is preferred

2. **Cardiogenic Cardiac Arrest**
   a. Confirm unconsciousness, and abnormal or absent breathing
   b. Chest Compressions
      i. 1/3 depth of chest
      ii. 110 compressions per minute
      iii. Full recoil (hand off chest between compressions)
      iv. Minimize interruptions
         1. No more than 5 seconds for any intervention
   c. Ventilations
      i. BLS
         1. Super Plug Airway
            a. Two NPAs
            b. One OPA
               i. Note: if NPA / OPA are too large, no need for adjuncts
            c. High flow O2 to include nasal cannula (if available)
         2. If two (2) rescuers are available, this is the preferred model
            a. Two-person Ventilation
               i. Position in “sniffing” position
                  1. Pad shoulders to align airway
                  ii. Thumbs Down face to mask technique
                  iii. Ventilate 1 time every 10 compressions on “upstroke of compressions”
            ii. ALS
               1. Intubation:
Cardiac Emergencies - Pediatric

a. Intubation is not to be performed *prophylactically* on children under 12 years of age
   i. Intubation is associated with worse outcomes in most causes of arrest in children < 12 years
   ii. Intubation is still recommended for airway situations where a secure airway will give the patient a better chance at survival
      1. Burns
      2. Severe swelling of airway
      3. Submersion injuries

d. Electricity
   i. Defibrillation
      1. 2j/kg
      2. And all subsequent 4j/kg
   ii. Cardioversion
      1. 1j/kg
      2. 2j/kg
      a. Up to three more

3. Contact Medical Control

e. Medications
   i. Follow Current AHA Guidelines and Pediatric Meds protocol

f. Change compressors every two minutes
   i. Utilize countdown
   ii. Pulses should be located *during* compressions
      1. Brachial
      2. Femoral
   iii. Monitor should be charged and ready to deliver shock *prior* to compressors switching
      1. Deliver shock as compressors switch
         a. “Compressor 1” hands off
         b. Confirm absent pulse
         c. Deliver shock
         d. “Compressor 2” hands on

g. Transport to closest facility with MICC as primary treatment goal
   i. Persistent Asystole can be terminated after 2-3 rounds of medication at discretion of crew.
      1. Medical control contact *is not* mandatory when terminating asystole arrest efforts

h. Return Of Spontaneous Circulation (ROSC)
   i. Acquire blood pressure
   ii. Provide supportive care
   iii. Transport to appropriate facility
iv. High Five each other