East of England Ambulance Service NHS Trust

# Adult medical cardiac arrest checklist

Date: ..... Resuscitation team coordinator: .....

Incident number: ..... Initial rhythm: .....

**Carry out procedures that are within your scope of practice**

## ON ARRIVAL

Manage the environment to ensure 360 access to the patient; if necessary, move the patient to the improve access. ☐

If not dispatched to a confirmed arrest, ensure that EOC is updated. ☐

Additional resources required and, if so, requested? ☐

Ensure effective chest compressions by:
- time off chests **under five seconds**
- defibrillator in manual mode
- CPR puck in use
- metronome in use
- clinician performing CPR swapped every **two minutes** ☐

High flow oxygen attached to BVM and bag inflated. ☐

Airway kit dump established. ☐

Consider contacting CCD on 202 with a clinical sitrep if patient could benefit from enhanced or critical care. ☐

## DURING RESUSCITATION

Establish resuscitation team leader who holds the check list. Communicate name with team. ☐

Share names and clinical grades with team. ☐

Decide on manual CPR or mechanical CPR as appropriate. ☐

Appropriate shocks being delivered at 200J biphasic. ☐

Advanced airway effective and ventilating. ☐

Apply ETCO2 immediately. ☐

Monitor ETCO2 via capnography:
- Is there a box wave form?
- If <1.5 kPa, why? (check for hyperventilation).
- Good chest compressions will result in improved ETC02.
- Sudden improvement of ETC02 may indicate a ROSC. ☐

Vascular IV/ IO access secured, flushed and IV fluids attached. ☐

Adrenaline & amiodarone cross checked and given as indicated. ☐

## ALS ESTABLISHED

History of event obtained from any bystanders. ☐

After six shocks, change pads and placement to anterior/posterior. (Contact CCD for persistent shockable rhythm) ☐

Aetiology and working diagnosis considered. ☐

BM & temperature measured. ☐

4H & 4T excluded or managed as appropriate.
Rationale for exclusion
- hypoxia .....
- hypovolemia .....
- hypothermia .....
- hypo/hyperkalaemia .....
- tension pneumothorax .....
- thromboembolic .....
- toxins .....
- tamponade ..... ☐

Consideration to transport any patient that could have improved outcome if rapidly transferred to hospital. ☐

**Clinical advice line 07753 950843**
**Critical care desk 01245 444496/ CH 202**

**Shocks @1.....2.....3.....4.....5.....6..... Change pads 7.....8.....9.....10..... ROSC@.....lost.....2nd.....lost.....3rd.....**
**Adrenaline@ 1.....2.....3.....4.....5.....6.....7.....8.....9.....10..... Amiodarone@1.....2(1/2dose).....**

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## UPON ROSC

Confirm the change of rhythm/ morphology supports life with palpable central pulses. ☐

Airway – advanced device in situ, patent, tolerated. ☐

Breathing – ETCO2 trace, RR, SP02, spontaneous breathing , ventilator considered.
- ETCO2 optimised to 4.0-4.5 KPa.
- Decrease ventilation rate to increase KPa. ☐

Circulation – peripheral pulses, HR, BP
- If BP< 90, 250mls normal saline administered.
- If BP still <90 contact CAL/CCD for support to administer inotropic support.
- If symptomatically bradycardic consider atropine. ☐

Disability – measure GCS, pupil response, BM. ☐

Evaluate – diagnostic ECG obtained. If ECG shows a STEMI aim to attend a PPCI centre irrespective of GCS. ☐

If the patient is breathing spontaneously or moving, consider updating CCD. ☐

Consider remaining on scene until the post ROSC care is attempted. ☐

Duty of care passed to (call-sign).....@...../
Hospital (name).....@.....
PLE / ROLE recognised @.....
By (name).....Call-sign.....

## POST ROSC CARE BUNDLE

Post ROSC management plan shared with team and family supported. ☐

Consider the use of a ventilator if not already in use.
- <10 support with **one ventilation** every **six seconds.**
- >10 support ventilations to maintain 4.0-4.5 KPa (aiming for SPO2 94-98%). ☐

Extrication planned any additional equipment or resources obtained. ☐

Extrication undertaken having ensured horizontal patient positioning, sufficient oxygen, management of wires and tubing. ☐

Allow passive hypothermia. Cover to maintain dignity only. ☐

If indicated, nearest PPCI centre contacted. ☐

## PRE CRITICAL CARE CHECK LIST

Cylinder (CD) $O_2$ x2. ☐

Charged unused LSU with both catheters . ☐

Patient packaged skin to scoop. ☐

Patient extricated to ambulance. ☐

Bilateral patent vascular access, with 500ml saline hung but not running unless clinically indicated. ☐

## DECISION SUPPORT

Clinical advice line contacted if PPCI refused to take indicated patient. ☐

Abandoning resuscitation as futile considered if ALL of the following are met:
- a minimum of 20 minutes of high quality ALS has been undertaken ☐
- the patient is in a non-shockable rhythm ☐
- if presenting with a Pulseless Electrical Activity (PEA) the capnography is bellow 1.2 KPa ☐
- there are no potentially reversible causes. ☐

Risk of the following excluded:
- drowning
- hypothermia
- poisoning or overdose
- pregnancy
- if patient is under 18 ☐

In any other circumstances, clinical advice line contacted for remote decision support prior to termination of resuscitative efforts. ☐

All ambulance staff involved in resuscitation efforts agree to support termination of efforts. ☐

QA form completed & crew debriefed. ☐

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