



DRUG PREPARATION:

Preparation of push dose epinephrine (14 years or older only):
 Mix 1 mL of 1 mg/10 mL (CARDIAC) epinephrine with 9 mL NS. This results in a 10 mcg/mL concentration



Return of Spontaneous Circulation (ROSC): The post-arrest period is dynamic, and re-arrest and dysrhythmias frequently occur. Prioritize vasopressor administration and target oxygen to optimize vital sign parameters. Dysrhythmias in this period are common and usually self-limiting; some warrant no further treatment, especially atrial dysrhythmias. Others, such as worsening bradycardia and wide-complex tachycardia, should be managed emergently. Due to the complex nature of post-arrest care, it is highly recommended to stay on scene to administer the interventions described in the AG.

After arrest,

- Monitor EtCO₂; EtCO₂ should remain above 20. Lower readings may indicate re-arrest or airway displacement.
- Monitor SpO₂ to maintain saturation between 94-99%
- Obtain a 12-lead; if STEMI, transmit ECG and expedite preparation for transport
- Prepare for transport and assure adequate personnel; once loaded, reassess airway and pulse
- Prepare your pressor; titrate fluid resuscitation and vasopressor administration to maintain SBP of 90-100 mmHg or Mean Arterial Pressure (MAP) of 65-80 mmHg.

Post-arrest Bradycardia: A common post-ROSC rhythm, the first-line treatment is push-dose epinephrine. Titrate the pressor as needed to target a perfusing heart rate (i.e. a SBP >90).

- **Pacing:** only attempt in severe bradycardia when mechanical capture can absolutely be verified (i.e. finger on the pulse with good blood pressure) and the patient is under constant monitoring. After ROSC, heart muscle is often stunned and pacing will be ineffective. **You must have a patient with a pulse for pacing to be an option.** If a patient is pulseless or you cannot verify a pulse with bradycardia, administer CPR.

Wide-complex tachycardia: See [Wide Complex Tachycardia AG](#)