



## **PROTOCOL 1**      **ROUTINE MEDICAL CARE**

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1. Assess ABCs; Protect C-Spine as necessary.
2. Oxygen therapy per New York State BLS Treatment Protocols.
3. Place patient in Semi-Fowlers position or position of comfort.
4. EKG Monitor and evaluate cardiac rhythm.
5. Establish IV or IO access with Normal Saline; draw appropriate bloods as necessary.
6. Obtain and record frequent vital signs (every five (5) minutes, as possible).
7. Contact Medical Control as indicated by specific protocol.

<p><b>N.B.</b>      IN AN UNCOOPERATIVE PATIENT, THE REQUIREMENT TO INITIATE FULL ALS ASSESSMENT AND CARE MAY BE WAIVED IN FAVOR OF ASSURING THE PATIENT IS TRANSPORTED TO AN APPROPRIATE FACILITY.</p>
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## **PROTOCOL 2**

## **RESPIRATORY ARREST / IMMINENT RESPIRATORY ARREST / INTUBATION**

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1. Oxygen therapy per New York State BLS Treatment Protocols.
2. If basic life support airway management cannot maintain adequate ventilation and oxygen saturation, airway control with advanced airway management, 100% OXYGEN with BVM.
3. EKG Monitoring.
4. IV of Normal Saline.
5. Refer to appropriate protocol for further assessment and treatment.

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### **MEDICAL CONTROL OPTIONS**

- DIAZEPAM 5 - 10 mg slow IVP
- MORPHINE SULFATE 2 - 10 mg IVP
- MIDAZOLAM 2 - 5 mg slow IVP
- LIDOCAINE 1.0 - 1.5 mg/kg IVP
- ETOMIDATE 0.3 mg/kg IVP (For credentialed Paramedics, if available)

**Rev. 11 - 02**



# **PEDIATRIC PROTOCOL 2a**

# **RESPIRATORY ARREST / IMMINENT RESPIRATORY ARREST / INTUBATION**

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1. Oxygen therapy per New York State BLS Treatment Protocols.
2. If basic life support airway management cannot maintain adequate ventilation and oxygen saturation, airway control with advanced airway management, 100% OXYGEN with BVM.
3. EKG Monitoring.
4. IV of Normal Saline at KVO, or IO if peripheral IV access not available.
5. Consider nasogastric tube placement with gastric distention after intubation.
6. Refer to appropriate protocol for further assessment and treatment.

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## **MEDICAL CONTROL OPTIONS**

- DIAZEPAM 0.1 mg/kg IV/IO over 2 minutes.
- MORPHINE SULFATE 0.1 mg/kg IV/IO (max).
- MIDAZOLAM:

6 mos to 5 years:	0.05 - 0.1 mg/kg slow IVP/IO
6 years to 12 years:	0.025 - 0.05 mg/kg slow IVP/IO
13 years to 15 years:	2 - 5 mg slow IVP/IO
- LIDOCAINE 1 - 1.5 mg/kg IV/IO
- ETOMIDATE .3 mg/kg IV/IO (For credentialed Paramedics, if available)

**Rev. 11 - 02**



## **PROTOCOL 3                    OBSTRUCTED AIRWAY, UNCONSCIOUS**

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### **PEDIATRIC PROTOCOL 3a                    OBSTRUCTED AIRWAY, UNCONSCIOUS**

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1.     BLS procedure.
2.     Direct laryngoscopy and remove foreign body using Magill forceps.
3.     If unable to ventilate, initiate Advanced Airway control.
4.     If unable to intubate because of obstruction, perform needle cricothyrotomy.
5.     Refer to appropriate protocol or contact Medical Control.



## **PROTOCOL 4**                      RESPIRATORY DISTRESS ASTHMA / BRONCHOSPASM / COPD

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1. Airway control and OXYGEN.
2. Pulse Oximetry and Peak Flow.
3. ALBUTEROL 2.5 mg/ 3 ml normal saline plus IPRATROPIUM 0.5 mg/ 2.5 ml Normal Saline via nebulizer, followed by peak flow. May repeat ALBUTEROL every 10 minutes.
4. EKG Monitor.
5. IV of Normal Saline at KVO if clinically indicated.

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### **MEDICAL CONTROL OPTIONS**

- ALBUTEROL 2.5 mg/ 3 ml Normal Saline via nebulizer.
- TERBUTALINE 0.25 mg S/C; repeat as directed.
- EPINEPHRINE 1:1,000 0.3 mg S/C; repeat as directed.
- MAGNESIUM SULFATE 1 - 2 gm IV over 5 minutes.
- METHYLPREDNISOLONE 125 mg/ 50 ml Normal Saline over 2 minutes.

<b>CAUTION</b> USE EPINEPHRINE WITH CAUTION IN PATIENTS WITH HISTORY OF OR PRESENCE OF HYPERTENSION, HEART DISEASE, CURRENT PREGNANCY, BETA-BLOCKERS.
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**PEDIATRIC**                      RESPIRATORY DISTRESS ASTHMA /  
**PROTOCOL 4a:**                BRONCHOSPASM / CROUP / EPIGLOTTITIS

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**N.B.**                      IF THE PATIENT HAS STRIDOR OR DROOLING, DO NOT INITIATE  
IV ACCESS WITHOUT MEDICAL CONTROL.

1.     Airway control and OXYGEN.
2.     Pulse Oximetry, Peak Flow (if patient is cooperative).
3.     ALBUTEROL 2.5mg/ 3ml Normal Saline plus IPRATROPIUM 0.5 mg/2.5 ml normal saline via nebulizer followed by peak flow (if patient is cooperative); May repeat only ALBUTEROL every 10 minutes if needed.
4.     IV of Normal Saline at KVO if clinically indicated.

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**MEDICAL CONTROL OPTIONS**

- ALBUTEROL 2.5 mg/ 3 ml Normal Saline via nebulizer; repeat as directed.
- EPINEPHRINE 1:1,000 0.01 mg/kg SC; maximum dose 0.3 mg; repeat as directed.
- MAGNESIUM SULFATE 20 - 40 mg/kg IV over 5 minutes.
- METHYLPREDNISOLONE 2 mg/kg IV over 2 minutes.

**Rev. 4 - 02**



## **PROTOCOL 5**                      **KINEMATICS OF TRAUMA**

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**INDICATIONS:** For patients presenting with any of the following, a high index of suspicion must exist for hidden injuries even if the patient is hemodynamically stable:

1. Penetrating injury to the head, neck, abdomen, or groin;
2. Two or more proximal long bone fractures;
3. Trauma combined with burns equal to or greater than 15% Body Surface Area;
4. Flail Chest;
5. Falls equal to or greater than 20 feet or 3 times the patient's height;
6. Vehicle crash causing any of the following:
  - a) 20 inch deformity of the vehicle;
  - b) Displacement of axle toward passenger compartment;
  - c) Intrusion of passenger compartment by 15" on patient side or 20" on opposite side;
  - d) Rollover;
  - e) Death of another passenger in the vehicle;
  - f) Ejection of the patient;
7. Pedestrian struck by a vehicle at speed equal to or greater than 20 MPH.

### **IF PATIENT MEETS ANY ABOVE CRITERIA:**

1. Initiate Routine Medical Care.
2. Begin transportation consistent with regional trauma transport guidelines. **(APPENDIX B).**
3. Contact Medical Control or receiving hospital as soon as possible.
4. Large bore IV/IO with Normal Saline at rate appropriate for vital signs (2 IV lines if possible).
5. If patient deteriorates, go to the appropriate protocol.

<b>N.B.</b> INITIATING IV/IO THERAPY SHOULD NOT DELAY TRANSPORT; IF TRANSPORTATION IS UNAVOIDABLY DELAYED, IV THERAPY MAY BE STARTED PRIOR TO TRANSPORT. MEDICAL CONTROL CAN BE CALLED SOONER IF NECESSARY.
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## **PROTOCOL 6                   HYPOVOLEMIC SHOCK**

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1.     Initiate Routine Medical Care.
2.     Transport.
3.     Start two large bore IVs of Normal Saline wide open.
4.     EKG Monitor.

<b>N.B.</b> DO NOT ALLOW PROCEDURES TO DELAY TRANSPORT.   IF TRANSPORT IS UNAVOIDABLY DELAYED, IV THERAPY MAY BE STARTED PRIOR TO TRANSPORT.
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### **MEDICAL CONTROL OPTION**

- DOPAMINE 400 mg/ 250 ml Normal Saline; initiate drip at 5 – 10 mcg/kg/min. If there is insufficient improvement in status, the infusion rate may be titrated upward every 5 minutes in increments of 5 mcg/kg/min until desired therapeutic effect (maximum dose of 25 mcg/kg/min).



# PEDIATRIC PROTOCOL 6a HYPOVOLEMIC SHOCK

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1. Initiate Routine Medical Care.
2. Transport.
3. Fluid bolus of 20 ml/kg normal saline. Repeat bolus in 10 minutes if shock persists.

**N.B.** DO NOT ALLOW PROCEDURES TO DELAY TRANSPORT. IF TRANSPORT IS UNAVOIDABLY DELAYED, IV THERAPY MAY BE STARTED PRIOR TO TRANSPORT.



## **PROTOCOL 7**      **TRAUMATIC CARDIOPULMONARY ARREST**

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1.      Initiate Routine Medical Care.
2.      Transport to the closest receiving hospital.
3.      Initiate the appropriate cardiac arrest protocol.

<b>N.B.</b> DO NOT ALLOW PROCEDURES TO DELAY TRANSPORT. IF TRANSPORT IS UNAVOIDABLY DELAYED, IV THERAPY MAY BE STARTED PRIOR TO TRANSPORT. MEDICAL CONTROL CAN BE CONTACTED SOONER IF NECESSARY.
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# **PEDIATRIC PROTOCOL 7a**      **TRAUMATIC CARDIOPULMONARY ARREST**

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1.      Initiate Routine Medical Care.
2.      Transport to the closest receiving hospital.
3.      Initiate the appropriate cardiac arrest protocol.

<b>N.B.</b> DO NOT ALLOW PROCEDURES TO DELAY TRANSPORT. IF TRANSPORT IS UNAVOIDABLY DELAYED, IV THERAPY MAY BE STARTED PRIOR TO TRANSPORT.
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## **PROTOCOL 8                      TENSION PNEUMOTHORAX**

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1.     Initiate Routine Medical Care.
  
2.     Pleural decompression using large bore over the needle catheter, or other REMAC approved device, if:
  - a)    If there is evidence of respiratory/cardiovascular compromise,  
  

**AND**
  - b)    Two (2) of the following:
    - Absent/decreased breath sounds on the affected side;
    - Tracheal deviation;
    - Subcutaneous emphysema.
  
3.     Repeat procedure if signs and symptoms recur.



## **PROTOCOL 9 HEAD TRAUMA**

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### **PEDIATRIC PROTOCOL 9a HEAD TRAUMA**

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1. Initiate Routine Medical Care.
2. In patients with head trauma who have a Glasgow Coma Score of 8 or lower:
  - a) Advanced Airway Management;
  - b) Administer LIDOCAINE 1.5 mg/kg IV immediately prior to intubation;
  - c) DO NOT hyperventilate the patient unless signs of brain herniation are evident.
3. If signs of shock, refer to Shock Protocol (traumatic or non-traumatic).
4. Transport Decision.

<b>N.B.</b> CONSIDER ALTERED MENTAL STATUS AND SEIZURE PROTOCOLS.
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## **PROTOCOL 10      THERMAL BURNS**

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1.     Initiate Routine Medical Care.
2.     For respiratory burns, refer to Advanced Airway Management.
3.     Transport to an appropriate facility. If transport is delayed, IV/IO access may be obtained prior to transport.
4.     Consider fluid / bolus-fluid challenge per shock protocol.

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### **MEDICAL CONTROL OPTIONS**

- MORPHINE SULFATE 2 - 5 mg IVP; can be repeated to maximum 20 mg.
- NALOXONE 2.0 mg IVP



# **PEDIATRIC PROTOCOL 10a      THERMAL BURNS**

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1. Initiate Routine Medical Care.
2. For respiratory burns, refer to Advanced Airway Management.
3. Transport to an appropriate facility. If transport is delayed, IV/IO access may be obtained prior to transport.
4. Consider fluid / bolus-fluid challenge as per shock protocol.

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## **MEDICAL CONTROL OPTIONS**

- MORPHINE SULFATE 0.1 mg/kg IVP or SC (maximum dose 10 mg).
- NALOXONE 0.1 mg/kg IVP or IM.



## **PROTOCOL 11      CARDIOPULMONARY ARREST (Non-Traumatic)**

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1.     Initiate Routine Medical Care.
2.     Follow the appropriate sub-protocol:
  - a)    Ventricular fibrillation or pulseless ventricular tachycardia;
  - b)    Asystole;
  - c)    Electromechanical dissociation / Pulseless electrical activity.

**N.B.**

ET DOSING OF DRUGS IS TWICE THE AMOUNT OF THE USUAL IV DOSE FOLLOWED BY 10 - 20 ML OF NORMAL SALINE FLUSH.

IV MEDICATIONS BY BOLUS ARE FOLLOWED BY A 20 - 30 ML BOLUS OF NORMAL SALINE. WHEN PRACTICAL, ELEVATION OF THE ARM IS RECOMMENDED.

CONSIDER FIELD TERMINATION OF RESUSCITATION EFFORTS (PROTOCOL # 15).



# **PEDIATRIC PROTOCOL 11a**      **CARDIOPULMONARY ARREST (Non-Traumatic)**

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1.     Initiate Routine Medical Care.
  
2.     Follow the appropriate sub-protocol:
  - a)    Ventricular fibrillation or pulseless ventricular tachycardia;
  
  - b)    Asystole;
  
  - c)    Electromechanical dissociation / Pulseless electrical activity.



## **PROTOCOL 12**      VENTRICULAR FIBRILLATION OR PULSELESS VENTRICULAR TACHYCARDIA

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1. Initiate Routine Medical Care.
2. If arrest is witnessed by the pre-hospital provider, administer precordial thump.
3. DEFIBRILLATE at 200 Joules (**a, b**); if no change, DEFIBRILLATE at 300 Joules; if no change, DEFIBRILLATE at 360 Joules.
4. If the rhythm is not converted, CPR is continued, IV access with Normal Saline is obtained, and airway control is established.
5. EPINEPHRINE 1:10,000 1.0 mg (10 ml) IVP; may be repeated every 3 minutes.  
**OR**  
VASOPRESSIN 40 units IVP; if no acceptable response after 5 - 10 minutes, resume EPINEPHRINE 1.0 mg IVP every 3 minutes.
6. DEFIBRILLATE at 360 Joules
7. AMIODARONE 300 mg (dilute to 20 ml D5W) IVP (**c**); if necessary, repeat at 150 mg/ 20 ml IVP.  
**OR**  
LIDOCAINE 1.5 mg/kg IVP (**c**); same dose may be repeated in 3 minutes.
8. DEFIBRILLATE at 360 Joules.

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### **MEDICAL CONTROL OPTIONS**

- AMIODARONE 150 - 300 mg IVP. (**c**)
- VASOPRESSIN 40 units IVP.
- DEFIBRILLATE at 360 Joules.
- NALOXONE 2 mg IV or ET.
- SODIUM BICARBONATE 1.0 mEq/kg IVP; may be repeated at 0.5 mEq/kg every 10 minutes.
- DEXTROSE 50% 50 ml IVP.
- PROCAINAMIDE 20 mg/min IVP to a maximum of 17 mg/kg.

**PROTOCOL 12 CONTINUED ON NEXT PAGE**



## **PROTOCOL 12: (MEDICAL CONTROL OPTIONS CONTINUED)**

- LIDOCAINE, AMIODARONE, or PROCAINAMIDE drip. (c)
- MAGNESIUM SULFATE 1 - 2 gm IV over 5 minutes.
- EPINEPHRINE 1:10,000 1 mg (10 ml) IVP.

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### **FOOTNOTES**

Check for rhythm after each defibrillation:

- a. If at any point, the rhythm converts to supraventricular and the patient has not received an anti-arrhythmic, administer LIDOCAINE 1 mg/kg IVP and then administer a drip of LIDOCAINE at 2 mg/min.
- b. If at any point after receiving an anti-arrhythmic drug the rhythm converts to supraventricular, administer a drip of the effective anti-arrhythmic:

LIDOCAINE:

3 mg/min if 1 - 2 mg/kg of Lidocaine was used.  
4 mg/min if 3 - 4 mg/kg of Lidocaine was used.

AMIODARONE:

1.0 mg/min

PROCAINAMIDE:

1 - 4 mg/min

- c. It is recommended that not more than one antiarrhythmic agent be used on any patient.

<b>N.B.</b> CONSIDER FIELD TERMINATION OF RESUSCITATION EFFORTS (PROTOCOL # 15).
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## **PEDIATRIC PROTOCOL 12a**

## **VENTRICULAR FIBRILLATION OR PULSELESS VENTRICULAR TACHYCARDIA**

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1. Initiate Routine Medical Care.
2. If the arrest is witnessed by the pre-hospital provider, administer a precordial thump.
3. DEFIBRILLATE at 2 Joules/kg (**a, b**); if no change, DEFIBRILLATE at 4 Joules/kg; if no change, DEFIBRILLATE at 4 Joules/kg.
4. If the rhythm is not converted, CPR is continued, establish advanced airway control, start IV/IO access with Normal Saline.
5. EPINEPHRINE 1:10,000 0.01mg/kg IVP or IO; may be repeated every 3 minutes; ET dose is 1:1,000 0.1mg/kg.
6. DEFIBRILLATE at 4 joules/kg 30 seconds after receiving EPINEPHRINE.
7. AMIODARONE 5 mg/kg IVP or IO (**c**);  
**OR**  
LIDOCAINE 1.0 mg/kg IVP, ET or IO (**c**); may be repeated at 1.0 mg/kg every 3 minutes to a total dose of 3 mg/kg.
8. DEFIBRILLATE at 4 Joules/kg 30 seconds after the antiarrhythmic is given.

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### **MEDICAL CONTROL OPTIONS**

- LIDOCAINE 1.0 mg/kg IVP, ET or IO every 3 minutes to a total dose of 3 mg/kg. (**c**)
- AMIODARONE 5 mg/kg IVP or IO. (**c**)
- DEFIBRILLATE at 4 Joules/kg.
- NALOXONE 0.1 mg/kg IVP, ET, or IO.
- SODIUM BICARBONATE 1.0 mEq/kg IVP or IO; may be repeated at 0.5 mEq/kg every 10 minutes.
- DEXTROSE 25% 2 ml/kg IVP or IO.

***PEDIATRIC PROTOCOL 12a CONTINUED ON THE NEXT PAGE***



## **PEDIATRIC PROTOCOL 12a (MEDICAL CONTROL OPTIONS CONTINUED)**

- LIDOCAINE drip (**b, c**)
- MAGNESIUM SULFATE 200 mg – 1.0 gm IV or IO over 5 minutes (for suspected Torsades de Pointes or hypomagnesaemia).
- DEXTROSE 10% 2 ml/kg IVP or IO.

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### **FOOTNOTES**

Check for rhythm after each defibrillation.

- a. If at any point the rhythm converts to supraventricular and the patient has not received LIDOCAINE, administer LIDOCAINE 1.0 mg/kg IVP and then start a LIDOCAINE drip at 20 mcg/kg/min.
- b. If at any point after the administration of LIDOCAINE the rhythm converts to supraventricular, start a LIDOCAINE drip at 20 - 50 mcg/kg/min.
- c. It is recommended that not more than one antiarrhythmic agent be used on any patient.



## PROTOCOL 13 ASYSTOLE

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1. Initiate Routine Medical Care.
2. The rhythm is checked in more than one lead before the interpretation of asystole is made. If the rhythm is unclear and possibly low amplitude ventricular fibrillation, follow the ventricular fibrillation protocol.
3. Advanced airway control, hyperventilation, IV access of Normal Saline
4. Consider TRANSCUTANEOUS PACING if clinically indicated.
5. EPINEPHRINE 1:10,000 1.0 mg (10 ml) IV, ET, or IO; may be repeated every 3 minutes.
6. ATROPINE 1.0 mg IV, ET, or IO. Dose may be repeated every 3 minutes to a maximum 0.04 mg/kg.
7. Consider SODIUM BICARBONATE 1.0 mEq/kg IVP with suspected hyperkalemia, profound acidosis, tricyclic antidepressant, cocaine, or diphenhydramine overdoses. Dose may be repeated at 0.5 mEq/kg every 10 minutes.

<b>N.B.</b>	CONSIDER DEXTROSE 50% 50 ML IVP IF CLINICALLY INDICATED; MAY BE REPEATED ONCE.
	CONSIDER NALOXONE 2MG IV, ET, OR IO IF CLINICALLY INDICATED.
	CONSIDER FIELD TERMINATION OF RESUSCITATION EFFORTS (PROTOCOL # 15).

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### MEDICAL CONTROL OPTIONS

- DEFIBRILLATE at 200 - 300 Joules
- CALCIUM CHLORIDE 250 - 500 mg. IVP; may be repeated to a maximum of 1.0 gm. Only indicated with hyperkalemia, hypocalcemia, or calcium channel blocker toxicity.



# PEDIATRIC PROTOCOL 13a ASYSTOLE

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1. Initiate Routine Medical Care.
2. Rhythm is checked in more than one lead before the interpretation of asystole is made. If the rhythm is unclear and possibly low amplitude ventricular fibrillation, follow the ventricular fibrillation protocol.
3. Advanced airway control, hyperventilation, IV or IO access with Normal Saline
4. Consider TRANSCUTANEOUS PACING if clinically indicated.
5. EPINEPHRINE 1:10,000 0.01 mg/kg IVP or IO; may be repeated every 3 minutes. ET dose of EPINEPHRINE is 1:1,000 0.1 mg/kg.
6. ATROPINE 0.02 mg/kg IVP or IO (minimum dose 0.1 mg); ET dose is 0.04 mg/kg.
7. Consider SODIUM BICARBONATE 1.0 mEq/kg IVP/IO with suspected hyperkalemia, profound acidosis, tricyclic antidepressant, cocaine, or diphenhydramine overdoses. Dose may be repeated at 0.5 mEq/kg every 10 minutes.

<b>N.B.</b> CONSIDER DEXTROSE 25% 2 ML/KG IV or IO IF CLINICALLY INDICATED; MAY BE REPEATED ONCE.  CONSIDER NALOXONE 0.1 MG/KG IV, ET, OR IO IF CLINICALLY INDICATED.
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## MEDICAL CONTROL OPTIONS

- DEFIBRILLATE at 2 - 4 Joules/kg; repeat as indicated
- EPINEPHRINE 1:1,000 (0.1 mg/kg.) IV or IO may be repeated every 3 - 5 minutes. ET dose of EPINEPHRINE is 1:1,000 0.1 mg/kg.

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## **PROTOCOL 14      PULSELESS ELECTRICAL ACTIVITY (PEA)**

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1. Initiate Routine Medical Care.
2. Advanced airway control.
3. If hypovolemia or tension pneumothorax is present, refer to the appropriate protocol.
4. EPINEPHRINE 1:10,000 1.0 mg (10 ml) IV, ET, or IO; may be repeated every 3 minutes.
5. If no response to initial dose of EPINEPHRINE, IV fluid challenge of Normal Saline by rapid infusion. May be repeated as needed.
6. If absolute bradycardia of < 60 BPM, ATROPINE 1.0 mg. IV, ET, or IO; may be repeated every 3 minutes to a maximum of 0.04 mg/kg.
7. Consider TRANSCUTANEOUS PACING if clinically indicated.
8. Consider SODIUM BICARBONATE 1.0 mEq/kg IVP with suspected hyperkalemia, profound acidosis, tricyclic antidepressant, cocaine, or diphenhydramine overdoses. Dose may be repeated at 0.5 mEq/kg every 10 minutes.

<b>N.B.</b>	CONSIDER DEXTROSE 50% 50 ML IVP IF CLINICALLY INDICATED; MAY BE REPEATED ONCE.
	CONSIDER NALOXONE 2MG IV, ET, OR IO IF CLINICALLY INDICATED.
	CONSIDER FIELD TERMINATION OF RESUSCITATION EFFORTS (PROTOCOL # 15).

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### **MEDICAL CONTROL OPTIONS**

- ATROPINE 0.5 – 1.0 mg rapidly IV, ET, or IO.
- DOPAMINE 400 mg in 250 ml Normal Saline; initiate drip at 5 - 10 mcg/kg/min. If there is insufficient improvement in status, the infusion may be titrated upward every 5 minutes in increments of 5 mcg/kg/min until desired therapeutic effect (max. 25 mcg/kg/min).
- CALCIUM CHLORIDE 250 – 500 mg IVP; may be repeated to a maximum of 1.0 gm. Only indicated with hyperkalemia, hypocalcemia, or calcium channel blocker toxicity.



# **PEDIATRIC PROTOCOL 14a PULSELESS ELECTRICAL ACTIVITY (PEA)**

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1. Initial Routine Medical Care.
2. Advanced airway control.
3. If hypovolemia or pneumothorax is present, refer to the appropriate protocol.
4. EPINEPHRINE 1:10,000 0.01 mg/kg IVP or IO; may be repeated every 3 minutes. ET dose of EPINEPHRINE is 1:1,000 0.1 mg/kg.
5. If no response to an initial dose of EPINEPHRINE, IV or IO fluid challenge of 20 ml/kg Normal Saline and may be repeated as needed.
6. Consider SODIUM BICARBONATE 1.0 mEq/kg IVP/IO with suspected hyperkalemia, profound acidosis, tricyclic antidepressant, cocaine, or diphenhydramine over-doses. Dose may be repeated at 0.5 mEq/kg every 10 minutes.

<b>N.B.</b> CONSIDER DEXTROSE 25% 2 ML/KG IVP IF CLINICALLY INDICATED.  CONSIDER NALOXONE 0.1 MG/KG IVP IF CLINICALLY INDICATED.
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## **MEDICAL CONTROL OPTIONS**

- Fluid Challenge of Normal Saline 10 – 20 ml/kg
- ATROPINE 0.02 mg/kg (minimum dose 0.1 mg) rapidly IV or IO. ET dose is 0.04mg/kg.
- TRANSCUTANEOUS PACING
- DOPAMINE infusion: starting at 5 mcg/kg/min.
- EPINEPHRINE infusion; starting at 0.1 to 1.0 mcg/kg/min.
- CALCIUM CHLORIDE 20mg/kg IV/IO.



## **PROTOCOL 15**      **FIELD TERMINATION OF RESUSITATION EFFORTS**

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### **MEDICAL CONTROL OPTION ONLY**

WITH RARE EXCEPTIONS, RESUSCITATION EFFORTS SHOULD CEASE IF THE FOLLOWING CRITERIA HAVE BEEN MET:

1. Non-traumatic adult cardiac arrest.
2. Achieved airway control with tracheal intubation or advanced airway device, confirmed proper tube placement, and secured tube to prevent dislodgement.
3. Achieved effective oxygenation and ventilation.
4. Shocked VF when present.
5. Gained access to circulatory system and administered EPINEPHRINE (or VASOPRESSIN), ATROPINE, and antiarrhythmics as appropriate.
6. Considered, searched for, and corrected reversible causes or special resuscitation circumstances.
7. Considered continuous and documented pulseless arrest after all of the above has been accomplished for 20 - 30 minutes.

### **EXCLUSIONS**

1. PROFOUND HYPOTHERMIA.
2. TOXIN OR DRUG INGESTION.
3. COMMUNICATION FAILURE.
4. ENVIRONMENTAL SITUATION NOT CONDUCIVE TO TERMINATION.

**IF THE PATIENT MEETS THE ABOVE CRITERIA MEDICAL CONTROL WILL BE CONTACTED FOR THE FOLLOWING OPTIONS:**

- Termination of resuscitative efforts. Leave all tubes and lines in place.
- Transport of the body, if:
  - a) Arrest in public place.
  - b) No police agency is present.
  - c) Family request.
- Grief Counseling.

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**NOTE**      POLICE ARE TO NOTIFY THE MEDICAL EXAMINER.